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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD
AGENDA

1.00 pm	Wednesday, 27 January 2016	Committee Room 2 - Town Hall

Members: 12, Quorum: 5

BOARD MEMBERS:

Elected Members:	Cllr Wendy Brice-Thompson (Chairman) Cllr Meg Davis Cllr Roger Ramsey
Officers of the Council:	Cheryl Coppell, Chief Executive Isobel Cattermole, Interim Deputy Chief Executive, Children, Adults and Housing Susan Milner, Interim Director of Public Health Phillipa Brent-Isherwood, Head of Business and Performance
Havering Clinical Commissioning Group:	Dr Atul Aggarwal, Chair, Havering Clinical Commissioning Group(CCG) Dr Gurdev Saini, Board Member Havering CCG Conor Burke, Accountable Officer, Havering CCG Alan Steward, Chief Operating Officer, Havering CCG
Healthwatch:	Anne-Marie Dean, Healthwatch Havering
	John Atherton, NHS England

For information about the meeting please contact:
Lorna Spike-Watson 01708 434029
Lorna.spikewatson@havering.gov.uk

What is the Health and Wellbeing Board?

Havering's Health and Wellbeing Board (HWB) is a Committee of the Council on which both the Council and local NHS and other bodies are represented. The Board works towards ensuring people in Havering have services of the highest quality which promote their health and wellbeing and to narrow inequalities and improve outcomes for local residents. It will achieve this by coordinating the local NHS, social care, children's services and public health to develop greater integrated working to make the best use of resources collectively available.

What does the Health and Wellbeing Board do?

As of April 2013, Havering's HWB is responsible for the following key functions:

- Championing the local vision for health improvement, prevention / early intervention, integration and system reform
- Tackling health inequalities
- Using the Joint Strategic Needs Assessment (JSNA)and other evidence to determine priorities
- Developing a Joint Health and Wellbeing Strategy (JHWS)
- Ensuring patients, service users and the public are engaged in improving health and wellbeing
- Monitoring the impact of its work on the local community by considering annual reports and performance information

1. **WELCOME AND INTRODUCTIONS**

The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

2. **APOLOGIES FOR ABSENCE**

(If any) – receive.

3. **DISCLOSURE OF INTERESTS**

Members are invited to disclose any pecuniary or personal interests in any of the items on the agenda at this point of the meeting.

Members may still disclose any pecuniary interest in any item at any time prior to the consideration of the matter.

4. **MINUTES OF LAST MEETING AND MATTERS ARISING** (Pages 1 - 6)

To approve as a correct record the minutes of the Committee held on 11 November 2015 (attached) and to authorise the Chairman to sign them.

5. **ACTION LOG** (Pages 7 - 8)

To consider the Board's Action Log (attached).

6. **CHANGES TO BOARD MEMBERSHIP** (Pages 9 - 12)

Report attached.

7. **END OF LIFE STRATEGY** (Pages 13 - 34)

- Dr Gurdev Saini and Dr Jacqui Lindo (report and strategy attached).

8. **ACCOUNTABLE CARE ORGANISATION** (Pages 35 - 42)

Update from Keith Cheeseman (report attached).

9. **HEALTH AND WELLBEING BOARD TERMS OF REFERENCE AND STRATEGIC PRIORITIES** (Pages 43 - 90)

For discussion.

(Existing Terms of Reference and Joint Health and Wellbeing Strategy attached).

10. **HEALTH PROTECTION FORUM ANNUAL REPORT** (Pages 91 - 118)

Attached for noting.

11. **FORWARD PLAN**

12. **DATE OF NEXT MEETING**

23 March 2016, CR2, 1 pm – 3 pm

(NB a Health and Wellbeing Board 'development session' is scheduled for 17 February 2016).

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MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD
Committee Room 2 - Town Hall
11 November 2015 (1.00 - 3.00 pm)

Present:

Board Members Present:
Councillor Steven Kelly (Chairman) **(SK)**
Cheryl Coppell – CEO, LBH **(CC)**
Isobel Cattermole, Deputy Chief Executive of Children's, Adults and Housing, LBH **(IC)**
Councillor Meg Davis – Cabinet Member – Children & Learning, LBH **(MD)**
Dr Gurdev Saini, Clinical Director, Havering CCG **(GS)**
Anne Marie Dean, Chairman Healthwatch Havering, **(AMD)**

Officers Present:
Phillipa Brent-Isherwood, Head of Business and Performance **(PB)**
Deborah Redknapp – Head of Public Health Commissioning (interim) **(DR)**
Mary Phillips, Head of Learning and Achievement, LBH**(MP)**
Jade Fortune – Public Health Strategist **(JF)**
Mark Ansell – Consultant in Public Health, LBH **(MA)**
Brian Boxall, Chair of Safeguarding Adults and Children's Boards **(BB)**
Tim Aldridge, Assistant Director Children's Services, LBH **(TA)**
Elaine Greenway – Acting Consultant in Public Health, LBH **(EG)**

Lorna Spike-Watson, Acting PA to Interim Director of Public Health (minutes)

Guest
Clare Burns, Deputy Chief Operating Officer, Havering CCG **(CB)**

The Chairman reminded Members of the action to be taken in an emergency.

15 **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman advised of arrangements in case of fire or other event that would require evacuation from the meeting room.

16 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from:

Dr Atul Aggarwal, Chair, Havering CCG
Alan Steward, Chief Operating Officer, Havering CCG *(representative Clare Burns)*

Conor Burke, Accountable Officer, Barking & Dagenham, Havering and Redbridge CCGs

Susan Milner, Interim Director of Public Health LBH (*representative Elaine Greenway)*

John Atherton, Head of Assurance North Central and East London, NHS England

17 DISCLOSURE OF PECUNIARY INTERESTS

No pecuniary or personal interests were disclosed.

18 MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 19th August 2015 were agreed as a correct record and signed by the Chairman.

19 MATTERS ARISING

There were no matters arising. It was agreed to vary the order of the agenda items.

20 SAFEGUARDING ADULTS AND CHILDREN'S BOARDS

The Chair of the Safeguarding Adults and Children's Boards, BB, presented his reports (previously circulated).

Clarifications were sought on the following content of the Adult Safeguarding Report:

IC expressed concerns regarding why there had been a marked increase in domestic violence offences, and what actions were being taken to address the increase. PB explained that the eligibility definition had changed, and now includes 16 and 17 year olds, and that safeguarding also now includes emotional abuse. However the projected activity had not been increased accordingly. Havering partners continue to address the issues, with action that includes delivering a multi-agency Violence Against Women and Girls Strategy, which reports to the Safeguarding Board. A conference on Safeguarding was due to take place in November, which will include the topic of domestic violence, and will result in a multi-agency action plan.

Action: Following the conference, BB will circulate the action plan to Health and Wellbeing Board members

SK raised general concern as to how the Safeguarding Boards will meet their statutory duties in relation to prevention of abuse, raising awareness, and involving the community. BB advised that:

- A group comprising communities and voluntary sector has been established that will contribute to raising awareness and involve the community. A community development day is planned,

Action: BB will circulate information to HWB members in December on outcomes from the Development Day

There continued further discussions on matters contained in the Safeguarding Adults report

- There had been a strengthening of arrangements, such as working with the Council Housing Service
- Learning from Serious Case Reviews (Adults) will support a greater understanding of risks and how to improve the local response.

There was a discussion about the Multi-agency Safeguarding Hub (MASH) for adults:

- That there was to be a review of the MASH processes, which will consider
  improvement in the quality of information included in the referrals
- That Probation Services had withdrawn from the MASH

Actions:

- **BB to share the SACB action plan with the board to ensure that all partners are delivering the agreed actions.**
- **BB to raise with London Safeguarding Boards Chairs Group that Probation Services are withdrawing from local MASH**
- **IC to raise the issue of Probation Services and MASH with the Directors Group**
- **CC to raise the issue of Probation Services and MASH with London Councils**

The following were highlighted from the Safeguarding Children's Report:

- Havering was one of the most effective boroughs for identifying Child Sexual Exploitation.
- There could be improvement in the quality of information included in the referrals
- There had been an increase in numbers of child protection conferences
- The demographic changes in the borough had contributed to the increasing numbers of Looked After Children

CC highlighted increased demographic pressures. There is an overspend of £1m on Children's Services.

It was noted that both IC and TA were currently undertaking a review of children services to gain a better understanding of the pressures experienced by the services, and assurance that these of being managed.

The Board noted the reports.

21 HEALTHWATCH ANNUAL REPORT

AMD presented highlights from the report (previously circulated with the agenda papers). The report was noted.

Action: presentation slides to be circulated

22 CCG COMMISSIONING INTENTIONS FOR CHILDREN AND YOUNG PEOPLE

CB gave a presentation, and highlighted that the CCG had two main priorities: Looked After Children health checks (assessments), and equipment for children with special needs.

There was a discussion on Looked After Children's health checks. CB explained that late delivery of health assessments was a major issue, and that a written plan was being prepared describing how the backlog of health assessments will be cleared by end December and on-going assessments will be delivered on time. It was noted by the Board that the same pressures experienced by MASH and increased child protection cases were also affecting arrangements for Looked After Children health checks, with an increase in numbers of Looked After Children.

Clarification was sought on whether the plan will include consideration of Looked After Children placed in the Borough from outside the Borough. CB confirmed that the plan would include this information.

Clarification was sought on the quality of the health checks. CB explained that CCG now has a lead doctor for Looked After Children who ensures standards of quality, and that some GPs also specialise in paediatrics.

The Board noted the presentation.

Action

- **CB to circulate the written plan to HWB members during week ending 20 November**
- **CB to circulate Children's Equipment Plan**
- **Presentation slides to be circulated**

23 HEALTH OF HAVERING'S LOOKED AFTER CHILDREN

DR presented highlights from a report (previously circulated with the agenda papers).

Actions:

- **DR to consider the CCG Looked After Children Health Check Plan, and identify any recommendations from her report that have not**

been taken into account by CCG Plan, and assess the significance of any not included

- **TA / DR to feedback to the next Health and Wellbeing Board Meeting regarding the backlog for Initial Checks of Health Assessments being on track to be cleared.**

24 UPDATE ON TRANSFER OF THE HEALTH VISITOR SERVICE

MA presented highlights from a report (previously circulated with the agenda papers).

The Chair and members of the Board raised serious concerns about funding and transfer arrangements of the health visitor service, including the implications for effective safeguarding of under 5s:

- The reduction in Public Health Grant, which means that the mandated health visitor service cannot be delivered.
- Whereas inner London local authorities are experiencing a reduction in numbers of Looked After Children, local authorities such as Havering are experiencing increases in numbers, and yet there is no scope for readjustment of the funding formula
- Although the government had aimed for a rapid growth in health visitor numbers, NELFT had not been able to recruit sufficient despite best attempts. This meant that health visitors caseloads were even higher, and far above national recommendations
- There remains a query about succession planning for health visitors, including responsibilities for training new health visitors.
- That the service specification transferred to the Council in October did not reflect latest practice (Ages and Stages Questionnaire) – adoption of best practice would reduce performance against mandated elements of the service specification
- That the extra numbers of Looked After Children have created additional pressures on the health visitor service, including participation in case conferences, and undertaking follow up health reviews etc

In the light of these serious issues, the Board agreed that Havering should seek advice on a Judicial Review of the Department of Health's decision to reduce public health grant funding.

Actions

- **BB, DR, TA and MA to write a technical report of the issues and submit to IC by 20 November**
- **IC to request that LBH Legal Team engage specialist counsel by Christmas**

25 ACO UPDATE

CC presented highlights from a previously circulated presentation and informed the meeting that Confirmation on the outcome for the Accountable

Care Organisation Pilot applications would be formally announced by the end of 2015.

26 **CQC/OFSTED INSPECTION UNDER THE CHILDREN AND FAMILIES ACT**

MP presented highlights from a report previously circulated with the agenda and MP highlighted that the inspection would focus on how the area meets local needs according to the requirements of the Children and Families Act, not an individual agency.

The Chair thanked all presenters for their reports.

27 **DATE OF NEXT MEETING**

27th January 2016

Chairman

HWB Formal Board - ACTION LOG

Date Raised	Owner	Brief Description	Action to be taken	Date for completion	Chased date	Completed	Comments
Chairman's Briefing 01/04/2015	Sue Milner	Scoping Paper	Need to reframe and review Board priorities as delivery and performance needs to be measured. More focus on prevention required. HWB Strategy needs to be overarching. ½ day workshop to be arranged to flesh out.	13 May and 2 June mtgs		Yes	Review of HWB on hold pending outcome of local devolution discussions.
01 April 2015	Sue Milner	Primary Prevention	To be centrally focused – SM will produe presentation			Yes	
01 April 2015	Sue Milner	JSNA	How can we make this into a more user friendly / "live" - possibly Dashboard?			Yes	
01 April 2015		Affordable Housing and Mental Health	Agenda items to be added to Forward Plan.	April		Yes	
01 April 2015		Bi-monthly Board and Development Sessions	Board mtgs to take place bi-monthly, with a Development Session on alternative months. First Development Session mtg scheduled for May - agenda items will be Mental Health and Re-visiting priorities. Chairman's Briefing mtgs will continue to be held 2wks before Board mtgs.			Yes	
Development Session 13/05/2015	Cllr Kelly	Next Meeting	Cllr Kelly requested that the next meeting of the HWB, scheduled for 16 June, be used as a private meeting to continue our review of the role and function of the HWB			Yes	
13 May 2015	Sue Milner	Forward Plan	The Forward Plan has been amended to cover all HWB-related meetings. This will provide a complete overview of what is being scheduled where. Any additions/deletions/errors to Sue Milner and c.c. in Agatha Williams (Clerk).			Yes	
13 May 2015	Cllr Kelly	Distribution List	Distribution list to be reviewed to ensure that only HWB members, their PAs and appropriate LBH support officers are included.	18-May		Yes	
13 May 2015		Agenda Items / Themes	12 August should have a Mental Health theme. 8 July HWB development session will be used as an opportunity to look at mental health issues in more depth in preparation for the board meeting and any formal decisions that the board has to make. We need to start pulling the programme together for the development session and identify any items that need to go to the formal board. All ideas and suggestions for what should be covered under this theme to Sue Milner by CoP 29 May			Yes	
19-Aug-15	Alan Steward	Paper	AS to bring to a future Health and Wellbeing Board the "Stroke Services: Case for Change" paper.	TBC			
19-Aug-15	Sue Milner	Forward Plan	SM to take off the topic of Health Visiting from the forward plan.	Immediately		Yes	
19-Aug-15	Alan Steward, Mary Phillips, Debbie Redknapp	Governance of CYP MH issues	A single governance structure to be established to deal with all aspects of CYP MH service commissioning and provision. A TFG initially set up and then combine with Adults MH Partnership Board.	Dec-15			TFG to be set up ASAP
11-Nov-15	Brian Boxall	Safeguarding board action plan	Circulate Safeguarding board action plan to Health and Wellbeing Board members and will also provide outcomes from the Development Day by 3rd week in December, information to be fed back by IC.	Dec-15			
11-Nov-15	Isobel Cattermole, Brian Boxall, Clare Burns	Safeguarding identifying areas for improvement	Agree a process for identifying if there are areas of the borough failing.	Dec-15			
11-Nov-15	Cheryl Coppel, Isobel Cattermole and Brian Boxall	Raise the issue of Probation Services and MASH with the key partners	Raise the issue of Probation Services and MASH with the London Safeguarding Boards Chairs Group, Directors Group and London Councils	Dec-15			
11-Nov-15	Anne Marie Dean	Healthwatch Annual Report	Circulate presentation slides to Health and Wellbeing Board members	Dec-15			
11-Nov-15	Clare Burns	CCG Commissioning intentions for children and young people	Circulate the CCG Commissioning Intentions and Children's Equipment plans to Health and Wellbeing Board members	Dec-15			
11-Nov-15	Tim Aldridge, Deborah Redknapp	Health of Looked After Children	Provide an update to the Health and Wellbeing Board on the backlog for initial checks of health assessments	Dec-15			
11-Nov-15	Brian Boxall, Deborah Redknapp, Tim Aldridge, Mark Ansell, Isobel Cattermole	Transfer of Health Visitor Service	Provide a technical report of issues to Isobel Cattermole - IC to discuss with LBH Legal Team re engagement of specialist counsel	Dec-15			

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Havering
LONDON BOROUGH

HEALTH AND WELLBEING BOARD

27 January 2016

Subject Heading:	**Changes to Board Membership**
CMT Lead:	Daniel Fenwick, Director of Legal and Governance Daniel.fenwick@onesource.co.uk 01708 432714
Report Author and contact details:	Anthony Clements, Principal Committee Officer 01708 433065 anne.brown@onesource.co.uk
Policy context:	The Leader of the Council is authorised to make changes to Council nominations on the Board as appropriate
Financial summary:	No implications.

The subject matter of this report deals with the following Council Objectives

Havering will be clean and its environment will be cared for	[]
People will be safe, in their homes and in the community	[]
Residents will be proud to live in Havering	[X]

SUMMARY

The report asks the Board to note some changes to the Council representatives on it and to thank the previous Chairman for his service in the role.

RECOMMENDATIONS

It is recommended that the Health and Wellbeing Board:

1. Note that Councillor Steven Kelly has ceased to be Chairman and a member of the Board with immediate effect and that Councillor Brice-Thompson is the new Chairman of the Board.

2. Note that Councillor Roger Ramsey has joined the Board, also with immediate effect.

3. Record its thanks to Councillor Steven Kelly for his past work as Chairman of the Health and Wellbeing Board.

REPORT DETAIL

1 Under the Constitution of the Council, the Leader of the Council has the right to appoint the Councillor representatives (including the Chairman) on the Health and Wellbeing Board. Such notification has recently been received that Councillor Wendy Brice-Thompson will, with immediate effect, be appointed as Chairman of the Health and Wellbeing Board, replacing Councillor Steven Kelly, who has left the Board. The Leader of the Council – Councillor Roger Ramsey, will also become a member of the Board, with immediate effect. Councillor Meg Davies will continue in her role as a member of the Board.

2 Health and Wellbeing Board members are therefore asked to note the changes to Council representation on the Board and consider if they wish to record their thanks to Councillor Steven Kelly for his work as the previous Chairman.

IMPLICATIONS AND RISKS

Financial implications and risks:

None.

Legal implications and risks:

Under paragraph 16(b) of the Committee Procedure Rules of the Council's Constitution, the Leader of the Council has the right to appoint the Chairman of the Health and Wellbeing Board, along with other Councillor representatives.

Human Resources implications and risks:

None

Equalities implications and risks:

None.

BACKGROUND PAPERS

None.

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Havering
LONDON BOROUGH

Agenda Item 7

HEALTH & WELLBEING BOARD

Subject Heading:	Havering End of Life Care Strategy 2016 -2019
Board Lead:	Dr Gurdev Saini, Clinical Director, Havering CCG
Report Author and contact details:	Dr Jacqui Lindo, Havering Public Health Service Jacqui.lindo@havering.gov.uk 01708 431789

The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- ☐ Priority 1: Early help for vulnerable people
- ☐ Priority 2: Improved identification and support for people with dementia
- ☐ Priority 3: Earlier detection of cancer
- ☐ Priority 4: Tackling obesity
- ☒ Priority 5: Better integrated care for the 'frail elderly' population
- ☐ Priority 6: Better integrated care for vulnerable children
- ☒ Priority 7: Reducing avoidable hospital admissions
- ☒ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

Nationally health and social care services for people with end of life care needs have improved considerably over recent years. As people live longer, and with the increasing prevalence of chronic conditions, it is essential that health and social care services collaborate further to meet the challenge of planning and delivering high quality palliative and end of life care for increasing numbers of patients and clients in Havering.

This strategy provides a vision and direction for service planning and delivery, and will be implemented by the Havering End of Life (EoL)

Steering Group. This group consists of representatives from all relevant stakeholders including clinicians; health and social care providers; commissioners and independent and voluntary organisations. The group reports into the BHR Integrated Care Coalition to which regular performance reports will be taken.

The purpose of the strategy is to improve the quality of the care that people (their carers and families) receive when they are approaching the end of their lives by embedding within commissioned services the principles of the national End of Life Care strategy.

In Havering a significant number of people die in hospital rather than at home if the cause of death is not due to cancer; this gap needs to be reduced.

This strategy builds upon a large amount of work that has already been undertaken in Havering, for example, implementation of Gold Standards Framework (GSF) training, the development of a standardised 'Do not resuscitate(DNR) form and the use of electronic EoL Care Plans; the work of existing services such as the local hospices; general practice; and community services.

RECOMMENDATIONS

The Board is being asked to

1. Discuss and comment on the strategy
2. To confirm the governance arrangements for 'sign off' and reporting.

Havering
LONDON BOROUGH

NHS
Havering Clinical Commissioning Group

End of Life Care Strategy

Promoting high quality integrated care for all Havering residents

2016-2019

Author/s	Dr Jacqui Lindo, Consultant in Public Health Dr Laidon Shapo, Senior Public Health Strategist
Acknowledgments	**Task & Finish group** Havering CCG: Dr Gurdev Saini, Bob Barr. Havering Local Authority : Dr Jacqui Lindo, Syed Rahman, Jenny Gray Havering EoL steering group: Amanda Young (NELFT), Rachael Chapman (M.Curie) and Cathy Mansfield (SFH) BHR – EoL steering group: Carla Morgan, Kirsty Boettcher
Implementation date	2016
Expiry date	2019
Responsibility for Implementation	Havering EoL Steering Group
Links with other documents	Havering H&WBB Strategy This is Havering – JSNA chapter http://www.haveringdata.net/research/jsna.htm. DH 2008 End of Life Care Strategy ..\..\End-of-Life-Care-Strategy-Fourth-Annual-report-web-version-v2[1].pdf Ambitions to Palliative and End of Life Care ..\Background papers\Ambitions-for-Palliative-and-End-of-Life-Care.pdf Paediatric palliative care Paediatric Palliative Care NHS Standard Contract Havering CCG Commissioning Plan ..\..\HAVERING CCG COMMISSIONING STRATEGIC PLAN 20142015.pdf

Version Control

Version	Author (A) Reviewer (R)	Issue Date	Reason for change
Draft 1-2	Laidon Shapo (A) Dr Jacqui Lindo (R) PH team and HCCG - as part of T&F group (R)	(v.1) 28/08/2015 (v.2) 10/09/2015	Changes made after comments from Dr J.Lindo and the working team
Draft 3	Laidon Shapo (A) Dr Jacqui Lindo (R) Dr Saini / Bob Barr/ Amanda Young (R)	(v.3) 25/09/15	Submitted for comments to Dr J.Lindo and the Task & Finish group
Draft 4	Laidon Shapo (A) Dr Jacqui Lindo/ Bob Barr/A.Young/Claire (R)	(v.4) 6/10/15	Comments from Jacqui Lindo, A.Young, B.Barr and C. Mansfield
Draft 5	Laidon Shapo (A) & Dr Jacqui Lindo(A)	(v.5) 9/10/15	Comments EoLC steering group
Draft 6	Dr Jacqui Lindo (A) T&F Group (R)	(v.6) 9/11/15	Submitted for comments to T&F group
Draft 7	Dr Jacqui Lindo (A) Bob Barr & Dr Saini (R)	(v.7) 8/12/15	Comments from Dr Saini
Draft 8	Dr Jacqui Lindo (A) Bob Barr & Dr Saini (R)	(v.8) 4/1/16	
Darft 9	Dr Jacqui Lindo (A) HWBB (R)	(v.9) 27/1/16	

Contents

1. Foreword

In England, about 1,300 people die every day. Around 900 of them will have wanted to die at home, but less than half will do so. Some 975 may have needed palliative care to relieve suffering but 469 will not have received it (Dying Matters Coalition 2010). About 25% of all hospital beds are occupied by someone who is dying. The National Audit Office estimates that at least 40% of those people have no medical need to be there.

People's preferences regarding place of death were summarised within the 2008 National End of Life Care Strategy, in that "most people would prefer to be cared for at home, as long as high quality care can be assured and as long as they do not place too great a burden on their families and carers". Despite this the acute hospital remains the most frequent place of death (54%) for 2,195 people that die every year in Havering.

We know that where a patient has a plan in place, and everyone who is involved in the care of that patient knows about that plan, he/she is much more likely to die in their preferred place. Good community support can realise 70% of deaths at home and halve unplanned hospital admissions (National Council for Palliative Care/Dying Matters Coalition 2011). In order to achieve this, a cultural and behavioural shift in how end of life care is perceived and in how it is delivered is required.

The overall aim of this strategy is to raise the profile and importance of choices in death and dying across all care settings, cancer and non-cancer conditions and across all age groups.

Key stakeholders make up the membership of the Havering End of Life Steering Group, and we are committed to ensuring that the people of Havering have access to high quality end of life care, irrespective of their condition, or where they live.

2. Executive Summary

A working definition for End of Life Care has been developed by the National Council for Palliative Care (2009):

> End of life care is care that helps all those with advanced, incurable conditions to live as well as possible in the last year of life. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes physical care, management of pain and other symptoms and provision of psychological, social, spiritual and practical support.

It applies to people who are likely to die within the next 12 months"[1] as a result of

- advanced, progressive, incurable conditions (including children and young people)[2]
- general frailty
- existing conditions if they are at risk of dying from a sudden acute crisis
- life-threatening acute conditions caused by sudden catastrophic events

It can be identified by using the 'trigger' question – 'would I be surprised if this patient died within the next 12 months?'

Nationally health and social care services for people with end of life care needs have improved considerably over recent years. As people live longer, and with the increasing prevalence of chronic conditions, it is essential that health and social care services collaborate further to meet the challenge of planning and delivering high quality palliative and end of life care for increasing numbers of patients and clients in Havering.

This strategy provides a vision and direction for service planning and delivery, and will be implemented by the Havering End of Life Steering Group. This group consists of representatives from all relevant stakeholders including clinicians; health and social care providers; commissioners and independent and voluntary organisations.

This strategy builds upon a large amount of work that has already been undertaken in Havering, for example, implementation of Gold Standards Framework (GSF) training, the development of a standardised DNR form and the use of electronic EoL Care Plans; the work of existing services such as the local hospices; general practice; and community services.

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1 NICE . Guide for Commissioners for End of Life Care. 2011.
Available at: https://www.nice.org.uk/guidance/cmg42#12-defining-end-of-life

2 2008 End of Life Care Strategy – promoting high quality of care for all adults at the end of life.

The improvement in service delivery that is expected from this strategy will require ownership and leadership from across the system in partnership with patients, carers and the public. This strategy acknowledges the importance of current collaborative arrangements between the statutory, community and voluntary sector agencies; and recognises that going forward these arrangements need to be strengthened through local and regional strategic planning.

The key objectives of this strategy are to embed the recommendations from the National Palliative and EoL Care Partnership ambitions framework[3]. This framework builds on the 2008 Department of Health (DH) Strategy for EoL Care and the improvements and changes that have followed since.

Strategic Objectives

Ensure each person approaching end of life is seen as an individual

Ensure that each person gets fair access to care

Improve care planning and maximise patients' comfort and wellbeing

Have co-ordinated care across the health and social care system

Ensure services are prepared and offer high quality care Ensure we build compassionate and resilient communities that will cope better and help each other in times of crisis and loss

[3] Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020. www.endoflifecareambitions.org.uk

3. Introduction

This strategy was developed in collaboration with Havering statutory and voluntary partners and local stakeholders, and sets out a vision for high quality care across Havering for all adults and children approaching the end of life.

This local strategy reflects national and local policies including the National End of Life Care Strategy 2008 and Ambitions for Palliative and End of Life Care: A national framework for local action (2015 -2020).

The purpose of this strategy is to respond locally to both national and local drivers for change, and to commission and develop services for patients with end of life care needs, regardless of diagnosis.

This strategy will be implemented through the End of Life Steering Group and will report to the Havering Clinical Commissioning Group (HCCG) and the Havering Health and Wellbeing Board (HHWBB).

4. National Context

Actions for End of Life Care: 2014-16 – sets out NHS England's commitments for adults and children. It is one component of a wider ambition to develop a vision for end of life care beyond 2015. This can only be achieved in partnership with all those in health and social care. The 2008 Strategy managed to reverse the upward trend of people dying in hospital. We now need to ensure that living and dying well is the focus of end of life care, wherever it occurs. This is the challenge: together we can and must achieve it.

The National Palliative and End of Life Care Partnership, made up of statutory bodies including NHS England, the Association of Directors of Adult Social Services, charities and groups representing patients and professionals, has developed a framework for action.

This framework is aimed at health, social care and community leaders. It builds on the Department of Health's 2008 Strategy for End of Life Care and responds to an increased emphasis on local decision making in the delivery of palliative and end of life care services since the introduction of the Health and Social Care Act 2012.

This national framework for action sets out six 'ambitions' – principles for how care for those nearing death should be delivered at local level. These have been adopted as our key strategic objectives.

5. Vision and Strategic Objectives to Deliver Improvements for End of Life Care

Building on the progress and work already undertaken locally, the vision for End of Life care will be to:

- Provide compassionate care that meets agreed national standards in a consistent and coordinated way for all Havering residents approaching the end of their life; and,
- Commission services that will enable and support our residents to live and die with dignity and in the place of their choice.

Strategic Objectives

Ensure each person approaching end of life is seen as an individual

Ensure that each person gets fair access to care

Improve care planning and maximise patients' comfort and wellbeing

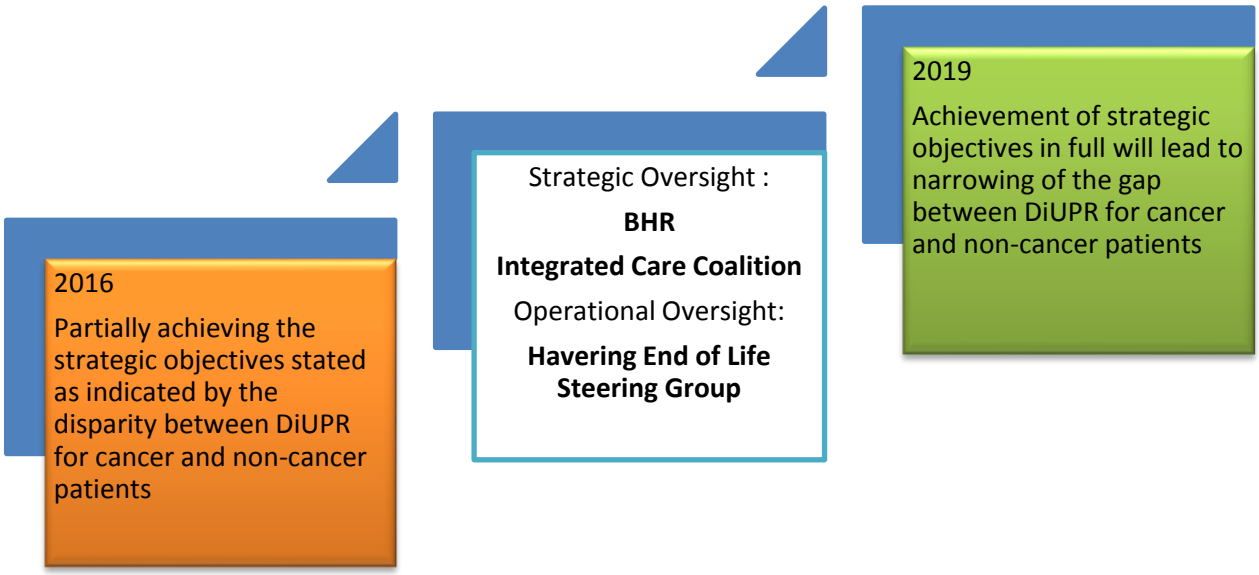
Have co-ordinated care across the health and social care system

Ensure services are prepared and offer high quality care Ensure we build compassionate and resilient communities that will cope better and help each other in times of crisis and loss

The scope of this strategy encompasses:

- Care provided in all settings (e.g. home, residential/care home, nursing home, hospice, acute hospital, prison or any other institution)
- Care provided to adults and children with any advanced, progressive, incurable illness
- Care given in the last year of life
- Patients (adults and children), carers, the public, family members and staff (including care after bereavement)

Fig. 1 Strategic Vision



6. Local Context

6.1. Commissioning End of Life Care

Currently, HCCG commissions all health based end of life care services in Havering. Contractual relationships exist with GPs, Barking Havering Redbridge University Trust (BHRUT), London Ambulance Service (LAS), St Francis Hospice, North East London Foundation Trust (NELFT) Community Health Services and PELC (out of hours service).

End of Life Care is a priority for Havering as reflected in the

- Havering Health and Wellbeing Strategy - to ensure informed choice on end of life care through robust information and guidance for patients and carers.

- HCCG commissioning plan (2014/15) - to improve end of life care through an integrated approach with the local authority using Integrated Case Management (ICM) and community nursing. This will include increasing identification of EoL patients and patients dying in their preferred place of choice, and fully implementing the Gold Standard Framework in all nursing homes and GP practices.

- Better Care Fund - to provide training for domiciliary care providers, long-term care homes, together with strengthening co-ordination of end of life care services.

- The BHR Integrated Care Coalition, established as an Advisory Board to oversee strategic change across health and social care, is supporting the development of a Frailty programme with the purpose of avoiding unnecessary hospital admissions including at the end of life.

6.2. Local Need

Key messages

- Havering has an ageing population. In the next ten years (2015-2025), we would expect an increase of 20% in those aged 5-10, 26% in those aged 11-17, 13% in those aged 65-84 and 25% in those over 85 years of age[4]. As the population ages there is an increase in the incidence of long term conditions and their complications; and consequent hospitalisations and need for palliative and end of life care.
- Fortunately deaths are uncommon in children and young people in Havering with the majority occurring during the neonatal period.
- Although one of the most ethnically homogenous places in London, Havering is expected to become more ethnically diverse with the proportion of BAME groups doubling from 5% (2015) to 10% in 2030. Approximately 1% of the population die in Havering each year (on average 2,195 people)[5]. On average mortality (rates) in Havering is lower than England and similar to London. The directly age-standardised rate of mortality from all causes for the period 2009-13 is 238 per 100,000 persons aged less than 75 years but with significant variation within borough. The major causes of death are cancers, circulatory diseases, and respiratory diseases.
- People in Havering are living longer, including those with learning difficulties. As a result many will have multiple co-morbidities including dementia, and so may have more complex palliative and EoL care needs.
- People with a Learning Disability make up an estimated 1-3% of the population. Whilst the EoLC needs of people with a learning disability may be no different from those of the general population, the way in which these needs are met should take account of this. Based on the Death in Usual Place of Residence (DiUPR) indicator measured over the period 2013-2015, more people are dying in their place of residence 40.2%, which equates to an 8.3% improvement. Based on this indicator it

4 This is Havering; a demographic and socioeconomic profile 2015

5 Based on the number of deaths over 3-year period (2011-2013) – 6,585 (Data source: ONS PCMD)

means that approximately 878 deaths occur in their usual place of residence and 1317 occur in hospital each year. There is also evidence that there is variation in DiUPR across wards in Havering.

- The national (VOICES) survey of bereaved people found that three out of four (75%) of bereaved people rate the overall quality of end of life care for their relative as outstanding or good; with 10% rated as poor. The relatives of people who died in hospital rated overall quality of care significantly worse than any other place of death. There is also evidence of significant variation in access[6] and quality of end of life care that people receive. [7] Havering has been selected for CQC End of Life Care fieldwork review[8] for 2015. The findings of this review will be used to update the implementation plan.
- GSF training is offered to all GP practices with 90% uptake at the time of writing. There was a 62% uptake of training provided by SFH to nursing homes. Work on the use of electronic EoL care plans is progressing and are accessible to local service providers. In addition a standardised DNR proforma has been locally agreed.

6.3 Current End of Life Care Provision

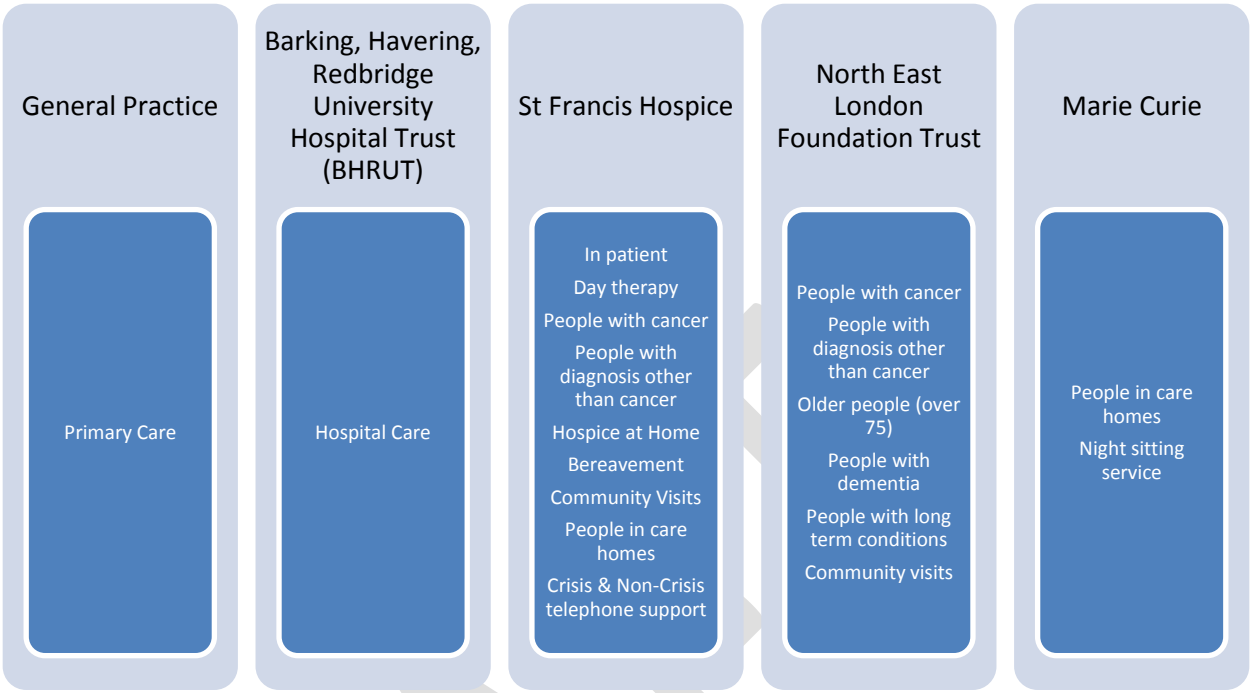
A synopsis of current arrangements is shown in the following diagram. Once patients are identified with EoLC needs they have access to a range of services that provide both urgent and supportive care at home, in the community and in hospital.

[6] Dixon J, King D et al .Equity in the Provision of Palliative Care in the UK: Review of Evidence.2015

[7] http://www.cqc.org.uk/sites/default/files/20150415%20Inequalities%20in%20EOLC%20project%20briefing%20updated.pdf

[8] http://www.cqc.org.uk/content/themed-review-end-life-care

Figure 2 Current End of Life Care Provision in Havering



7. Specific needs

7.1 End of Life Care for Children

Infants, children and young people with life-limiting conditions, including those who are approaching the end of their life, need high-quality treatment and care that supports them to live as well as possible and to die with dignity. Providing such treatment and care often involves decisions that are complex and emotionally distressing, especially towards the end of their lives.

Together for Short Lives[9] states that most adults only need palliative care at the end of their lives, but many infants, children and young people with life-limiting conditions need palliative care over a much longer period. During this time their condition may fluctuate and there may even be times when it is difficult to determine if death is imminent.

Those who are unlikely to be cured by treatment are offered palliative care. Palliative care for young people is not simply end-of-life care[10] but focuses on enhancing the quality of life.

[9] Together for Short Lives - A guide to end of life care

[10] Marie Curie Cancer Care and Together for Short Lives (2012).Don't let me down: ensuring a good transition for young people with palliative care needs.

7.2 End of Life care for people with a Learning Disability

Getting it right' for people with intellectual disabilities has huge advantages for palliative care services (or any other mainstream services). The skills needed to meet the norms in this White Paper are transferable. The way in which palliative care is provided for people with intellectual disabilities could thus be a benchmark for all service provision.

In addition there are a significant number of people with LD who live at home with elderly parents who have not ever been supported by services. When the elderly parent becomes terminally ill/dies the person with LD often has to be placed in extremely expensive placements, for they often lose their parent and their home at the same time, which is not helpful for the person with LD. If, when people are terminally ill and they have a vulnerable person they care for, it would be very useful for this to be highlighted so supportive services can be put in touch to assist the vulnerable person to make their loss and bereavement less painful and more planned.

7.3 End of Life Care for people from BAME groups

The available evidence suggests that people from Black, Asian and Minority Ethnic (BAME) groups are less likely to use/have access to end life care services[11]. Potential explanatory factors for the low uptake included lack of referrals, lack of knowledge about services or about what palliative care involves and religious traditions and family values in conflict with the idea of palliative/hospice care. Other factors included structural barriers such as geographical location of inpatient hospices and social segregation, previous bad experiences when in receipt of care.

This research found that ethnic monitoring was inconsistent so that it is difficult to make comparisons over time and to identify where specific needs are not being met. This report also highlighted the fact that BAME groups tend to be labelled 'hard to reach' with the implication that it is people from BAME groups that are not accessible rather than the service. There was also a lack of awareness that ethnicity is something that everyone possesses and that the professionals' beliefs and values underpin attitudes.

The Commission for Racial Equality[12] uses the term 'ethnic minorities', believing that cultural and religious differences are important. Thus there is a tendency to use the notion of 'ethnicity' rather than race in relation to common features such as language, religion and origin. Many religious groups will have their own philosophical and social systems. It is important to recognise the distinct differences in culture between people from different communities. Each situation is unique and will require creative and flexible responses. Staff

[11] Natalia Calanzani, Dr Jonathan Koffman, Irene J Higginson. Demographic profile and the current state of palliative and end of life care provision for Black, Asian and Minority Ethnic groups in the UK. King's College London, Cicely Saunders Institute June 2013

[12] Together for Short Lives - A guide to end of life care

must be prepared to acknowledge and respect an individual's beliefs and values, even though they may not understand or share them. It is helpful for staff to have some knowledge of the beliefs and rituals associated with death and dying, particularly in relation to issues immediately following death and in care of the body.

7.4 End of Life Care for people with Dementia

People with dementia who are dying should have the same access to end of life care services as those without dementia. However, treatment decisions for people with dementia differ from decisions for other people approaching end of life because:

- The time from diagnosis to death is usually much more difficult to predict and dementia may last several years, or just days because of concurrent illness.
- The deterioration in communication skills for people with dementia prevents them from expressing their views and wishes later in the disease pathway.

It is important that people with dementia and their carers receive information and support that helps them think and plan early for future care. Therefore, health and social care providers should ensure that early diagnostic and assessment services for people with dementia are available, and that they provide good quality information about dementia.

A considerable transformation programme in relation to the diagnosis and treatment of those with dementia in Havering is currently underway, with the implementation of a memory screening clinic and an ageless dementia service. Refocusing services to enable more diagnosis, treatment, care and support in primary and community services requires a trained workforce[13]. End of life care will of course be pivotal to these work streams.

7.5 Bereavement Support

It is well recognised that the period in which EoLC is needed ranges from a few years to a matter of months, weeks or days, and into bereavement[14].

People closely affected by a death should feel that information and support was available to them around the time of death and afterwards, which was appropriate for them and offered at the right time. As such partners involved in the delivery of EoLC need to ensure that there are accessible bereavement support that includes sensitive communication and provision for

[13] Joint Havering Dementia Strategy 2014

[14] NHS England. Actions for End of Life Care: 2014-16

immediate and on-going emotional and spiritual support appropriate to their needs and preferences.

Bereavement support is provided but there is evidence of variation in access[15] and quality[16] and we need to improve the local offer to patients, carers and families in Havering.

8. Issues for consideration

8.1 Financial

Achieving the aims and objectives of this strategy requires a re-examination of the financial investment in end of life care. To advance a strategic approach to investment there must be greater engagement in discussion about death and dying across the Havering population; improved communication; better provision of operational and financial information; the establishment of an end of life pathway; improved community based end of life care and support; and greater IT interaction to identify and support the coordination of care to end of life patients. This approach will enable service gaps to be filled and duplication of response to be removed, leading to more efficient use of resources.

8.2 Demography

The need for ever improving and more cost efficient end of life care is further highlighted by the Havering population projections, particularly in the over 65 age group. As the population lives longer, the proportion of people with various long term conditions continues to rise and the End of Life Care pathway needs to adjust to these changes appropriately.

The services implementing the strategy will take account of the increasing ethnic diversity of people in Havering and the considerable life expectancy variations between the most affluent and most deprived parts of the borough.

8.3 Public Awareness

In current UK culture, death and dying are not widely talked about. This is to the detriment of people with dementia. If death and dying were more widely discussed, and planning for end of life was routine practice among the general public, there would be clear plans in place so that most people would not reach the end of their lives and not have their wishes known. The national strategy recognises that as a nation we face multiple challenges in responding to the needs and preferences of people who are approaching death. Focus is therefore clearly placed on improving and changing the way in which we respond to end of life care and how we communicate difficult news and information. This strategy acknowledges the need to develop new approaches and initiatives which can initiate a cultural change and

[15] Dixon J, King D et al .Equity in the Provision of Palliative Care in the UK: Review of Evidence.2015

[16] http://www.cqc.org.uk/sites/default/files/20150415%20Inequalities%20in%20EOLC%20project%20briefing%20updated.pdf

enable patients, friends, relatives and carers of patients approaching the end of their life's to openly discuss their personal needs and preferences and choices.

Havering Death Café events were held in 2015. Each 'café' provided the opportunity for interested persons to discuss issues that are relevant to them. We aim to expand this programme based on the learning from the events.

8.4 Electronic Care Plans

Electronic Palliative Care Co-ordination Systems (EPaCCS) enable the recording and sharing of people's care preferences and key details about their care with those delivering their care. The systems support co-ordination of care. The use of EPaCCS began with eight locality pilot sites in 2009-2011 and roll-out across England has progressed since then.

8.5 Workforce Implications

Workforce development plays an integral role in the delivery of high quality, responsive end of life care. As part of both national and local reviews it has been recognised that there are major deficiencies in the knowledge, skills, attitudes and behaviours of staff groups who come into frequent contact with people at the end of their lives.
In response to these shortfalls, we have begun to identify current and future training needs in line with the national strategy guidance. Everyone should be GSF trained

9. Strategy Implementation

An action plan (Table 1) will be developed by the End of Life Care Steering Group. It will outline the prioritised actions to be implemented within the next three years. The implementation plan will take into account the responses from the 2014 EoLC conference and the CQC visit in Oct 2015. The plan will be reviewed annually and amended where necessary to ensure that the actions put in place achieve high quality care.

The EoLC Steering Group will review and update this plan on an annual basis, or more frequently if required.

The key performance indicators listed in Table 2 will be used by the EoLC steering group to monitor the progress of this strategy.

Table 1: ACTION PLAN

Action Plan 16-17	Activity	Outcome	Owner	Timescale
End of Life care Quality Assessment tool	Complete the self - assessment- consider and agree	Baseline of true position of quality and capacity across Havering	EoLC Steering Group- partners	Aug 2017
Electronic Care Plans				March 2017
GSF Training	Training sessions for professionals	All GPs and Care Homes GSF trained	TBC	March 2017
Awareness raising with BAME groups	Focus groups	Better understanding of the needs/views of BAME groups	TBC	Dec 2017
Withdrawal At Home			TBC	
Death Café's		Raised awareness and opportunities to discuss death and dying	Dr Saini	
CQC Visit- Out of Hours Provision			Bob Barr	
GP Education	PTI Session to present EoLC Strategy; EoLC Plans Medications/Scripts	Increased awareness of Havering approach; more complete EoLC registers; Improved pain management	Dr Saini	
Bereavement service-		local service specification developed in partnership with acute, community, voluntary and private sector providers and local authorities		

Table 2: EOLC DASHBOARD

<table>
<tr><th>Strategic Objective</th><th>Key Performance Indicator</th><th>Baseline 15/16</th><th>Target 16/17</th><th>Comments</th></tr>
<tr><td>Ensure each person approaching end of life is seen as an individual</td><td>Number of people with EOLC who are identified
EolC registers</td><td>TBC</td><td></td><td></td></tr>
<tr><td>Ensure that each person gets fair access to care</td><td>Gap in the in DiUPR between cancer and non-cancer patients</td><td>TBC</td><td></td><td>EoL Profiles 2012-2014 Place of death by cause: (biggest gap by condition cancer and respiratory)<table><tr><td></td><td>Hospital</td><td>Home</td></tr><tr><td>Cancer</td><td>37%</td><td>30%</td></tr><tr><td>Respiratory</td><td>68%</td><td>14%</td></tr></table></td></tr>
<tr><td>Improve care planning</td><td>Proportion of patients with EOLC needs that have a completed care plan</td><td>TBC</td><td></td><td>Based on GP registers?</td></tr>
<tr><td>Have co-ordinated care across the health and social care system</td><td>Proportion of people with EoLC plan who is known to all agencies</td><td>100%</td><td></td><td>Partial roll out of electronic records; will need to ensure that new providers have access to plans</td></tr>
<tr><td>Ensure services are prepared and offer high quality care</td><td>Proportion of eligible health and social care staff GSF trained</td><td>TBC</td><td></td><td></td></tr>
<tr><td>Ensure we build compassionate and resilient communities that will cope better and help each other in times of crisis and loss</td><td>Awareness raising activities: Death Cafe</td><td>2 sessions</td><td>6</td><td></td></tr>
</table>

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Agenda Item 8

HEALTH & WELLBEING BOARD

Subject Heading:	**Devolution through an Accountable Care Organisation in Barking & Dagenham, Havering, and Redbridge**
Board Lead:	Cheryl Coppell / Conor Burke
Report Author and contact details:	Keith Cheesman Interim Head of Integration (Adult Services) London Borough of Havering Keith.Cheesman@havering.gov.uk 01708 433742

The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- ☒ Priority 1: Early help for vulnerable people
- ☒ Priority 2: Improved identification and support for people with dementia
- ☒ Priority 3: Earlier detection of cancer
- ☒ Priority 4: Tackling obesity
- ☒ Priority 5: Better integrated care for the 'frail elderly' population
- ☒ Priority 6: Better integrated care for vulnerable children
- ☒ Priority 7: Reducing avoidable hospital admissions
- ☒ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

Further to previous updates, this report summarises the current position with respect to the development of the business case to determine whether or not an Accountable Care Organisation is a viable form for future integrated health and social care delivery across Barking & Dagenham, Havering & Redbridge. This follows the announcement by the Chancellor on 15 December of a devolution pilot for Barking & Dagenham, Havering and Redbridge for health and social care.

The approach to devolution through an Accountable Care Organisation would be a very significant change to how health and social care services are planned and delivered across Barking &Dagenham, Havering and Redbridge. The development of the business case on which these decisions can be made is a substantial programme, and through this and the planned on-going reporting to the Board, Board members are invited to contribute to shaping the developing business case. The update is provided for Board members' information and comment, and in particular to introduce the governance arrangements that will oversee the development of the business case.

RECOMMENDATIONS

Members of the Health and Wellbeing Board are recommended to note the update provided with this report, and to provide comments on the proposed approach to governance.

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REPORT DETAIL

1. Background

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

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

1.3 Accountable Care Organisations are forms of joint health and social care delivery that emerged in the United States in response to the need to improve preventive care, and reduce the costs associated with poorly planned care. They were referenced in the *NHS 5-Year Forward View* as one of the possible mechanisms for improving joint working across health and social care. In essence, they involve groups of providers taking responsibility for all healthcare for a defined population, under agreements with a commissioner about the sharing of financial risk. In the UK context, it is expected that there will be a softening of the commissioner/provider split at a local level, as the new organisation takes on a shared responsibility for population-level health outcomes. It is intended that the health of population, as well as the services that are provided for it, are improved through fully integrated service delivery and an ability to ensure that greater levels of preventive activity are better targeted, both of which should release savings and efficiencies.

1.4 The exact details of how the organisation would be structured, the services that would be in scope, and the financial commitment and risk involved are all to be determined through the process of developing the business case. It is to be stressed that, at this stage, there is no decision on whether to proceed with an Accountable Care Organisation. All participating organisations will take a decision on whether to proceed, through their established governance processes, based on the business case that is developed by summer 2016.

2. General Approach to Developing the Business Case

2.1 Work on the business case, and the bid to NHS England, is being managed through the Integrated Care Coalition. The Coalition was formed in 2011 as a vehicle for bringing the three local authorities and three CCGs together with healthcare provider organisations, to jointly manage the transformation of health and social care services across Barking & Dagenham, Havering and Redbridge. It oversees a range of key transformation programmes, including the Urgent & Emergency Care Vanguard Programme and improvements to primary care and planned care.

2.2 The focus of the business case development is therefore on whether the model of an Accountable Care Organisation can provide the right mechanism to help the partners of the Integrated Care Coalition to deliver the vision that they are already shaping for the future of health and social care services.

Governance for the development of the ACO business case

2.3 A formal governance structure has been developed which puts statutory decision makers at the forefront through the Democratic and Clinical Oversight Group (proposed membership is set out in the Governance Structure attached). Clinicians/ professionals will lead the design through the Clinical Leadership and Strategic Planning Group which will be comprised of clinicians and professionals from across health and social care in BHR. The public, clinicians and professionals will be engaged throughout the process to enable co-design of the emerging proposed model.

2.4 Beneath this will set the Accountable Care Organisation Executive Group into which the ACO programme team will report. The Senior Responsible Officers for the programme are Conor Burke, Accountable Officer for BHR CCGs, and Cheryl Coppell, Chief Executive of London Borough of Havering, and they jointly chair the ACO Executive Group. The programme's governance structure is attached at Appendix 1.

2.5 The Clinical & Democratic Oversight Group is to be comprised of Elected Members from the three local authorities and non-executives and senior clinicians from across the health system. This membership (as proposed) is included at Appendix 1. However, the first meeting of this group is currently being arranged in late January, and details of how it intends to operate will be shaped by the members through that first meeting.

2.6 For Havering the representatives on these groups are:

- **Clinical & Democratic Oversight Group:** Cllr Roger Ramsey and Cllr Steven Kelly
- **ACO Executive Group:** Cheryl Coppell
- **ACO Steering Group:** Keith Cheesman

2.7 The Accountable Care Organisation Executive Group has developed a set of guiding principles for the programme. They are that the development of the ACO business case:

- Will be led by clinicians and professional groups;
- Will be owned by decision-making statutory bodies;
- Recognises that a radically new and innovative approach and commitment to working in different ways is required;
- Will include extensive engagement with staff, clinicians/professional groups and the public to shape proposals going forward;
- Will embed and adopt best academic practice;
- Has already brought together stakeholders form across Barking & Dagenham, Havering and Redbridge to shape the initial expression of interest and develop the business case; and
- Will learn from national and international best practice examples and guidance.

Programme Management Office

2.8 To undertake the work on the business case, a programme management office has been formed, led by Jane Gateley, Director of Strategic Planning for BHR CCGs, as Programme Director. All participating organisations are committing staff resources into the PMO, having committed to an equivalent of £100,000 per organisation to match a bid to NHS England for the additional resources needed to support the development of the bid. At the time of drafting this report, the detail of this bid is still subject to discussion with NHS England, but £750,000 of investment has been requested for the commissioning of external advice and support for the development of the business case, including a significant level of engagement with the public, staff and other stakeholders.

Programme structure

2.9 A programme structure is in the process of being developed, currently including workstreams around design of the model; communications and engagement; regulation; governance; financial modelling; estates; and workforce. Leads are being established, as well as contributors to the workstreams from across the participating organisations.

2.10 The programme is receiving substantial support from UCL Partners, the academic health sciences network which covers this area. They are providing policy and technical expertise, and playing a lead role in some areas, including discussions with regulators about the impact of the ACO development on the regulatory regime for health and social care.

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3. Communications and Engagement

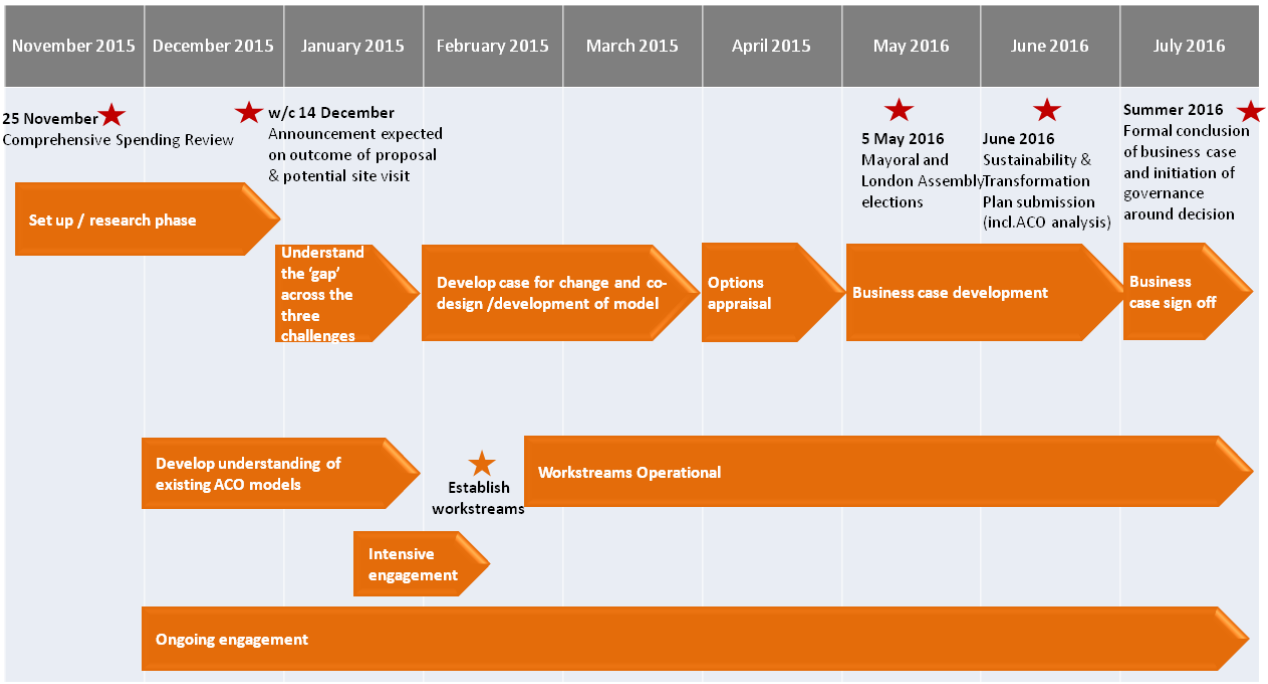
3.1 It is vitally important that the business case is informed by the views of the users and staff of local health and social care services. The programme therefore includes substantial plans for engagement activities, commencing in January 2016. A baseline survey of service user and staff experience is planned, and officers from across the participating organisations are being invited to help shape the approach.

3.2 In order to ensure consistency in communications about the ACO business case development, both publicly and within organisations, a network of communications officers has been formed, co-ordinated by the Associate Director of Communications for NELFT.

4. Timeline and links to other programmes

4.1 An overview of the timeline for developing the business case is set out below, and further detail has been set out in programme documentation that has been reviewed by the ACO Executive Group.

BHR Accountable Care Organisation Roadmap



4.2 It is recognised that the development of the business case will need to take account of a number of related programmes and begin to reflect their established ambitions. These include:

- The Urgent & Emergency Care Vanguard;
- Primary care transformation;
- Mental health service transformation and strategy;

- Wider local authority service transformation programmes, across adults' and children's social care in particular
- Programmes designed to redesign and improve planned/integrated and preventive care, including those in the three boroughs' Better Care Fund programmes and work to develop the various forms of integrated locality working across the three boroughs.

4.3 In the event that the business case does not evidence that the ACO model is a viable proposition for future devolution and integration of services, it is expected that the coming months will contribute strongly to future service planning across the three boroughs. This is consistent with the emphasis in the ACO programme being on testing whether this is a vehicle for delivering the combined ambition already scoped by the Integrated Care Coalition and its partners.

5. Next steps

5.1 The immediate priorities for the programme in the coming weeks are:

- To establish the Clinical and Democratic Oversight arrangements and to ensure that they have the support and buy-in of the clinicians and Elected Members;
- To commission and conduct the baseline survey of service user and staff experience and to understand perceptions of the opportunity for an ACO to improve population health and the delivery of care;
- To establish the programme workstreams and to clarify leads and participants from across the organisations;
- To develop a clear model for how the Accountable Care Organisation development relates to other transformation programmes in health and social care, for circulation to stakeholders.

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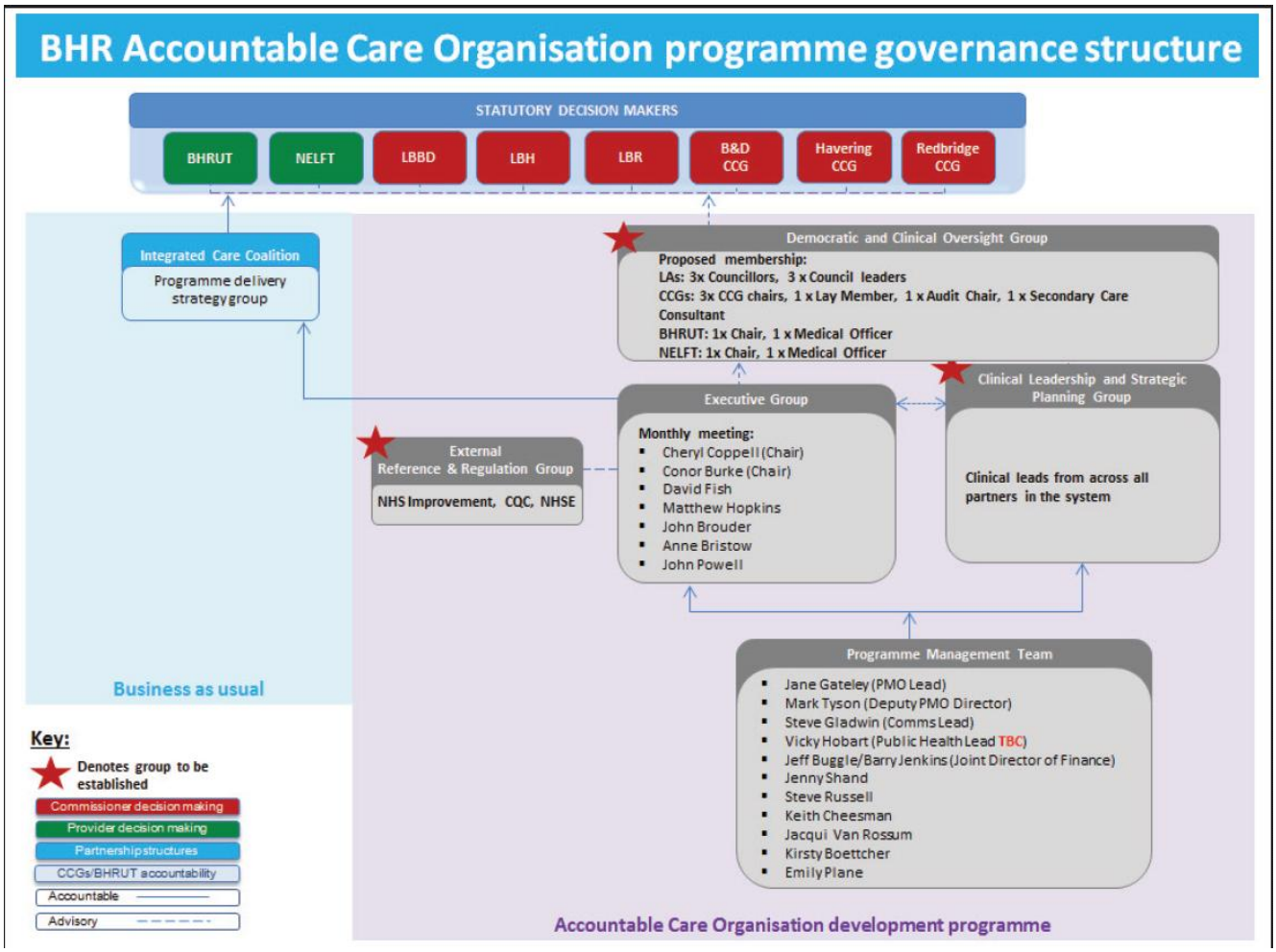
Appendix 1 – Governance Structure



Agenda Item 9

Havering Shadow Health and Wellbeing Board: Terms of Reference

Introduction

- As set out in the 2010 Health White Paper (Liberating the NHS) and subsequent public health consultations, it is proposed that (subject to parliamentary approval) local authorities will have a statutory responsibility to establish a Health and Wellbeing Board from 1st April 2013. Local authorities are expected to establish the Board in shadow form during 2011/12.

Aim of the Health and Wellbeing Board

- To join up commissioning across the NHS, social care, public health and other health and wellbeing services in order to secure better health and wellbeing outcomes for the local population, better quality of care for patients/care users and better value for the taxpayer.

Objectives

The main roles of the group will be to:

1. Agree health and wellbeing priorities for Havering

2. Assess the health and wellbeing needs of local people

3. Act as a mechanism through which the joint strategic needs assessment and pharmaceutical needs assessment can be developed

4. Develop a joint health and wellbeing strategy to provide a framework within which joint commissioning plans for the NHS, social care and public health can be developed, and promote joint commissioning

5. Seek to influence the commissioning arrangements for the NHS (including GP consortia), social care and public health, consider whether these are in line with the joint health and wellbeing strategy. Write formally to the NHS commissioning board/local authority leadership where commissioning plans have not had sufficient regard to the strategy

6. Ensure that health and wellbeing commissioning arrangements are aligned

7. Consider how to best use the totality of resources available for health and wellbeing e.g. consider pooled budgets. Also oversee the quality of commissioned health services.

8. Provide a key forum for public accountability of NHS, public health, social care and other health and wellbeing services, ensuring local democratic input to the commissioning of these services

9. Monitor the outcomes of the public health outcomes framework (framework introduced from April 2012).

10. Undertake additional responsibilities as delegated by the local authority e.g. considering wider health determinants such as housing, or co-ordinating commissioning of children's services

Membership

Statutory Members

- Minimum of one elected member - Councillor S Kelly, Deputy Leader of the Council and Cabinet Member for Individuals

- Director of Public Health - Mark Ansell, Acting Director of Public Health, London Borough of Havering

- Joy Hollister, Director of Adult Social Care and Learning, London Borough of Havering.

- GP consortia representation

- Local Healthwatch

- Representative of commissioning at sector level (to be agreed)

Other Core Members as Agreed by the Health and Wellbeing Board

- Leader of the Council

- Councillor A Curtin, Cabinet Member for Towns and Communities, with special responsibility for culture

- Councillor L Kelly, Cabinet Member for Housing

- Cynthia Griffin, Group Director for Culture and Community, the London Borough of Havering

- Non executive Director of NHS Havering (nomination to be agreed)

Other Members

- NHS commissioning board – presence may be requested for appropriate meetings, but will not form part of the core membership of the group

Nb. Councillors who are members of the Health and Wellbeing Board should not also be members of Health Overview and Scrutiny committees or Healthwatch.

Resources

Financial

The Board will receive £168,788 of performance reward grant funding from successful achievement of targets outlined in Local Area Agreement 1. The Health and Wellbeing Board will have a key role in deciding how this funding should be used to improve the health and wellbeing of local people.

From 2013, the Board will also oversee expenditure of Havering's public health budget of £X.

Staff

The theme group will be supported by the Corporate Policy & Partnerships Team at the London Borough of Havering, who will provide strategic, analytical and administrative support. Democratic services will provide administrative support to public meetings of the Board.

Reporting and Governance Arrangements

- The Health and Wellbeing Board will form part of the Havering Strategic Partnership and the Chair will represent the Board at the HSP Strategic Board

- Progress against the joint health and wellbeing strategy will be reported annually to the HSP Strategic Board

- The Board will receive regular progress updates on strategies and action plans relating to health and wellbeing e.g. the dementia strategy and the 50+ strategy

- When the Health and Wellbeing Board becomes statutory in April 2013, meetings of the Health and Wellbeing Board will be held in public unless confidential financial or other information should prevent this (as per the Local Government Act, 1972)

- Minutes of meetings of the Health and Wellbeing Board will be taken by a Committee Clerk from the London Borough of Havering.

- Chairing arrangements – when the Shadow Health and Wellbeing Board becomes a statutory board in April 2013, the leader of the Council will be required to formally delegate Chairship of the Board to Councillor S Kelly as the Lead Member.

- Voting rights will be held only be statutory and core members of the Board, and any additional members of the Board will not have such voting rights. Where a vote is tied, the Chairman will have the casting vote.

- Meetings will be held every six weeks. Special meetings may be requested by the Board at any time

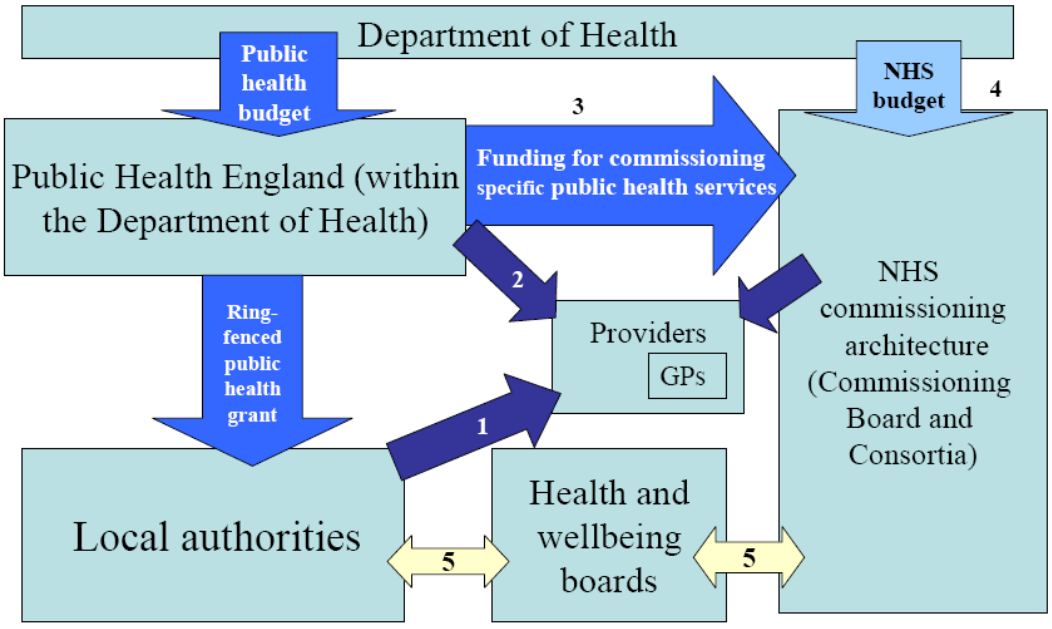
- Papers to be circulated at least 5 working days before a meeting

- Provider organisation representatives will be invited to the meetings when appropriate to the topic being discussed

- The Board may co-operate with similar Boards in other locations where their interests collide. This may include multi-area commissioning arrangements

- Terms of reference may be altered by the Board at any time

Structures and Relationship to Other Organisations



1. Public health services commissioned or provided by local authorities
2. Public health services commissioned or provided by Public Health England at a national level
3. Public health services commissioned via the NHS
4. The NHS will continue to fund and deliver some public health services e.g. public health activity carried out by GP practices
5. These arrows represent the role of the Health and Wellbeing Board in supporting integrated commissioning throughout the system e.g. by bringing together discussions about investment in cross cutting services e.g. social care primary prevention

Havering's Health and Wellbeing Strategy

2015 – 2018

Contents

Executive Summary

Our strategy has been developed by Havering's Health and Wellbeing Board and it is the overarching plan to improve the health and wellbeing of children and adults in our borough.

The vision of the Havering Health and Wellbeing Board remains *"For the people of Havering to live long and healthy lives, and to have access to the best possible health and care services."*

Informed by the Joint Strategic Needs Assessment and other needs analysis, we have identified the most pressing health and social care issues in the borough. By working collectively as a strategic partnership, we have prioritised the actions we need to take to deliver our vision and improve outcomes for local people. These are set out clearly in this Health and Wellbeing Strategy, which focuses on three overarching themes and eight priorities for action:

Overarching Themes	**Priorities**
Theme A: Preventing, reducing and delaying the need for care and support through effective demand management strategies	Priority 1: Provide effective support for people with long term conditions and their carers so that they can live independently for longer Priority 2: Improve identification and support for people with dementia and learning disabilities and their carers Priority 3: Reduce obesity Priority 4: Reduce premature deaths from cancer and cardiovascular disease.
Theme B: Better integrated support for people most at risk	Priority 5: Better integrated care for the "frail elderly" population Priority 6: Improve integrated care for children, young people and families most at risk Priority 7: Reduce avoidable hospital and long term care home admissions
Theme C: Quality of services and patient experience	Priority 8: Improve the quality of services to ensure that patient experiences and long term health outcomes are the best they can be

All member agencies of the Health and Wellbeing Board are facing significant budget pressures while operating in an environment where demand for higher quality services is increasing. Its strategy going forward therefore needs to be one of

demand management, with members of the Board working together, and with communities and members of the voluntary sector, to:

- Keep people out of the health and social care system altogether wherever possible, by taking action to reduce the need for health care and improving the health and wellbeing of the local population;
- Support people to stay independent, and
- Build community resilience and support people to manage their own conditions, by helping people and communities to look after themselves and each other wherever possible.

For those who absolutely do need to enter the health and social care system, the strategy sets out how members of the Health and Wellbeing Board will continue to work together to integrate care across the sectors, both in order to improve patient and service user experiences and outcomes and also to secure enhanced value for money.

All of the above will need to be supported and facilitated by the continued development and delivery of integrated commissioning strategies and activities across the organisations represented on the Board.

Foreword

Welcome to Havering's second Health and Wellbeing Strategy. This strategy sets out how, over the next three years, we will build on the successes of our first Health and Wellbeing Strategy and how, by working in partnership with each other and the community, we will improve the health and wellbeing of local people and improve the quality of, and access to, local healthcare services.

We believe that everyone in Havering has the right to enjoy good health and wellbeing. We have a lot to be proud of in this borough. Life expectancy is high and overall the borough is quite healthy. There is a wealth of open parks and spaces, good transport links and high levels of employment. Residents feel that Havering offers a very good quality of life. However, we want to continue to do more. We want to help people to live healthier lives and we want to provide better quality of care and services.

We are in a period of great change and legislative reform that brings with it many opportunities but also many challenges. As well as the impacts arising from the Care Act, the Children and Families Act and Government austerity measures, rising demands and expectations from service users are all forcing significant changes to both the commissioning and direct provision of health and social care services.

But despite the challenging context we are working in, we believe the most vulnerable people must continue to be valued and protected. Havering has an increasing older population and we believe we can improve support for people with dementia and learning disabilities, and also help older people to remain independent for as long as possible. We understand how important carers are and we will continue to provide support for them in their crucial role. We will also continue our on-going work to improve the quality of our local hospitals and community care services.

We are clear that a "one size" approach will not fit all and that, in many cases, both the current performance data and the need to achieve more with our declining resources will mean that we will have to focus our efforts by targeting "hotspot" areas. Tackling health inequalities across the borough and improving life expectancy continue to remain priorities, particularly in the most deprived areas of Havering.

We know that it is only by working together can we create a borough where everyone can realise their potential and have the best life chances. To this end, we must ensure that everyone can access the support they need, but also empower communities to take responsibility for their own health and wellbeing and that of their families and loved ones.

Despite the challenging environment, we must be ambitious in our thinking and desire for change. Good health and wellbeing is everyone's responsibility and everyone must play their part.

By Cllr. Steven Kelly (Chair of the Havering Health and Wellbeing Board)

Dr. Atul Aggarwal (Chair of the Havering Clinical Commissioning Group)

1. Achieving our Vision

The vision of this strategy is:

"For the people of Havering to live long and healthy lives, and have access to the best possible health and care services."

To deliver this vision, we have identified the most pressing health and social care issues in the borough. Informed by the Joint Strategic Needs Assessment, we have identified the following three key themes:

Theme A: Preventing, reducing and delaying the need for care and support through effective demand management strategies

Theme B: Better integrated support for people most at risk

Theme C: Quality of services and patient experience

There are eight priorities for action to deliver these themes and each has a jointly agreed plan as to how improved outcomes for local people will be delivered. Partnership working, joint commissioning and integrated working are fundamental to the delivery of this strategy. Tables that set out the themes, priorities and key actions can be found at Appendix 4.

In accordance with the Council's obligations under the Public Sector Equality Duty, the strategy has been assessed for its equalities implications and the impact of the proposed actions on members of the population who possess protected characteristics. The Equality Impact Analysis is available on the Council's website. Individual schemes and initiatives arising from the Health and Wellbeing Strategy will also be subject to separate Equality Analyses which will likewise be published on the Council's website.

2. Scope and Purpose of the Strategy

The Health and Wellbeing Strategy sets out how we will work together as a strategic partnership, as well as with the local community, to improve the health and wellbeing of local people and to improve the quality of, and access to, local health and care services. It provides the overall direction for the commissioning of health and social care services across the borough.

This strategy replaces the Havering Health and Wellbeing Strategy 2012-2014.

The Strategy focuses predominantly on health and social care related factors that influence health and wellbeing. The wider determinants of health and wellbeing include factors such as housing, education and employment, and the environment. These are addressed through other key partnership strategic documents. A list of such documents can be found at Appendix 3.

3. Context

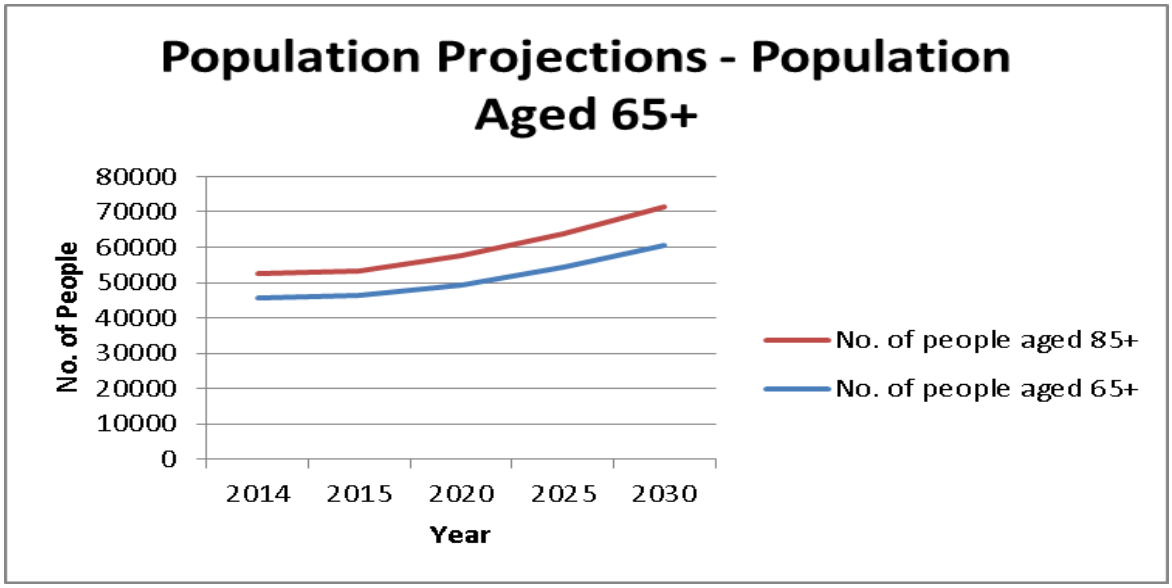
3.1 Our Population in Havering

The people of Havering are generally fairly healthy. Life expectancy is long and residents and visitors to the borough benefit from plenty of high quality parks and open spaces.

There are 237,232 people living in Havering and 256,731 people registered with a Havering GP. It is estimated that by 2016, Havering's population will have grown by 5.4% (12,699 people) and by 11.5% (27,095 people) by 2021, a faster rate of growth than the London average.

The life expectancy for people living in Havering is 78.6 years for men and 83 years for women. While life expectancy overall is above the England average, there is a 7.4 year gap in life expectancy for men and 4.6 years for women across Havering, with life expectancy particularly impacted by where people live and the circumstances of their upbringing.

Havering has one of the largest older populations in London, with more than 23% of residents (40,000) over the age of 65. Between the 2001 and 2011, growth in the 85+ age group saw the largest percentage increase (at 43%, which is higher than for both London and England), and the size of this age group is projected to continue to increase, by 20.3% by 2020.



This projected increase in the older people population is likely to result in increases in numbers of residents suffering from cardiovascular disease (CVD), cancer, respiratory illnesses (e.g. bronchitis and pneumonia), dementia, osteoporosis, incontinence and hearing impairments.

The borough has a large younger population too. It is estimated that around 23% (54,018) of the population in Havering is aged 0-19, similar to the England average of 24%. Future projections suggest that the 0-15 age group is estimated to grow by 8.2% by 2016 and 21.1% by 2026.

While the population is predominantly White British, it is becoming increasingly diverse. It is estimated that around 12% of Havering's working age population is of non-white ethnicity, however the school census reported that nearly 23% of school pupils in Havering were from non-white ethnic groups.

The borough is generally fairly affluent, being ranked 177th overall out of 326 local authorities for deprivation, but has pockets of deprivation. Two small areas of the borough (situated in Gooshays and South Hornchurch) fall into the 10% most deprived areas in England. When compared with other London boroughs, Havering has a relatively small proportion of children living in poverty, however this has risen in recent years (bucking the trend seen in most other London boroughs of declining levels of child poverty).

The results of the 2011 *Your Council, Your Say* survey indicated that health services are the top priority for local people in making the Borough a good place to live, followed by clean streets and the level of crime.

3.2 Key Achievements to Date

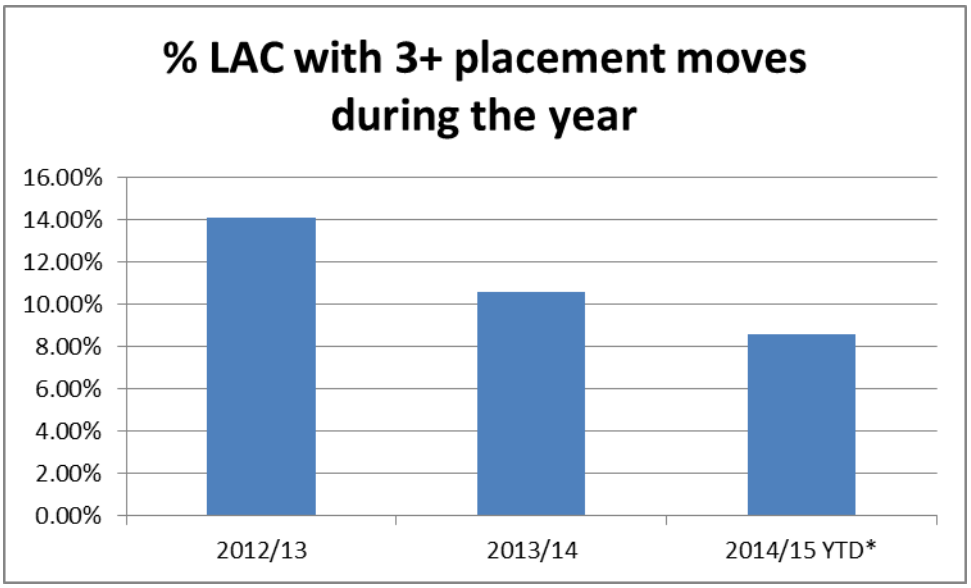
While we are aware that we still face significant challenges in addressing health inequalities and improving wellbeing, we are proud of the significant improvements that have been made during the life of the first Health and Wellbeing Strategy.

As we move into the next planning period, much good work has already started, giving the Board a strong foundation on which to build. As a partnership, we are particularly proud that:

- Urgent Care Centres have been set up in the borough, with the aim of reducing A&E attendances and helping patient flow by seeing patients in the most appropriate setting. Hospital staff and local GPs can book non-urgent cases directly into these clinics.
- An Integrated Care Strategy is in place and being delivered, which is helping to shift activity away from acute settings towards community and locality settings. As part of this, Integrated Case Management across health and social care has already been introduced.
- Residents of the borough now benefit from a Joint Assessment and Discharge (JAD) team, operating seven days a week, which provides a more collaborative approach across health and social care to ensure that planning for discharge takes place closer to the point of admission. This has played a large part in making Havering one of the best performing boroughs in London in terms of delayed transfers of care.

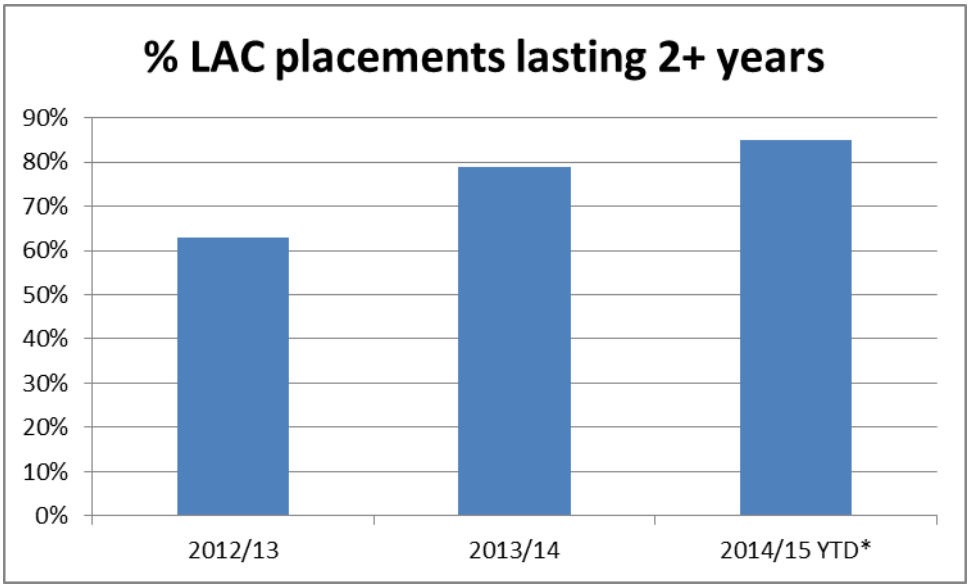
- In response to feedback from patients that they want to be supported closer to, or in, their own homes where possible, we have implemented Community Treatment Teams (CTTs) and the Intensive Rehabilitation at Home Service (IRS), and surveys indicate that most patients are very happy with these new models of care, with CTTs receiving a patient rating of 8.7 out of 10 and the IRS receiving a patient rating of 9 out of 10. In 2013/14, Havering's Intensive Rehabilitation Services received 159 referrals against a target of 69. During the same period, there were 1,576 referrals to the Queens Hospital hub of the new Community Treatment Team, 78% of which did not go on to be admitted to hospital. Within the community spoke of the CTT, 2,707 referrals were received during this time, 94% of whom were treated and maintained at home without the need for an acute admission.
- A Frailty Academy was launched across Barking and Dagenham, Havering and Redbridge in February 2014, to ensure that the lessons of various approaches and initiatives are learned and used to inform the development of mainstream services. As at May 2014, 34 participants had enrolled in the Academy, representing a range of agencies including the London Ambulance Service, NELFT, BHRUT and the Havering Care Association.
- The first stage of the new Community Health and Social Care Service (CHSCS) went live on 28 April 2014, with the reconfiguration of community nursing, Integrated Case Management, therapies and mental health services into locality based teams. We are now working towards the integration of partners outside of NELFT (e.g. social care and others) into this model.
- In June 2014, Havering became the first borough in London, and one of the first in the country, to expand its Multi-Agency Safeguarding Hub (MASH) to identify adults as well as children at risk. Alongside this, the Council and its partners developed a Community Multi-Agency Risk Assessment Conference (Community MARAC), to provide a multi-agency problem solving forum in respect of adults who do not meet the threshold for statutory services but who nonetheless require a multi-agency response in order to maintain them safely in the community. An independent evaluation is now underway, but anecdotal evidence and performance data suggests that both these initiatives are adding value to the partnership's work to identify and support vulnerable people and families.
- Havering has performed particularly well in the national Troubled Families programme. As at March 2014, the borough's initial target of identifying 415 "troubled families" to work with had been exceeded, with over 500 families having been identified. Havering's Troubled Families team is now closely involved nationally in the development and roll out of Phase 2 of the programme.

- Havering was awarded Dementia Friendly Borough Status in 2014, making the borough only the second London borough to receive this status.
- The stability of care placements for children looked after by the local authority has improved, with the percentage of looked after children with three or more placements during the year reducing each year.



* As at end November 2014

- The percentage of LAC placements lasting two or more years has also steadily improved.



*As at end November 2014

- Going forward, the recent successful bid to the Prime Minister's Challenge Fund will facilitate further improvements to the quality of and access to primary care services across the Clinical Commissioning Group by investing in improvements to complex care and facilitating access to services between

8am and 10pm seven days a week, as well as enabling technology to facilitate better information and data sharing.

3.3 The National Context

The Care Act 2014

The Care Act is the most important and far reaching piece of legislation impacting on adult social care since the NHS Community Care Act 1990. The Care Act combines many different laws regarding care and support into one piece of legislation that creates a range of duties and responsibilities.

Key areas of change to be implemented from April 2015 include:

- Greater responsibilities on local authorities, including to promote people's wellbeing, focusing on prevention and providing information and advice (including to self-funders);
- The introduction of a consistent, national eligibility criteria;
- New rights to support for carers, on an equivalent basis to the people they care for;
- A legal right to receive a personal budget and direct payment;
- A requirement to ensure more holistic and integrated provision of services across both statutory and non-statutory organisations;
- New guarantees of continuity of care when service users move between areas;
- The extension of local authority adult social care responsibilities to include prisons, and
- New responsibilities around transitions, provider failure, supporting people who move between local authority areas and safeguarding.

Major reforms to the way that social care is funded will be effective from April 2016, including:

- A lifetime 'cap' of no more than £72,000 for individuals on reasonable care costs to meet their eligible needs, and
- An increase in the capital threshold for people in residential care who own their own home.

Better Care Fund

The Better Care Fund (BCF) supports the transformation and integration of health and social care services to ensure local people receive better care. The BCF is a pooled budget that shifts resources into social care and community services for the benefit of the NHS and local government. The BCF is not new money but benefits in terms of better integrated working can be achieved from our combined budget.

The key objectives of the BCF (which will be linked to a payment by results mechanism) are to:

- Ensure more joined up and effective commissioning, including the procurement, specification and contracting of health and social care services;
- Deliver more integrated solutions for residents and service users, at the lowest and most appropriate level possible, and
- Avoid hospital and long term care home admissions by ensuring improved management of high cost resources through targeted locality interventions.

The Children and Families Act 2014

The Children and Families Act draws together the support a child or young person aged 0-25 with special educational needs (SEN) requires across education, health and social care into a single Education, Health and Care (EHC) Plan which will replace the current statementing system. These will be gradually implemented over a two to three year period from September 2014 and will require plans to be outcomes, rather than outputs, focussed as well as requiring a co-ordinated, multi-agency assessment process. The Act introduces a new legal requirement for the local authority to work with health to integrate services, as well as a requirement for joint commissioning arrangements across education, health and social care, and a mechanism to agree the levels of service required.

The Act also strengthens the rights of young carers to an assessment of needs for support. It is believed that the number of young carers in the borough is currently under identified and likely to increase. This in turn will increase the demand for assessments and services. This is recognised in the borough's BCF plan.

The Act also requires children, young people and their parents or carers to be offered personal budgets to meet their care needs. This will require increased transparency, signposting and market development of "the Local Offer" within an increasingly competitive health and social care economy.

The Marmot Review 2010

The Marmot Review 2010, *Fair Society, Healthy Lives*, proposed evidence based strategies for reducing health inequalities including addressing the social determinants of health. It concluded that a good start in life, a decent home, good nutrition, a quality education, sufficient income, healthy habits, a safe neighbourhood, a sense of community and citizenship are fundamentals for improving quality of life and reducing health inequalities. We are aware that, to reduce health inequalities and improve wellbeing, we must focus our efforts on those who are experiencing poverty and deprivation and must support our communities to lead healthy lives and to make healthy choices.

3.4 The Local Context and Delivery Arrangements

3.4.1 The Havering Health and Wellbeing Board

The Health and Wellbeing Board is the forum through which key leaders from health and social care work together in partnership to improve the health and wellbeing of the people of Havering and to reduce health inequalities across the borough. The Board is committed to ensuring that health and social care services in the borough are operationally and cost effective and oversees the implementation of the wider change agenda across the local health and social care economy. The Board will hold commissioners in the borough accountable for delivering the priorities and actions outlined in this strategy and its accompanying action plan.

Membership of the Havering Health and Wellbeing Board is set out at Appendix 1.

The Governance Structure (also attached at Appendix 1) illustrates how the Health and Wellbeing Board fits into the wider health and social care system and the other local governance structures which, whilst not all directly accountable to the Health and Wellbeing Board, provide the mechanisms through which the Board can receive assurance on progress against the priorities identified within this strategy.

3.4.2 Havering's Joint Strategic Needs Assessment (JSNA)

The JSNA identifies and assesses the health and wellbeing needs of the local population. It is carried out by analysing a range of data and intelligence from various sources, including feedback from local people. It identifies where our health and social care services perform well compared with others and where we need to improve. The JSNA is regularly updated and available to view on the Havering data intelligence hub at: www.haveringdata.net/research/jsna.htm.

3.4.3 The Financial Landscape

Both the local NHS and the Council are facing a highly challenging financial position for at least the short to medium term. We are facing significant budget pressures while operating in an environment where demand for higher quality services is increasing. The implementation of the Care Act 2014 and the Children and Families Act 2014 will also put further financial pressures on the Council and its partners. The Health and Wellbeing Board's strategy going forward therefore needs to be one of demand management, with partners working together with one another and with the local community to:

- Keep people out of the health and social care system altogether wherever possible, by taking action to reduce the need for health care and improving the health of the local population;
- Support people to stay independent, and

- Build community resilience and support people to manage their own conditions by helping people and communities to look after themselves and each other wherever possible.

In such a challenging financial context, it is crucial to ensure that projects and resources are managed diligently in order to ensure a sustainable financial position and, even more critically, to improve the health and wellbeing of local residents.

3.5 Action Plan

This Strategy sets out the Health and Wellbeing Board's eight priorities, and each has a jointly agreed action plan as to how improved outcomes for local people will be delivered. The Action Plan accompanying the Strategy is set out at Appendix 4. This includes a variety of interventions including individual, targeted and population-wide initiatives. Each intervention seeks to provide the most beneficial outcome for individuals, whilst being achievable within the constraints of health and social care budgets.

3.6 Monitoring and Review Arrangements

It is the responsibility of the Health and Wellbeing Board to oversee the delivery of the strategy. Performance against the key actions and indicators set out in this Strategy will be monitored on a quarterly basis by the Board.

The strategy will be critically reviewed and refreshed as necessary at the end of the three year period. In the meantime, plans will be continually reviewed in light of the best available evidence and amended, where necessary, to ensure that the best possible outcomes are achieved within the resources available.

4. Health and Wellbeing Themes and Priorities

Theme A: Preventing, reducing and delaying the need for care and support through effective demand management strategies

People with the most complex needs pose the greatest challenge to health and social care providers. Older people, especially those with **long-term conditions**[1], are the most intensive and costly users of health and social care services. In response to the 2011 *Your Council, Your Say* survey, more than a quarter (25.3%) of residents identified themselves as having a long standing illness or disability.

As well as treating the symptoms of these conditions, we need to address some of the lifestyle choices and factors that contribute to them. For example, one in five adults smoke and the alcohol consumption of one in five is at a harmful or increased level. By focusing on prevention and early intervention, we aim to help manage demand on services and enable more people to be healthier and to live independently and safely in their own homes for as long as possible. Our continued focus on reablement and rehabilitation services for those recovering from a period of illness, alongside support to help older and vulnerable people manage long-term conditions and to lead healthier lifestyles, will help more people to maintain independent living for longer.

In February and March 2014, Healthwatch Havering facilitated a series of workshops, attended by service users and carers as well as representatives from the voluntary and community sector, NHS organisations and the Council, to investigate what services were available in the borough for people with **dementia or learning disabilities** and what could be done to secure improvements. The findings of the resulting report are addressed in our Action Plan attached at Appendix 4.

Dementia is a particularly distressing illness for both the sufferers themselves and their friends and family and others who care for them. Supporting people with dementia is a high priority both nationally and locally and, whilst clinical diagnosis of dementia is predominantly a matter for the NHS, access to post-diagnostic support (for both the patient and their family and carers) is a matter for all members of the Health and Wellbeing Board. Dementia is a particularly pertinent issue in Havering due to its large and growing older population.

Obesity increases the likelihood of the development of a range of health conditions, with the most important of these in terms of the burden on health services being type II diabetes, cardiovascular diseases and several types of cancer. It increases the risk of morbidity, disability and premature mortality. Being obese also restricts mobility, can lead to poor mental health and reduce life quality. Obesity in pregnancy increases the risk of complications both for the mother and the child. These effects

[1] Defined as one or more of the following: Asthma, Cancer, Coronary Heart Disease, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Dementia, Depression, Diabetes, Epilepsy, Hypertension, Heart Failure, Learning Disability, Stroke and those receiving end of life services

can last throughout childhood and into adulthood, with babies born to obese women facing increased risk of foetal death, stillbirth, congenital abnormality, shoulder dystocia, macrosomia and subsequent obesity. Type II diabetes has increased in overweight children. Other risks associated with childhood obesity include early puberty, eating disorders, skin infections, asthma and other respiratory problems.

Obesity further costs society through the loss of disability-free life years, additional pension payments due to early retirement through ill health, increased absenteeism and / or reduced productivity at work due to ill health. There have also been links made between obesity and various emotional and psychological effects such as anxiety and depression. In children, this can have a knock-on effect on educational attainment. Once established, obesity is difficult and costly to treat, so prevention and early intervention are paramount. By promoting healthier lifestyles, increasing levels of physical activity and commissioning appropriate support services, the Havering Health and Wellbeing Board aims to help residents maintain healthy weight.

Partly linked to this, a greater proportion of people in Havering than in England and other statistically similar local authorities die prematurely from heart disease and strokes. The expected increase in the number of elderly residents in Havering is predicted to increase still further the numbers of residents experiencing cardiovascular diseases (CVD) and cancer, as well as respiratory illnesses (e.g. bronchitis and pneumonia), osteoporosis (and fractures due to falls), incontinence and hearing impairment. This emphasises the need to reduce the prevalence of **cardiovascular disease** through primary prevention.

Meanwhile **cancer** is one of the top for priorities for outcomes improvement across London and one of the top three causes of premature mortality across the Barking and Dagenham, Havering and Redbridge (BHR) Clinical Commissioning Group (CCG) and therefore warrants our continued attention.

What we want to see

- Earlier identification and diagnosis of dementia in order to improve treatment
- Earlier diagnosis and treatment of cancer
- Improved quality of life for those with one or more long term conditions
- Individuals feeling in control of their care, and empowered and enabled to live well.
- People remaining well and healthy for longer.
- Better co-ordination of end of life care.

Our four priorities are to

Priority 1: Provide effective support for people with long term conditions and their carers, so that they can live independently for longer

Priority 2: Improve identification and support for people with dementia and learning disabilities and their carers

Priority 3: Reduce obesity

Priority 4: Reduce premature deaths from cancer and cardiovascular disease

Priority 1: Provide effective support for people with long term conditions and their carers so that they can live independently for longer

What we know about Havering

- As at 19 September 2014, the number of people who were both registered with a Havering GP and resident in Havering with long-term conditions was as follows:

No. of long-term conditions	No. of people aged 18-64	No. of people aged 65-74	No. of people aged 75+	TOTAL
1	27,822	7,999	6,256	**42,077**
2	6,612	4,493	5,783	**16,888**
3	1,445	1,720	3,501	**6,666**
4+	413	773	2,424	**3,610**

- 17.3% of the population of Havering say that their day to day activities are limited due to their health, compared to 14.2% for London and 17.6% for England.

- There are 1,200 older people in the borough that have particularly complex health and social care needs.

- People aged 85+ have the most complex health and social care needs, with approximately 900 of them accounting for 38% of all emergency beds.

- 45.2% (2,656) of adult social care clients receive some form of self-directed support, with 22% (578) of these using a personal budget or direct payment

- 52% of those with a long term health condition in Havering feel they have had enough support from local services or organisations in managing their condition. This is slightly lower than the figure for the whole of England (55%) but in line with the London-wide figure (52%)

What we plan to do

- Work as a partnership to improve residents' choice and control over the health and social care services they receive.

- Provide co-ordinated health and social care services in individuals' own homes, or as close to where they live as possible

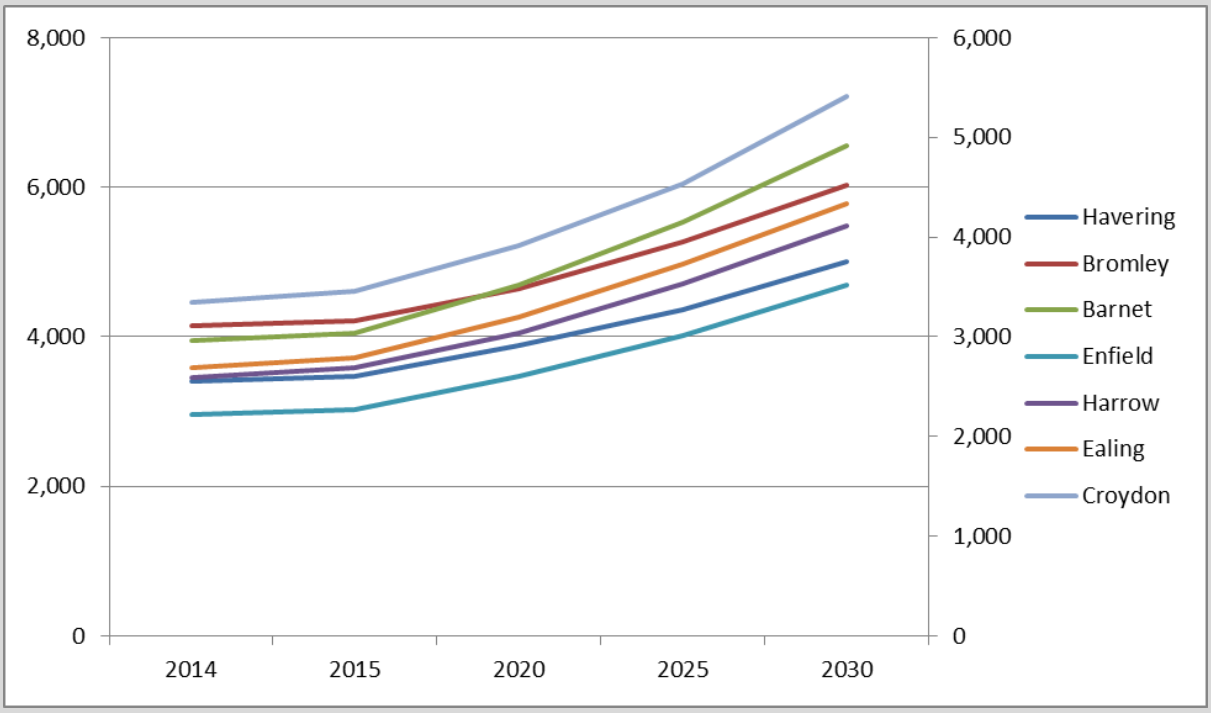
- Work with the voluntary and community sector to support vulnerable people in the community, including providing respite care and support schemes for people who have just left hospital and their carers.
- Build community resilience and support people to manage their own conditions through initiatives such as peer support, mentoring and time-banking.
- Strengthen the co-ordination of complex care and end of life services across health and social care.

Priority 2: Improve identification and support for people with dementia and learning disabilities and their carers

What we know about Havering

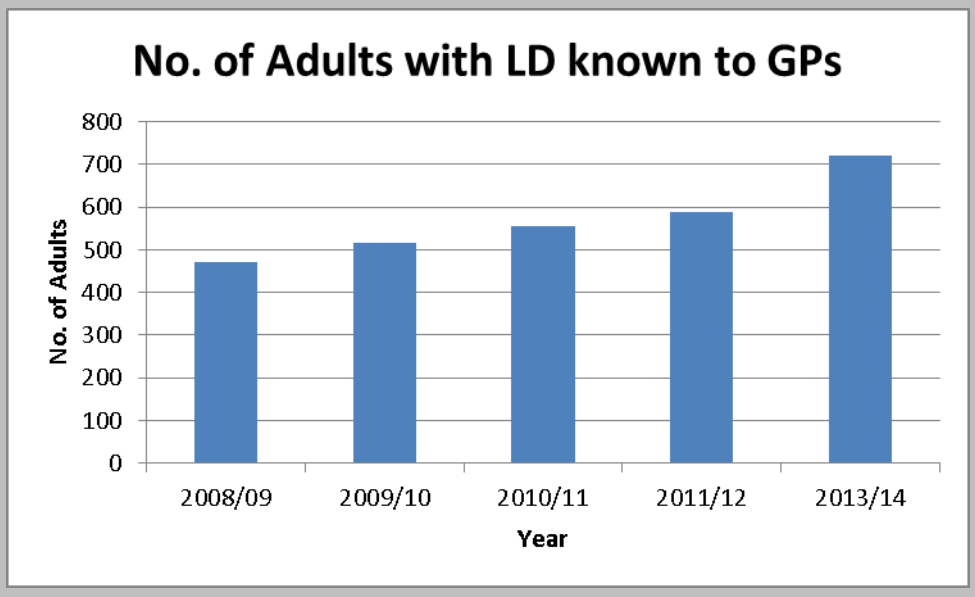
- It is estimated that, in 2014, Havering had over 3,000 people aged 65+ with dementia. This is predicted to rise to 3,794 by 2020 and to 5,005 by 2030, with Havering being home to the sixth highest number of residents with dementia in London

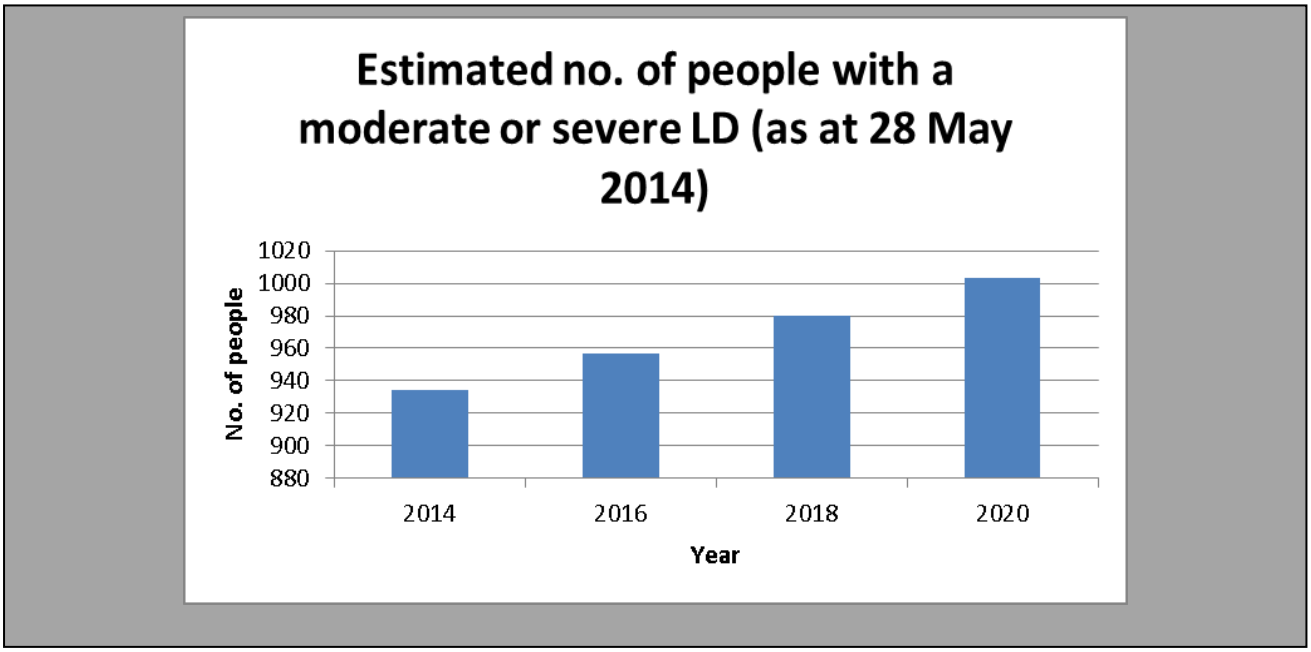
People aged 65 and over predicted to have dementia projected to 2030 in the top seven boroughs (POPPI) 2014



- As at December 2014, the dementia diagnosis rate for Havering had increased from 39% to 48.4%. However this remains considerably lower than the 55% national diagnosis rate and the 67% national target diagnosis rate. The Memory Service would need to see at least another 500 people to reach the national target.
- The recorded number of people with dementia in Havering is significantly lower than the expected number (given the borough's demographics), suggesting that more than 2,000 local people are living with undiagnosed dementia and, therefore, are not benefiting from treatments that could slow its progression and improve their wellbeing.
- Around 60 people aged 30-64 in Havering are estimated to be affected by early onset dementia

- It is estimated that around 63% of those with late onset dementia live in private homes in the community, and around 37% live in care homes
- Evidence suggests that the majority of people with dementia in Havering are white, aged 70+, and that there are considerably more female dementia cases than male.
- A large proportion of care for people suffering from dementia (particularly the undiagnosed) is provided by family and friends.
- As at 31 March 2014, 475 people with learning disabilities were in receipt of social care packages from the London Borough of Havering. This is above the London average but below the national average. At the same time, there were 55 people aged 65+ with learning disabilities receiving social care packages from the Council. This is below both the London and national averages.
- As at 28 October 2013, there were just 72 children registered with a Havering GP who were recorded as having a learning disability. This suggests substantial under-recording of learning disabilities.
- Comparisons of the number of adults with learning disabilities known to GPs (see below) or social care and the estimated numbers of adults with learning disabilities in Havering (also shown below) suggests that – as for dementia - a large proportion of people with learning disabilities are still being solely supported by their own families.





What we plan to do

- Aid prevention through early identification of dementia risk factors
- Increase referral and diagnosis rates
- Improve the level of local detail about learning disabilities and dementia within the Joint Strategic Needs Assessment (JSNA), thus providing a better opportunity to plan and design care for the longer term.
- Ensure that people with dementia and learning disabilities and their carers are supported by health and care services and the community to live as well and as independently as possible with their condition(s).

Priority 3: Reduce obesity

What we know about Havering

- Obesity rates in reception year children appear to be increasing over time**.** Just over one in ten (10.7 %) of reception year children in Havering are obese, whilst almost one in five (19.3%) year six children are obese. For children aged 4 – 11, there are correlations in Havering's Middle Layer Super Output Areas (MSOAs) between obesity and income deprivation and between obesity.
- At 27.3%, the proportion of adults in Havering who are obese is the second highest in London and also higher than both the England average of 24.2% and the London average of 20.7%
- In 2012, 41% of people were overweight and 22.3% were obese in Havering
- Pockets of high obesity prevalence across the Borough tend to be clustered in the less affluent wards of Gooshays, Heaton and South Hornchurch.
- Although a low number of Havering residents aged 16+ (17.5%) reported that they took part in the recommended 3x30 minutes of physical activity (which is lower than previously and below both London and England participation rates), Sport England's Active People Survey 2009/10 showed that almost 50% (54% men / 43% women) of borough residents took part in sport or active recreation at least once in the four weeks prior to the survey. In addition, the 2010/11 survey showed that 21% of the borough's residents were members of sports clubs, 13% had received sports tuition in the last 12 months and 13% had taken part in organised competition in the last 12 months. However data also suggests that 51.8% of adults in Havering do no physical activity at all.

What we plan to do

- Increase physical activity levels amongst residents in the borough
- Assist residents (particularly in the most deprived areas of the borough) to maintain healthy weight
- Continue to invest in the assessment, treatment and prevention of childhood obesity, especially for under 5s
- Capitalise on opportunities presented through the National Child Measurement Programme to identify overweight and obese children, and signpost them to services

Priority 4: Reduce premature deaths from cancer and cardiovascular disease

What we know about Havering

- The premature mortality rate (all causes) for Havering is 90.5 (1,684) for people aged under 65 and 92.1(3,327) for people aged under 75, compared to the England ratio of 100.

- Levels of smoking are high in the borough. 20% of adults smoke, which is worse than the London average, and the borough also has the highest rate of smoking during pregnancy in London. The proportion of women who smoke in maternity almost doubled between 2005/06 and 2013/14. There are around 400 smoking related deaths per annum in the borough.

- High numbers of Havering residents are diagnosed with and die from cancer each year; due in part to the large older population. This will increase even further as the population continues to get older.

- Cancer survival rates are not improving and are worse than the national average

- Breast, bowel, and lung cancer are the most common cancers in women in Havering, while prostate, lung and bowel cancer are most common in men

- Around a third of deaths in Havering are caused by Cardiovascular Disease (CVD), a large proportion of which are deaths from Coronary Heart Disease and Strokes. However, overall, mortality from CVD in Havering is lower than the England average, but above the London average

- There are nearly twice as many male deaths from CVD in Havering as in women (which is also the case in London and England).

- Those who live in the less affluent areas of Havering are more likely to die from CVD, and those registered at GP practices in the most “deprived” areas of the borough a 55% more likely to have hypertension, 36% more likely to have congestive heart failure and 70% more likely to have coronary artery disease than those registered at GP practices in the least “deprived” areas.

What we plan to do

- Improve support and care coordination for people living with and beyond cancer.
- Maximise participation in screening programmes and health checks by identifying communities with low participation rates and taking targeted action in those communities
- Commission well-evidenced prevention programmes to tackle factors such as smoking, unhealthy diets and alcohol consumption

Theme B: Better integrated support for people most at risk

Havering has large and growing population of vulnerable people and older people. As our older people population continues to grow, and so does the number of "frail elderly" residents in the borough, we are facing increasing demands on services. By better integrating services across the health and social care sectors, as well as the voluntary and community sector, we can improve service user experiences and outcomes and also secure better value for money.

Vulnerable children, such as those in care or with disabilities, also face particularly complex challenges. Physical and psychological ill-health tends to be more prevalent amongst looked after children and care leavers compared with their peers. It is therefore essential that all looked after cildren receive a comprehensive and holistic health assessment and annual reviews, and that looked after children and their carers are supported to lead healthy lives.

Having successfully reduced the incidence of delayed transfers of care, more work now needs to be done across the whole system to reduce the number of admissions and the average length of stay in hospital. 60% of deaths in the borough occur in hospital, often following unplanned and prolonged hospital admissions. Hospital admissions are costly to the health service and disrupt the lives of those affected, including family and friends. Long and frequent hospital stays also reduce people's confidence to manage at home in the future. Emergency admissions account for nearly two thirds of hospital bed days in England and are costly compared to other types of care. Some of these admissions could be avoided. The Havering Health and Wellbeing Board is therefore keen to reduce unnecessary and unplanned hospital admissions, particularly where these relate to ill health or injury that could have been avoided, and / or individuals who are admitted to hospital on a frequent basis.

The Havering Health and Wellbeing Board's vision for whole system integrated care is based on what individuals, communities of interest and local organisations have told us is most important to them. Our aim is to provide people with new ways to access primary care, and to offer other innovative services which are designed around the needs of the patient in order to reduce acute admission and A&E attendance and also to improve the patient experience.

What we want to see

- Seamless, integrated and people-centred health and social care services delivered to Havering residents.

- Greater co-commissioning across the CCG and local authority.

- The introduction of joint assessments of health and social care needs; interoperability between health and social care systems and the holding of single case records across the health and social care sectors

- A vibrant primary care model

- Services shifted out of secondary care and into the community and primary care

- A reduction in avoidable time spent in hospital

- A higher proportion of older people living independently following discharge

- Improved physical, social and psychological health across the looked after children population

Our three priorities are to

Priority 5: Better integrated care for the “frail elderly” population

Priority 6: Improve integrated care for children, young people and families most at risk

Priority 7: Reduce avoidable hospital and long term care home admissions

Priority 5: Better integrated care for the "frail elderly" population

What we know about Havering

- There are 1,200 older people in the borough that have particularly complex health and social care needs.
- Approximately 19,500 Havering residents aged 65 or older have a limiting long term illness
- 17,277 older people were estimated to be living alone in 2014 and this is predicted to rise to 20,590 by 2020.
- Havering experiences the second highest number of excess winter deaths in London. Between 2006 and 2009, there were an average of 137 winter deaths per annum involving a person aged 85+ in Havering and these deaths are expected to increase along with the age of the population.
- In 2014, 15,784 older people aged over 65 were estimated to be unable to manage at least one self care task on their own, and 19,248 were estimated to be unable to manage at least one domestic task (e.g. shopping, washing etc) on their own.

What we plan to do

- Work as a strategic partnership to design and deliver seamless, integrated and efficient care pathways for "frail elderly" people with care needs
- Enhance the independence and capability of individuals to manage their conditions at home
- Provide support within the community to people who have recently been discharged from hospital or who are at risk of admission / readmission.

Priority 6: Improve integrated care for children, young people and families most at risk

What we know about Havering

- Of just over 30,000 families in Havering, it is estimated that nearly 400 of them are categorised as 'families with multiple complex needs' and over 2,000 are 'barely coping'.
- The level of child poverty in Havering is better than the England average with 19.1% of children in Havering living in poverty as at March 2014. However in some wards (e.g. Gooshays, at 35.2%) the percentage of children living in poverty is above both the London (28.8%) and England (18.2%) average, and the proportion of children living in poverty in the borough has bucked London-wide trends by increasing over recent years. Havering is one of only two London boroughs in which the rate of child poverty has increased. This is a concern to the Health and Wellbeing Board as children in poverty are more likely to report a range of poor health outcomes.
- Between 1 April 2013 and 31 January 2014, domestic violence was a presenting factor in 10.9% of all initial contacts to children's social care and was the second highest reason for contacts progressing to a referral to children's social care (placed only behind physical abuse). Domestic violence also featured in 19.7% of Children in Need Plans and 16.4% of Child Protection Plans.
- As at the end of November 2014, there were 180 children from Havering on Child Protection Plans. This had increased from an average of 124 per month during 2013/14.
- As at the end of November 2014, there were 164 children on a Child in Need (CIN) Plan. This had reduced from a peak of 214 at the end of July 2014.
- As at the end of November 2014, there were 216 children looked after by the local authority. The numbers of LAC have been at their highest ever levels in the borough during 2014/15.
- At primary level, speech, language and communication difficulties are the most commonly identified type of special educational need (SEN), followed by moderate learning difficulties, then behaviour, emotional and social difficulties. At secondary level, moderate learning difficulties are more prevalent, followed by behaviour, emotional and social difficulties, then speech, language and communication needs. Special schools, meanwhile, have a very different profile, with most of their pupils having severe, moderate or profound and multiple learning difficulties.
- The number of children aged 5 – 10 with an emotional disorder is expected to rise by 26 between 2014 and 2017, split roughly equally between boys and girls.

What we plan to do

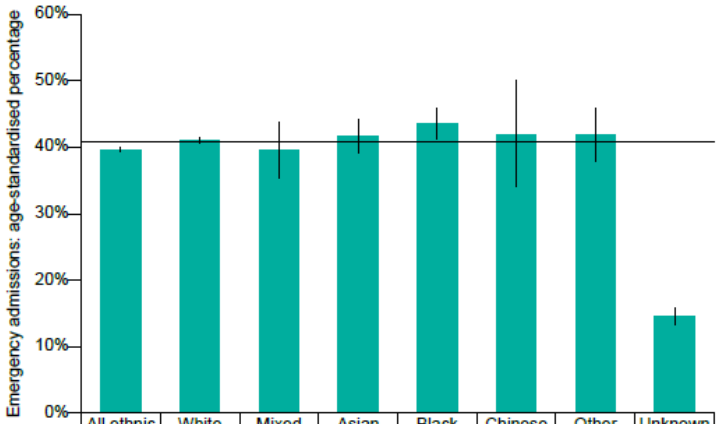
- Continue to provide intensive, bespoke support to families with multiple complex needs to avert the escalation of their difficulties.
- Reduce the numbers of children living in poverty in Havering
- Promote the physical, social and psychological health and wellbeing of children looked after by the local authority
- Improve transitions from children's to adults' care packages for young people with disabilities.
- Improve access to high-quality therapies for children and young people.

Priority 7: Reduce avoidable hospital and long term care home admissions

What we know about Havering

- Approximately 60% of deaths in the Havering occur in hospital, often following unplanned and prolonged hospital admissions.
- Rates of emergency hospital admission in Havering are significantly lower than the average for England and London but are increasing. A&E attendance rates, meanwhile, have declined in recent years with a reduction of 12% overall between Q3 2012/13 and Q3 2013/14, due largely to the work of the Integrated Care Coalition.
- The main health conditions responsible for avoidable admissions in Havering are chronic obstructive pulmonary disease (16.5% of all avoidable admissions), influenza and pneumonia (15.1%) and dehydration and gastroenteritis (11.3%)
- There are pockets across the borough with particularly high rates of avoidable hospital admissions. There is a cluster of high rates around Brooklands and Romford Town as well as some areas within Rainham and Wennington, Heaton, South Hornchurch and Harold Wood
- There are wide variations between Havering GP practices in terms of avoidable hospital admissions, ranging from 7 per 1,000 population to 32 per 1,000 population
- Readmission rates in Havering have risen by more than 4% over the last 10 years, in line with national trends. However, when emergency readmissions are analysed by age, Havering has consistently had a significantly higher (worse) percentage of older people (aged 75+) who are readmitted to hospital in an emergency within 28 days of discharge, compared with England

Percentage of hospital admissions that were emergencies, by ethnic group



This chart shows the percentage of hospital admissions in 2012/13 that were emergencies for each ethnic group in this area. A high percentage of emergency admissions may reflect some patients not accessing or receiving the care most suited to managing their conditions. By comparing the percentage in each ethnic group in this area with that of the whole population of England (represented by the horizontal line) possible inequalities can be identified.

Havering

England average (all ethnic groups)

95% confidence interval

Figures based on small numbers of admissions have been suppressed to avoid any potential disclosure of information about individuals.

All ethnic groups	White	Mixed	Asian	Black	Chinese	Other	Unknown	
22,082	19,779	223	625	725	57	245	428	Local number of emergency admissions
39.7	41.0	39.5	41.6	43.5	41.9	41.8	14.5	Local value
40.8	41.3	40.8	45.4	45.0	37.0	46.5	30.3	England value

Havering Health Profile 2014

What we are going to do

- Continue to develop effective care pathways both in and out of hospital and primary care
- Improve access to primary care, including in community settings
- Continue to develop Intermediate Care services
- Develop an integrated health and social care commissioning function

Theme C: Quality of services and patient experience

Ensuring that patients, their families and carers receive the best quality health and social care services is crucial to achieving the best long-term outcomes for patients and for the borough's population as a whole. In Havering, we want all patients to have as positive an experience as possible from the health and social care services they receive. Services across the whole health and social care economy should be delivered efficiently, safely and sustainably.

The Havering Health and Wellbeing Board remains aware of the serious quality and patient safety concerns identified within some of the borough's providers. CQC reports identified specific concerns relating to BHRUT (the borough's major acute provider) and it was placed in special measures in December 2013. This meant that it had to make significant improvements in the way it provides patient care and operates as an organisation. The Trust now has a new leadership team in place and is working to a robust improvement plan – *Unlocking our Potential* - that members of the Health and Wellbeing Board were instrumental in developing. Patient satisfaction has improved, with the Trust's Friends and Family Test inpatient score for June 2014 reaching 69, compared with 43 in June 2013. But while improvements have been made since, there is still more that needs to be done, and the Health and Wellbeing Board continues to have a vital role in scrutinising, challenging and supporting BHRUT to continue to make progress and improvements to benefit patients and their families.

The Council commissions Healthwatch Havering to engage local people on the health issues that matter most to them and to ensure that the voices of local patients and residents are represented on the Health and Wellbeing Board, in order to inform the development and improvement of local health and social care services.

What we want to see

- Consistently high quality and safety of care in all health and social care services provided in the borough.
- CCG and social care commissioners commissioning and procuring jointly, with a focus on improving outcomes for individuals within our communities.
- Improved patient engagement
- Better communication of the activities of the Health and Wellbeing Board and its impact on local health and social care services

Our priority is to…….

Priority 8: Improve the quality of services to ensure that patient experiences and long term health outcomes are the best they can be

Priority 8: Improve the quality of services to ensure that patient experiences and long term health outcomes are the best they can be

What we know about Havering

- The borough has two major service providers, these being the Barking, Havering and Redbridge University Hospitals Trust (BHRUT) for acute hospital services and the North East London Foundation Trust (NELFT) for community services (such as district nursing and mental health services). Community and mental health services are provided in clinics and hospitals as well as in people's own homes.
- We are working in one of the eleven most challenged health economies in the country and with one of the most challenged hospital trusts in the country. While improvements have been made, there is still more needing to be done to improve quality of services.
- Havering's patient experience of primary care and out of hours services is in the bottom quartile of London CCGs, while our patient-to-GP ratio (the number of patients to every GP in the borough) is very high.
- GP practices in Havering generally see lower levels of patient satisfaction with their GP than in most other CCGs nationally, and issues of patient access persist in some practices.

What we plan to do

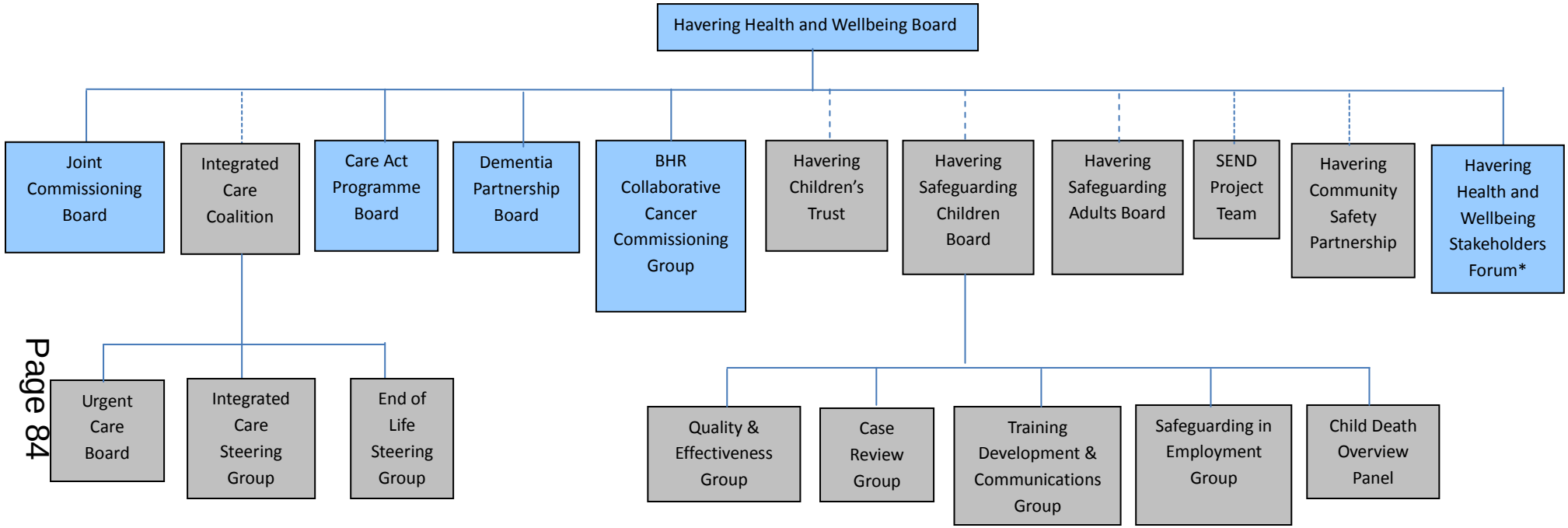
- Ensure that the CQC's findings and recommendations for improvements in the quality of care and patient safety at Queen's Hospital continue to be addressed.
- Work across the health and social care sectors to make the best use of our combined estates and assets.
- Ensure that patient and public engagement actively informs service improvement.
- Improve communication of the activities of the Health and Wellbeing Board and its impact on local health and social care services.

Appendix 1: Membership and Governance of the Havering Health and Wellbeing Board

Membership of the Health and Wellbeing Board

Name	Designation	Organisation
Cllr. Steven Kelly (Chair)	Elected Member	London Borough of Havering
Cllr. Meg Davis	Cabinet Member for Children and Learning	London Borough of Havering
Cllr. Wendy Brice-Thompson	Cabinet Member for Health	London Borough Of Havering
Cheryl Coppell	Chief Executive	London Borough of Havering
Joy Hollister	Group Director (Children, Adults and Housing)	London Borough of Havering
Andrew Blake-Herbert	Group Director (Communities and Resources)	London Borough of Havering
Mark Ansell	Acting Director of Public Health	London Borough of Havering
Conor Burke	Chief Officer	Barking, Havering and Redbridge Clinical Commissioning Group
Dr. Atul Aggarwal	Chair	Havering Clinical Commissioning Group
Alan Steward	Chief Operating Officer	Havering Clinical Commissioning Group
Dr. Gurdev Saini	Board Member (Lead for the Local Authority)	Havering Clinical Commissioning Group
Anne-Marie Dean	Chair	Healthwatch Havering
John Atherton	Head of Assurance	NHS England

The Health and Wellbeing Board's Governance Structure



Appendix 2: Glossary of Key Terms

Chronic Obstructive Pulmonary Disease (COPD) – A collection of lung diseases including chronic bronchitis, emphysema and Chronic Obstructive Airways Disease.

Community Health and Social Care Service (CHSCS) – A team developed through the reconfiguration of relevant NELFT services (community nursing, Integrated Case Management, therapies, and a mental health link worker) into locality based teams.

Community Treatment Team (CTT) – An expanded service operating in Havering between 8am and 10pm, seven days a week. This aligns with peak attendances in A&E, in an effort to help relieve the pressure on accident and emergency units. The team provides short-term intensive care and support to individuals with a health and / or social care crisis to help support them at home rather than in hospital. The team includes both health and social care professionals, including doctors, nurses, occupational therapists, physiotherapists, social workers and support workers. The CTT aims to:

- Provide short term intensive care and support to people experiencing health and / or social care crisis, to help them to be cared for in their own home rather than in hospital;
- Support people to return home as soon as possible following an acute or community inpatient stay, where this is appropriate, and
- Provide a single point of access to intensive rehabilitation at home or in a bed in a community rehabilitation unit if necessary.

Frailty Academy – A virtual academy operating across Barking and Dagenham, Havering and Redbridge and comprising of clinicians and other staff from across health and social care as well as academics from University College London (UCL). Its aim is to ensure that the lessons of various approaches and initiatives are learned and used to inform the development of mainstream services.

Healthwatch Havering – The consumer local champion for health and social care services within the borough. It aims to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for individuals locally.

Integrated Care Coalition (ICC) – Brings together senior executive leaders within the Barking and Dagenham, Havering and Redbridge health and social care economy to support the three Clinical Commissioning Groups and the three local authorities in commissioning integrated care and building a sustainable health and social care system. The ICC is responsible for developing recommendations for system wide integrated care for consideration by commissioners and the Health and Wellbeing Boards.

Integrated Care Steering Group (ICSG) – Co-ordinates (on behalf of the Integrated Care Coalition) the production of the five year strategic plan across the Barking, Havering and Redbridge health economy.

Integrated Case Management (ICM) – A model of practice which aims to ensure that patients with complex health and social care needs receive the right care, in the right place, at the right time. The ICM team in Havering includes a GP, a Community Matron, a District Nurse, a Social Care lead, a Care Liaison Officer and any other relevant staff needed in order to meet specific needs (e.g. from the mental health team).

Intensive Rehabilitation Service (IRS) – A team consisting of nurses, occupational therapy staff, physiotherapy staff and rehabilitation assistants, with access to a geriatrician as required via the Community Treatment Teams (see above). It aims to offer an alternative to admitting patients to an inpatient unit for rehabilitation by supporting people in their own homes where it is appropriate to do so. The in-home support provided is intensive and involves between one and four home visits each day, depending on the patient's needs. The service operates between 8am and 8om, seven days a week.

Joint Assessment and Discharge (JAD) team – Brings together the assessment and discharge teams across Barking and Dagenham, Havering and Redbridge into a single, integrated, ward based system, able to discharge to any of the three boroughs.

Multi-Agency Safeguarding Hub (MASH) – A co-located, multi-agency team working in a single, secure assessment and referral unit where protocols govern what information from each agency can be shared and how in order to ensure that the welfare of the individual is safeguarded and promoted. Information is gathered from a range of relevant agencies to inform the decision about what further action is required and which agency is best placed to lead this.

Nursing Home Scheme – A scheme designed to prevent unnecessary conveyances to hospital from nursing homes. As at May 2014, 31 nursing homes in Havering were signed up to the scheme.

Urgent Care Board (UCB) – Develops and delivers the improvement plan for urgent care

Abbreviations

A&E – Accident and Emergency Unit

BCF- Better Care Fund

BHRUT- Barking, Havering and Redbridge University Hospitals Trust

CAMHS- Child and Adolescent Mental Health Services

CCG- Clinical Commissioning Group

CHSCS – Community Health and Social Care Service

CIN – Child in Need

COPD – Chronic Obstructive Pulmonary Disease

CPP – Child Protection Plan

CQC- Care Quality Commission

CTT – Community Treatment Team

CVD- Cardiovascular Disease

DTOC – Delayed transfers of care

GP – General Practitioner

ICC – Integrated Care Coalition

ICM – Integrated Case Management

ICSG – Integrated Care Steering Group

IRS – Intensive Rehabilitation Service

JAD- Joint Assessment & Discharge Team

JCB – Joint Commissioning Board

JSNA- Joint Strategic Needs Assessment

LA – Local Authority

LAC – Looked After Child(ren)

LAS – London Ambulance Service

LBH – London Borough of Havering

LD – Learning Disability

LTC – Long Term Condition

MASH – Multi-Agency Safeguarding Hub

MARAC – Multi-Agency Risk Assessment Conference

NCMP – National Childhood Measurement Programme

NELFT- North East London Foundation Trust

NHS – National Health Service

NHSE – National Health Service England

PEF – Patient Engagement Forum

PHE – Public Health England

PPG – Practice Participation Group

SALT- Speech and language therapies

SEN – Special Education Need(s)

SEND – Special Educational Needs and Disabilities

UCB – Urgent Care Board

Appendix 3: List of key partnership strategic documents

Havering's Better Care Fund (BCF) submission

Children and Young People's Plan 2014 - 2017

Havering Joint Dementia Strategy 2014 - 2017

Integrated Care Strategy

Child Poverty Strategy

London Borough of Havering's Corporate Plan

London Borough of Havering's DRAFT Corporate Parenting Strategy

London Borough of Havering's DRAFT Looked After Children (LAC) Strategy

London Borough of Havering's DRAFT Voluntary Sector Strategy

Havering Clinical Commissioning Group's Commissioning Strategic Plan 2014/15 – 2015/16

Barking and Dagenham, Havering and Redbridge Integrated Care Coalition Strategic Plan Final Submission (June 2014)

Unlocking our Potential (BHRUT's improvement plan)

Culture and Leisure Strategy

Arts Strategy

DRAFT Violence against Women and Girls Strategy

Community Safety Strategy

Housing Strategy

Joint Strategic Needs Assessment (JSNA)

Appendix 4: Action Plan

TO BE INSERTED

Havering
LONDON BOROUGH

Agenda Item 10

HEALTH & WELLBEING BOARD

Subject Heading:	Health Protection Forum Annual Report 2015
Board Lead:	Dr. Susan Milner
Report Author and contact details:	Louise Dibsdall & Elaine Greenway Public Health Service

The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- ☐ Priority 1: Early help for vulnerable people
- ☐ Priority 2: Improved identification and support for people with dementia
- ☒ Priority 3: Earlier detection of cancer
- ☐ Priority 4: Tackling obesity
- ☐ Priority 5: Better integrated care for the 'frail elderly' population
- ☐ Priority 6: Better integrated care for vulnerable children
- ☒ Priority 7: Reducing avoidable hospital admissions
- ☐ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

The purpose of this report is to discharge the Director of Public Health's statutory duty to provide assurance and information on arrangements to protect the health of the population of Havering. It presents an overview of the key health protection functions of the Council and what actions are being taken.

On the whole, health protection in Havering is effective and the established processes are performing as expected. There have been no major outbreaks or incidents outside of what would normally be expected when health protection processes are working well.

The main highlights/issues are:

- Under 12month, under 2 years and under 5 year old routine vaccinations are all either surpassing, close to the 95% uptake target or on a par with England
- Childhood flu vaccinations are on target, with the exception of the four year old cohort, which is low across London on average
- Uptake of the adult seasonal flu vaccine has not reached its target to date; uptake in the whole of the UK is lower than recommended.

- There is currently better uptake of the bowel cancer screening programme in Havering compared to London (but lower than England), which is likely due to the poor acceptability of the test.
- Prevalence of HIV in Havering is lowest out of all the London boroughs, but many are diagnosed late

Key actions being taken are:

- Havering Public Health Service maintain surveillance of the health protection system
- NHSE have developed an immunisations action plan in partnership with Havering CCG and the council to improve uptake of immunisations and data quality
- GP practices have been reminded by NHSE to undertake call and recall for all immunisations cohorts (seasonal flu as well as routine vaccinations)
- NHSE has chaired monthly flu calls with CCGs and PH teams to give updates and share best practice
- PHE rolled out a national winter campaign which included the flu vaccination programme
- Visits to GP practices have been made by NHSE immunisations leads to support practices:
    - in ensuring they have processes in place to undertake call and recall for children who require immunisation;
    - access to IT support for implementing immunisations reports;
    - ensure failsafe systems are in place.
- NHSE will develop a good practice guide for London and circulate to GP practices
- NHSE and CCG to support practices to ensure that they are registered with SONAR (an information portal) to receive timely pharmacy flu vaccination data.
- NHSE and CCG to support GP practices to identify patients who are carers themselves and invite then to the flu clinic
- NHSE is currently piloting an alternative style of bowel cancer screening test, which is more sensitive than the current standard test, and only requires one stool sample rather than three, which makes the test more acceptable to people.

More people are being tested for HIV in A&E and through antenatal screening. For both HIV and TB, as a result of anticipated changes in our population, the Health Protection Forum is keeping a watching brief on the incidence and prevalence of both HIV and TB.

RECOMMENDATIONS

To note the contents of the report. No further action required.

REPORT DETAIL

Please see attached report.

IMPLICATIONS AND RISKS

Financial implications and risks: None
Legal implications and risks: None
Human Resources implications and risks: None

Equalities implications and risks: None

Havering Health Protection Forum Annual Report 2015

1.0 Background

1.1 Purpose

Under the Health and Social Care Act 2012, Local Authorities have enhanced statutory duties for health protection[1]. This Act requires local authorities, through their Director of Public Health, to **seek assurance that proper plans are in place to protect the health of the public**. Health protection as a function seeks to reduce the harm caused by communicable diseases and minimise the health impact from environmental hazards such as chemicals and radiation.

The purpose of this report is to provide assurance and information on arrangements to protect the health of the population of Havering. The following report outlines the statutory duties and responsibilities of the organisations involved in health protection, and particularly the role of the Director of Public Health and Local Authority following the introduction of the Health and Social Care Act 2012. The report also provides an overview of the role and functions of the Health Protection Forum (HPF) and highlights key issues relating to health protection in Havering, including immunisations, screening, infectious diseases, air quality and health aspects of emergency planning and, where necessary, what actions are being taken to strengthen local arrangements.

1.2 Roles and Responsibilities

- **Local Authorities and Director of Public Health** – Local Authorities have a critical role in protecting the health of their population, both in terms of planning to prevent health protection incidents and communicable disease outbreaks arising and in ensuring appropriate responses when things do go wrong. Working alongside Public Health England, who provide the specialist health protection response, advice and support, the local authority's role is to provide surveillance and local leadership for health[2].

  The Director of Public Health (DPH) is the chief officer responsible for seeking and gaining assurance of the local authority's contribution to health protection matters. The DPH and team provide surveillance of the health protection system, including monitoring of communicable disease outbreaks, effectiveness of screening and immunisation programmes, health protection and environmental health issues and incidents, and health emergency planning. Havering's DPH also chairs the Havering Health Protection Forum which is the primary local process for obtaining assurance that health protection arrangements are robust, as outlined below.

- **Public Health England (PHE)** – PHE works with national and local government, industry, and the NHS, to protect and improve the nation's health. It was established on 1 April 2013 to bring together public health specialists from more than 70 organisations into a single public health service. It has a responsibility to deliver the specialist health protection response, including the response to incidents and outbreaks, through the PHE Centres which take on the functions of the former Health Protection Units[3].

- **NHS England (NHSE)** –NHSE is responsible for commissioning routine vaccinations, and the national screening programme, which are key to protecting the health of the population

from infection, and identifying health issues (please refer to appendices A and B for more detail on these).

NHSE has also appointed a lead director for NHS emergency preparedness and response at the Local Resilience Forum (LRF) level (which for Havering is London), and provides necessary support to enable planning and response to emergencies that require NHS resources.

- **Chief Medical Officer (CMO)** – The Chief Medical Officer (CMO) acts as the UK government's principal medical adviser and is the professional head of all directors of public health in local government[4].
- **Havering Clinical Commissioning Group (CCG)** –The CCG's role is to commission most local health services, from cancer care to mental health, hospital operations to prescriptions[5]. From a health protection perspective, they are primarily responsible for monitoring and quality assuring infection control practices in acute and community settings.
- **Care Quality Commission (CQC)** – The CQC inspects health and social care organisations to ensure they are safe, effective, caring, responsive to people's needs and well-led. The safety of patients is paramount, and inspectors examine how risks such as infection control and hygiene practices are identified and mitigated.

1.3 Governance and Local Health Protection Arrangements in Havering

In accordance with national guidance, Havering Council established a Health Protection Forum in 2013, which supports the Director of Public Health in their health protection role: assurance that appropriate arrangements are in place to protect the health of local residents. The Forum provides surveillance of the respective components of the health protection system and challenges the system when risks are identified (Terms of Reference are attached in Appendix C). The organisations represented on the Forum include:

- London Borough of Havering (Environmental Health, Public Health)
- NHS England (NHSE)
- Public Health England (PHE)
- Havering Clinical Commissioning Group (CCG)
- Havering Borough Resilience Forum (BRF)
- North East London Foundation Trust (NELFT)
- Barking, Havering and Redbridge University Hospitals Trust (BHRUT)

The Havering Health Protection Forum meets quarterly and has received reports on health protection topics, including commissioned immunisations programmes; infectious diseases (PHE); pandemic flu; Ebola; children's flu pilot; heatwave planning; and policies and provision for offensive and clinical waste removal.

2.0 Health Protection Main Topics of Focus

On the whole, health protection in Havering is effective and the established processes are performing as expected. There have been no major outbreaks or incidents outside of what would normally be expected when health protection processes are working well. The topics listed below represent the areas of most interest and/or concern to the Health Protection Forum, and most importantly, what is being done about these issues.

2.1 Immunisations

There is a comprehensive programme of routine childhood immunisations that protect babies and children from serious preventable illnesses and vaccinations for adults, including shingles, flu and pneumonia[6]. Additional vaccinations are available to people at specific risk, such as Hepatitis B (Appendix A outlines the full vaccination schedule, Appendix E gives an overview of performance of immunisations and screening[7]).

In 2013, NHSE became responsible for commissioning Immunisation Programmes. Recommendations on which vaccinations to commission in the UK are made by the Joint Committee on Vaccination and Immunisation (JCVI), an independent Departmental Expert Committee and a statutory body[8]. NHSE then commission the routine vaccination programmes, which are delivered locally primarily by GPs, practice nurses, local immunisations teams, and pharmacists (flu only). Immunisations delivery is collated by PHE and the DPH receives regular reports. The HPF receives a quarterly report on vaccination uptake and interrogates the data, posing questions back to both commissioners and providers where relevant.

Throughout a challenging period of transition, the uptake of immunisations in Havering has been largely maintained:

- Under 12 month vaccinations are all very close to, or surpassing the challenging target of 95%, and are all better than the London average.
- The under 2 year old vaccinations are either surpassing the target, or are on par with the England performance (and close to target). NHS England and local practices have plans in place to maintain good performance, and make improvements where possible.
- The under 5 year old vaccinations are also either surpassing the target or are close to the 95% target; Havering's uptake of vaccinations amongst this age group are all higher than that for both London and England.
- Childhood flu vaccinations are on target, with the exception of the four year old cohort, which is low across London on average (see* below for further explanation).
- Seasonal flu vaccinations are on a par with London and England amongst both the under 65 years at clinical risk, and those 65 years and over. NHSE are working with GP practices and pharmacies to deliver plans to increase uptake particularly in those aged 6 months to 65 years clinically at-risk.

*In 2014/15 Havering took part in the national child flu school vaccination pilots for children in reception year (generally aged 4-5 years). 2014/15 was also the first year that the flu programme was nationally rolled out to offer four year olds flu vaccination via GP practices. Four year old children in Havering had the opportunity to receive their flu vaccination from GP practices or in schools. The published data shows flu vaccination data held on GP systems as of week 4 (end of January 2015), but not data held via the school vaccination provider as these data was not published. Therefore, many more Havering children received flu vaccination in 2014/15 than is reported. For 2015/16 the child flu vaccination programme has rolled out nationally which offers school children in years 1 and 2 flu vaccinations in school. Children in reception year are not being vaccinated in school, therefore children of reception year age will go to their GP practice for vaccination. Specific actions taken include:

- GP practices have been reminded by NHSE to undertake call and recall for all cohorts
- NHSE has chaired monthly flu calls with CCGs and PH teams to give updates and share best practice

- PHE rolled out a national winter campaign which included the flu vaccination programme

Historically, uptake of the adult seasonal flu vaccine has been below target across the UK. NHSE have developed an action plan to achieve improvement during the 2015/16 flu season. It is crucial that those in prority groups, including healthcare workers continue to take up the vaccine. Campaigns such as the NHS Employers' 'Flu Fighters' has been promoted to increase uptake of the flu vaccination amongst frontline health and social care workers, including those working in residential care.

Since the recent measles outbreak in Wales, and the discreditation of the research linking the Measles, Mumps and Rubella (MMR) vaccine to autism, MMR uptake (MMR2 by 5 years old by Local Authority) has increased to 90.6% in Havering, higher than both the London (80.1%) and England (88.6%) averages[9].

NHSE and the CCG, with support from Havering Public Health Service, has developed an immunisations action plan with the aim of achieving good uptake. Actions include:

- Visits to GP practices by NHSE immunisations leads to support practices:
    - in ensuring they have processes in place to undertake call and recall for children who require immunisation;
    - access to IT support for implementing immunisations reports;
    - and ensure failsafe systems are in place.
- NHSE will develop a good practice guide and distribute to GP practices
- NHSE and CCG to support practices to ensure that they are registered with SONAR, the information portal, to receive timely pharmacy flu vaccination data.
- NHSE and CCG to support GP practices to identify patients who are carers and invite then to the flu clinic

2.2 Screening

Screening is "a process of identifying apparently healthy people who may be at increased risk of a disease or condition." They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition. The NHS runs a comprehensive screening programme for a range of adult cancers, and adult non-cancer conditions, antenatal and newborn screening (Appendix B outlines the full list of screening programmes).

Breast, bowel and cervical cancer screening is delivered by the NHS and co-ordinated by the national office of the NHS Cancer Screening Programme, part of Public Health England (PHE)[10]. People who are eligible for screening of breast, bowel and cervical cancer receive routine invitations. Every aspect of screening is monitored against quality programme standards. Staff at regional Quality Assurance Reference Centres work with screening services to ensure the national screening standards are met, including undertaking quality assurance visits.

Prostate cancer screening is not part of the national cancer screening programme, as there is currently no reliable screening test for prostate cancer. However, the Prostate Cancer Risk Management Programme has been set up to ensure that men who are concerned about the risk of prostate cancer receive clear and balanced information about the advantages and disadvantages of the PSA test and treatment for prostate cancer. This will help men to decide whether they want to have the test[11].

The Health Protection Forum receives a report on all cancer and non-cancer screening programmes (antenatal, newborn, Abdominal Aortic Aneurism (AAA) and Diabetic Eye Screening Programme (DESP)) from NHS England.

- Breast and cervical screening coverage in Havering is better than the average for both London and England.
- There is currently better uptake of the bowel cancer screening programme in Havering compared to London (but lower than England).

Overall, the bowel cancer screening programme has not achieved the level of uptake of other screening programmes, which is most likely attributable to the poor acceptability of the test. NHSE is currently piloting an alternative style of test to potentially improve uptake, which began in November 2015. The Fecal Immunochemical Test (FIT) has a number of advantages over the current screening test, called Faecal Occult Blood Test, or FOBt. The FIT is a more sensitive test than the FOBt and therefore likely to detect more cancers or pre-cancerous polyps. It also only requires one stool sample rather than three, which makes the test more acceptable to people. This will help improve the uptake of screening, currently less than 60%.

Six of Public Health England's population screening programmes focus on ante-natal and newborn screening to ensure a healthy pregnancy for both mum and baby. The majority of tests are delivered on time and meet quality standards. There are 7 tests that the HPF is monitoring, including:

- HIV
- Hepatitis B
- Down's Syndrome
- Antenatal Sickle Cell and Thalassaemia
- Newborn hearing
- Newborn and infant physical examination
- Newborn blood spot

The proportion of laboratory request forms for Down's syndrome screening submitted within the recommended timeframe, and newborn and infant physical examination both appear to require some improvement in performance. It should be noted here that there are several mitigating factors to this apparent lower performance – for example, if a parent cancels a screening appointment or does not attend a scheduled appointment the laboratory may as a consequence not be able to process the results of the screen in the recommended time frame. Similarly, although all babies are given a newborn physical examination, not all appeared to have been completed within the recommended 72 hours due to other mitigating factors, including non-attendance at appointments, home births and delays to uploading paperwork. It should be noted that there is good uptake of testing, it is the tight timescales that are not being achieved. The HPF is aware of the actions being taken to improve this.

A new screening programme, a bowel scope, is being introduced for men and women aged 55 years to help prevent bowel cancer. The new one-off test finds and removes any small bowel growths, called polyps, that could eventually turn into cancer. This programme is being introduced for Havering in 2016.

2.3 Infectious Diseases

Surveillance and response systems are in place to ensure that the infectious diseases of most concern are monitored and appropriate actions taken. Under the Health Protection Regulations

2010, medically qualified practitioners are required by law to report a range of infectious diseases to the "proper officer", which for Havering is Public Health England (PHE) (Appendix D gives the full list of notifiable diseases). Environmental Health officers also report incidents to PHE, including food poisoning, water or airborne and environmental hazards.

PHE monitor and investigate outbreaks of infection, and provide advice on the control and prevention of infections. PHE provide a weekly report to DsPH on cases of infectious diseases, which form part of the surveillance function of Directors of Public Health. The DPH and team keep close surveillance of such reports and provide advice, challenge and advocacy appropriately.

During the period of this report, the notifications and response mechanism is working well, and there are no issues of concern out of the normal expected numbers of cases. This report contains a description below of the infections that are of greatest concern:

2.3.1 HIV

In 2012 (the latest available data), Havering's prevalence of diagnosed HIV was the lowest – and remains the only borough with less than 1 per 1,000 population aged 15-59 years – in London. In Havering, the most important aspect is late diagnosis, in which one in every two people diagnosed with HIV in 2011 were diagnosed late. This is higher than London (44%) and 13th highest of the 31 London boroughs[12].

Late diagnosis of HIV infection is associated with increased morbidity and mortality, increased costs to healthcare services and a reduced response to anti-retroviral treatment. An earlier diagnosis can decrease onward transmission of HIV as an individual's knowledge of their HIV status has also been found to reduce their risk behaviour and it is therefore important to continue to promote acceptability of testing for HIV. Local sexual health services are recommended to focus on raising awareness of early testing of HIV particularly for at risk heterosexual groups.

The antenatal and newborn screening programme makes a vital contribution to identifying women with HIV who are unaware that they were infected. National uptake of antenatal screening for hepatitis B, HIV, syphilis and rubella susceptibility ranged between 97.54% and 97.79% in 2013, with less than 0.16% positivity rate for new diagnoses in these conditions and 6.59% rate of susceptibility for rubella[13]. If identified as HIV positive during pregnancy, then interventions can reduce the risk of a mother passing on HIV to her baby from 25% (1 in 4) to less than 1% (1 in 100), as well as protecting the mother's own health[14].

As a result of anticipated changes in our population (6% growth predicted by 2020), primarily due to migration of people from inner to outer London Boroughs, the Health Protection Forum is keeping a watching brief on the incidence and prevalence of HIV. The largest changes in population are expected in South Hornchurch, Brooklands, Harold Wood and Gooshays wards.

2.3.2 Tuberculosis (TB)

Havering continues to have very low rates of TB (11.4 per 100,000 compared with 41.9 per 100,000 for London)[15]. The local TB service continues to treat individuals and trace close contacts at higher risk. At present, NICE guidance includes vaccinating newborn babies who were born in an area of high TB incidence, have one or more parents or grandparents who were born in a high-incidence country, or have a family history of TB in the last 5 years[16]. However, the London Immunisations Board has endorsed a universal offer of neonatal BCG across London, including areas where prevalence is less than 40/100,000. The TB service also works closely with the HIV service, due to the risk of co-infection with both TB and HIV in some communities.

As with HIV, as a result of anticipated changes in our population, primarily due to migration of people from inner to outer London Boroughs, the Health Protection Forum is keeping a watching brief on the incidence and prevalence of both HIV and TB.

2.3.3 Ebola

The recent outbreak of the Ebola virus, which began in March 2014, mainly affected three countries in West Africa: Guinea, Liberia and Sierra Leone. This is the largest known outbreak of Ebola[17] with around 25,200 cases and more than 10,400 deaths reported by the World Health Organization.

The risk of Ebola to the UK remains very low. Whilst the UK expected to see isolated cases of imported Ebola, mainly from affected healthcare workers who were volunteering in Sierra Leone, management and processes in place meant minimal risk of it spreading to the general population. This is due to the high quality of the health care system within England with robust infection control systems and processes, including screening at UK entry points (airports), and disease control systems in place.

During the period, the DPH received weekly reports on any Ebola enquiries or exposed persons from PHE as part of the Notifications of Infectious Diseases (NOIDs) report. The DPH also received the Ebola Top Lines Briefing from the Emergency Planning Service for surveillance and assurance purposes.

2.3.4 Health Care Associated Infections (HCAI)

Healthcare-associated infections (HCAIs) can develop either as a direct result of interventions such as medical or surgical treatment, or from being in contact with the infection in a healthcare setting. The term HCAI covers a wide range of infections. The infections that are of most concern are methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* (*C. difficile*). HCAIs pose a serious risk to patients, staff and visitors. They can incur significant costs for the NHS and cause significant morbidity to those infected. As a result, infection prevention and control is a key priority for the NHS.

Public Health England provides a quarterly report to the Health Protection Forum, which includes data on MRSA cases and *c.difficile*. In addition, the membership of the HPF includes representation from infection control teams at Barking, Havering and Redbridge University Hospital Trust (BHRUT) and North East London Foundation Trust (NELFT). The CCG, as commissioner of healthcare, is also a member of the HPF.

In Havering, HCAIs are within expected limits and are being adequately managed through effective infection control practices.

2.3.5 Antimicrobial Resistance

Antibiotic resistance is one of the most significant threats to patients' safety in Europe. It is driven by overusing antibiotics and prescribing them inappropriately. The response to this issue is being led globally by the World Health Organisation, with individual nations responding with their own plans.

The UK Government published its 5-year Anti-Microbial Resistance (AMR) strategy in September 2013, led by DH, DEFRA, and PHE. Public Health England has also set up an AMR Strategy Programme Coordination Group to bring together delivery partners from across the health and social care sector. This group will coordinate the implementation of the human health aspects of 4

(out of 7) important areas of the AMR strategy for England. PHE's Antibiotic Guardian campaign (www.antibioticguardian.com) supports the AMR strategy.

Locally, Outer North East London Antimicrobial Resistance Strategy Group meets quarterly, and Havering is represented on this group via attendance of one of the Public Health Service team. The HPF receives a quarterly update on key issues and progress made by this group.

2.4 Air Quality

In 2006 Havering borough was declared an Air Quality Management Area (AQMA) by the Council. The declaration of Havering as an AQMA was considered the most appropriate action as a report indicated that the health related Air Quality Objectives for Nitrogen Dioxide (NO_2) and Airborne Particulate Matter (PM_{10}) at some locations would not be met by the relevant target date. In Havering the main source of air pollution is road traffic tailpipe emissions, although significant amounts are produced from residential and commercial gas use, industry, construction sites and emissions from outside London.

In order to improve the air quality in the Borough this Council is currently working on several initiatives;

- Mayor's Air Quality Fund (MAQF) Round I: The Council successfully secured funding in 2014 for three years to implement Air Quality Improvements across the Borough, including:
    - creating a 'Pocket Park' – Ludwigshafen Place – on one of the main roundabouts in the Romford Ring Road
    - installation of new trees in Romford Air Quality Hotspots
    - creation of the 'Target Your Trip' Business Pack
    - extension of the air quality monitoring network to include additional diffusion tube locations
    - Air Quality Mesh Monitors and reference monitors
    - a promotional campaign on the use of AirTEXT
- MAQF Round II: The Council placed a bid for further funding for 2016 – 2019 to continue improving Havering's Air Quality.
- Low Emission Neighbourhood: The Council successfully secured £20,000 in order to complete a feasibility study into creating a Low Emission Neighborhood within the Borough. The feasibility study will be used to create a detailed bid which will be submitted in April 2016 with the opportunity to obtain £1 million to then implement the Low Emissions Neighborhood.

The Health Protection Forum receives an annual report on air quality from the Air Quality Working Group, who have a comprehensive action plan to locally address the air quality issues.

2.5 Emergency Planning

Local resilience forums are multi-agency partnerships of local public services that plan for and respond to large scale localised incidents; identifying potential risks and emergency plans to either prevent or mitigate the impact of any incidence on their local communities. The Chairperson of the Havering Borough Resilience Forum is a member of the HPF.

Under the Civil Contingencies Act (2004), NHS organisations and providers of NHS-funded care need to prepare for and be able to respond to a wide range of incidents that could affect health or patient care, including extreme weather, outbreak of infectious diseases or a major transport accident. Since the introduction of the Health and Social Care Act 2012, there have been a number

of changes in the role of the NHS in emergency planning functions. In the health community, this is referred to as Emergency Preparedness Resilience and Response (EPRR)[18].

Local Health Resilience Partnerships (LHRPs) have now been established to deliver national EPRR strategy in the context of local risks. These bring together the health sector organisations involved in EPRR at the Local Resilience Forum (LRF) level – there is one LHRP for London. Building on existing arrangements for health representation at LRFs, the LHRP will be a forum for coordination, joint working and planning for emergency preparedness and response by all relevant specific health bodies. Through the London Local Health Resilience Partnership (LLHRP), London NHS emergency preparedness plans are due to be tested in Spring 2016. The LLHRP is also currently developing an EPRR training, exercising and lessons strategy to ensure emergency plans are prepared and tested.

3.0 Continuing to Protect the Health of Havering

The Health Protection Forum will continue to undertake surveillance of health protection in Havering through challenge and monitoring of health protection programmes and services. It will do this by continuing to receive a dashboard of key indicators that health protection arrangements are working well, and receiving reports on the main issues of concern

It should be noted that there are structural changes anticipated. As part of its change programme, "Securing Our Future", PHE is reviewing its local health protection functions. The purpose of the review is to support PHE's Centre Directors in the re-design of the local health protection function as part of the wider design of the new PHE Centres. The strengthened role of the new PHE Centres is designed to further improve their ability to support and respond to local health priorities and by gaining influence with local government, to translate PHE priorities into local action and to ensure that local perspectives and priorities are both understood and taken into account nationally.

Appendix A

The complete routine immunisation schedule from summer 2015

When	Diseases protected against	Vaccine given	Site[1]
Two months old	Diphtheria, tetanus, pertussis (whooping cough), polio and *Haemophilus influenzae* type b (Hib)	DTaP/IPV/Hib (Pediacel or Infanrix IPV Hib)[2]	Thigh
	Pneumococcal disease	PCV (Prevenar 13)	Thigh
	Meningococcal group B disease (MenB)	MenB (Bexsero) (from 1 September 2015)	Left thigh
	Rotavirus	Rotavirus (Rotarix)	By mouth
Three months old	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib (Pediacel or Infanrix IPV Hib)	Thigh
	Meningococcal group C disease (MenC)	Men C (NeisVac-C)[2]	Thigh
	Rotavirus	Rotavirus (Rotarix)	By mouth
Four months old	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib (Pediacel or Infanrix IPV Hib)	Thigh
	MenB	MenB (Bexsero)	Left thigh
	Pneumococcal disease	PCV (Prevenar 13)	Thigh
Between 12 and 13 months old – within a month of the first birthday	Hib/MenC	Hib/MenC (Menitorix)	Upper arm/thigh
	Pneumococcal disease	PCV (Prevenar 13)	Upper arm/thigh
	Measles, mumps and rubella (German measles)	MMR (Priorix or MMR VaxPRO)[2]	Upper arm/thigh
	MenB	MenB (Bexsero) booster	Left thigh
Two, three and four years old[3] and children in school years 1 and 2	Influenza[4] (from September)	Flu nasal spray (Fluenz Tetra) (annual) (if Fluenz is contraindicated and child is in clinical risk group, use inactivated flu vaccine)	Nostrils (Upper arm)
Three years four months old or soon after	Diphtheria, tetanus, pertussis and polio	DTaP/IPV (Infanrix IPV or Repevax)[2]	Upper arm
	Measles, mumps and rubella	MMR (Priorix or MMR VaxPRO) (check first dose has been given)[2]	Upper arm
Girls aged 12 to 13 years old	Cervical cancer caused by human papillomavirus types 16 and 18 (and genital warts caused by types 6 and 11)	HPV (Gardasil)	Upper arm
Around 14 years old	Tetanus, diphtheria and polio	Td/IPV (Revaxis), and check MMR status	Upper arm
	MenC and Meningococcal group W disease (MenW)[5]	MenACWY (Nimenrix, Menveo)[2]	Upper arm
65 years old	Pneumococcal disease	PPV Pneumococcal polysaccharide vaccine (Pneumovax II)	Upper arm
65 years of age and older	Influenza[4]	Flu injection (annual)	Upper arm
70 years old	Shingles (from September)	Shingles (Zostavax)	Upper arm (subcutaneous)

Immunisations for those at risk[6]

At birth, 1 month old, 2 months old and 12 months old	Hepatitis B	Hep B	Thigh
At birth	Tuberculosis	BCG	Upper arm (intradermal)
Six months up to two years	Influenza[4]	Inactivated flu vaccine (annual)	Upper arm/thigh
Two years up to under 65 years	Pneumococcal disease	PPV Pneumococcal polysaccharide vaccine (Pneumovax II)	Upper arm
Over two up to less than 18 years	Influenza[4] (from September)	Flu nasal spray (Fluenz Tetra) (annual) (if Fluenz is contraindicated, use inactivated flu vaccine)	Nostrils (Upper arm)
13 to 18 years	MenW[5]	MenACWY	Upper arm
18 up to under 65 years	Influenza[4]	Inactivated flu vaccine (annual)	Upper arm
At any stage of pregnancy	Influenza[8]	Inactivated flu vaccine	Upper arm
From 28 weeks of pregnancy[7]	Pertussis	dTaP/IPV (Boostrix-IPV)[8]	Upper arm

[1] Where two or more injections are required at once, these should ideally be given in different limbs. Where this is not possible, injections in the same limb should be given 2.5cm apart. For more details see Chapters 4 and 11 in the Green Book. All vaccines are given intramuscularly unless stated otherwise.

[2] Where two or more products to protect against the same disease are available, it may on occasion be necessary to substitute an alternative brand.

[3] This is defined as children aged two, three or four year (but not five years) on 31 August 2015.

[4] The vaccine is given prior to the flu season – usually in September and October.

[5] This vaccine will be delivered in a phased catch-up programme mainly in schools between August 2015 and 2017

[6] See individual chapters of the Green Book for clinical risk groups.

[7] See CMO letter of October 2012.

[8] Between September and March or later at GP's clinical discretion.

Immunisation
The safest way to protect children and adults

NHS

Vaccines for the routine immunisation schedule from summer 2015

When	Diseases protected against	Vaccine given
Two months old	Diphtheria, tetanus, pertussis (whooping cough), polio and *Haemophilus influenzae* type b (Hib)	**Pediacel** or **Infanrix IPV Hib** (DTaP/IPV/Hib)
	Pneumococcal disease	**Prevenar 13** (PCV)
	Rotavirus	**Rotarix** (Rotavirus)
	Meningococcal group B disease (MenB)	**Bexsero** (MenB)
Three months old	Diphtheria, tetanus, pertussis, polio and Hib	**Pediacel** or **Infanrix IPV Hib** (DTaP/IPV/Hib)
	Meningococcal group C disease (MenC)	**NeisVac-C** (Men C)
	Rotavirus	**Rotarix** (Rotavirus)
Four months old	Diphtheria, tetanus, pertussis, polio and Hib	**Pediacel** or **Infanrix IPV Hib** (DTaP/IPV/Hib)
	Pneumococcal disease	**Prevenar 13** (PCV)
	MenB	**Bexsero** (MenB)
Between 12 and 13 months old – within a month of the first birthday	Hib/MenC	**Menitorix** (Hib/MenC)
	Pneumococcal disease	**Prevenar 13** (PCV)
	Measles, mumps and rubella (German measles)	**Priorix** or **MMR VaxPRO** (MMR)
	MenB	**Bexsero** (MenB) booster
Two, three and four years old and children in school years 1 and 2	Influenza	**Fluenz Tetra** (Flu nasal spray) (annual) (if Fluenz is contraindicated and child is in clinical risk group, use inactivated flu vaccine)
Three years four months old or soon after	Diphtheria, tetanus, pertussis and polio	**Infanrix IPV** (DTaP/IPV) or **Repevax**[3]
	Measles, mumps and rubella	**Priorix** or **MMR VaxPRO** (MMR) (check first dose has been given)
Girls aged 12 to 13 years old	Cervical cancer caused by human papillomavirus types 16 and 18 (and genital warts caused by types 6 and 11)	**Gardasil** (HPV)
Around 14 years old	Tetanus, diphtheria and polio	**Revaxis** (Td/IPV), and check MMR status
	MenC and Meningococcal group W disease (MenW)[5]	**Nimenrix** or **Menveo** (MenACWY)[5]
At any stage of pregnancy	Influenza	Influenza injection during the flu season
From 28 weeks of pregnancy[7]	Pertussis	**Boostrix-IPV**[8]
65 years old	Pneumococcal disease	**Pneumovax II** (PPV Pneumococcal polysaccharide vaccine)
65 years of age and older	Influenza	Flu injection (annual)
70 years old	Shingles	**Zostavax** (Shingles)

*NB Where two or more products to protect against the same disease are available, it may, on occasion be necessary to substitute an alternative brand.

All these vaccines, including flu vaccine for all eligible children but excepting flu vaccine for healthy adults aged 65 and over, and Pneumovax II for those aged 65, are available free of charge at **www.ImmForm.dh.gov.uk**

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NHS

Appendix B

National Screening Programmes[1]

- NHS abdominal aortic aneurysm (AAA) programme : The NHS abdominal aortic aneurysm (AAA) screening programme is available for all men aged 65 and over in England. The programme aims to reduce AAA related mortality among men aged 65 to 74. A simple ultrasound test is performed to detect AAA. The scan itself is quick, painless and non-invasive and the results are provided straight away. A result letter is also sent to all patients' GPs.
- NHS diabetic eye screening (DES) programme: Evidence shows that early identification and treatment of diabetic eye disease could reduce sight loss. The eligible population for DES is all people with type 1 and type 2 diabetes aged 12 or over. Screening gives people with diabetes and their primary diabetes care providers information about very early changes in their eyes. The main treatment for diabetic retinopathy is laser surgery. People already under the care of an ophthalmology specialist for the condition are not invited for screening. The programme also offers pregnant women with type 1 or type 2 diabetes additional tests because of the risk of developing retinopathy.
- NHS fetal anomaly screening programme (FASP) : The NHS fetal anomaly screening programme (FASP) is one of the antenatal and newborn NHS population screening programmes. FASP offers screening for pregnant women to check the baby for Down's syndrome and other fetal anomalies, including:
    - Anencephaly
    - open spina bifida
    - cleft lip
    - diaphragamtaic hernia
    - gastrochisis
    - exomphalos
    - serious cardiac abnormalities
    - bilateral renal agenesis
    - lethal skeletal dysplasia
    - Edwards' syndrome (T18)
    - Patau's syndrome (T13)

- NHS infectious diseases in pregnancy screening (IDPS) programme: The IDPS programme currently screens for HIV, Hepatits B, Syphilis and Rubella susceptibility. Midwives and healthcare professionals should offer and recommend testing to all pregnant women as part of their antenatal care. The woman's decision to accept or decline testing should be noted in the woman's health records.
- NHS newborn and infant physical examination (NIPE) screening programme: NIPE screens newborn babies within 72 hours of birth, and then once again between 6 to 8 weeks for conditions relating to their:
    - Heart – congenital heart disease
    - Hips – developmental dysplasia of the hip
    - Eyes – congenital cataracts
    - Testes – cryptorchidism (undescended testes)

  The 6 to 8 week screen is necessary as some conditions appear later in a child's development.
- NHS newborn blood spot (NBS) screening programme: The NHS newborn blood spot (NBS) screening programme aims to identify rare conditions that can lead to serious illness, development problems and even death. Midwives carry out heel prick tests (taking blood from a baby's heel) when babies are 5 days old (the first day of life being day 0) and sends the samples off for testing. Babies who are new to the country or are yet to have a heel prick test are eligible for testing up to a year old. This excludes the cystic fibrosis screening test, which is not reliable after 8 weeks of age.

[1] HM Government, NHS Screening Programmes. Available on: https://www.gov.uk/topic/population-screening-programmes

- NHS sickle cell and thalassaemia (SCT) screening programme: The NHS Sickle Cell and Thalassaemia (SCT) screening programme is a genetic screening programme. This means that it also identifies people who are genetic carriers for sickle cell, thalassaemia and other haemoglobin disorders. If 2 people who are carriers have a baby together, there is an increased risk that their baby could inherit a haemoglobin disorder. The screening process is not perfect and in every programme there are a number of false positives and false negatives. It screens for:
  - genetic carriers for sickle cell, thalassaemia and other haemoglobin disorders
  - sickle cell disease
  - thalassaemia
  - haemoglobin disorders

  It offers screening to:
  - all pregnant women
  - fathers-to-be, where antenatal screening shows the mother is a genetic carrier
  - all newborn babies, as part of the newborn blood spot screening programme
- NHS newborn hearing screening programme (NHSP): Early identification of hearing impairment gives children a better chance of developing speech and language skills, and of making the most of social and emotional interaction from an early age. The parents of all babies born or resident in England should be offered hearing screening for their baby within 4 to 5 weeks of birth. Babies that miss screening should receive it as soon as possible, but not after 3 months of age.Some babies are not eligible for screening; this may be because the babies have an already-known risk of hearing impairment or deafness, from another condition. Healthcare staff can refer these babies for full audiological assessment without requiring a routine hearing screen. The programme offers 2 types of test:
  - automated otoacoustic emission (AOAE): usually the default test for well babies.
  - automated auditory brainstem response (AABR): test performed on both ears when there was no clear AOAE response.
- Screening and quality assurance (all programmes): All screening programmes are audited and quality assured to minimise the risk of harm to patients. Screening processes are not perfect, and in every screen there are a number of false positives and false negatives. Utilisation of failsafe procedures, programme standards and quality assurance by regional quality teams aims to make the screening process as rigorous and effective as possible.

Appendix C

Havering Health Protection Forum

Terms of Reference (Revised June 2015)

1. Introduction

The implementation of the Health and Social Care Act 2012 led to the transfer of responsibility for the delivery of local Public Health Services to the London Borough of Havering. The Act required local authorities, through their Director of Public Health, to **seek assurance that proper plans are in place to protect the health of the public**. These new arrangements were expected to build on existing partnerships, leading to a streamlined, integrated process for the prevention, planning and response to health protection incidents and events[2].

In order to put the legislation into practice and enable Local Authorities to discharge their new responsibilities, the Department of Health suggested that Local Authorities create a local forum to facilitate, review and instigate actions to protect the health of the local population. Within this context, Havering Council has established a Health Protection Forum which supports the Director of Public Health in their role of leading the response, planning and preparedness to health protection challenges.

These Terms of Reference define the aims and objectives of the Forum, its membership, and governance arrangements.

2. Aim of the Health Protection Forum

To enable the Director of Public Health to assure the Health and Wellbeing Board that appropriate arrangements are in place to protect the health of local residents.

3. Scope of the Health Protection Forum

The forum provides surveillance of the respective components of the health protection system and offers challenge to the system when risks are identified. Topics that are within the scope of the forum include, but are not restricted to:

- Health emergency planning, resilience and response
- Infectious disease prevention and control e.g. pandemic influenza, tuberculosis (TB), Blood Borne Viruses (BBV), Sexually Transmitted Infections (STIs)
- Health Care Associated Infections (HCAI)
- Immunisation programmes
- National screening programmes
- Environmental hazards

The delivery of these health protection functions in this new environment requires effective working relationships which are underpinned by a legislative framework that puts a duty on new bodies such as the Clinical Commissioning Groups (CCGs) and NHS England to cooperate with Local Authorities in respect of health and wellbeing.

[2] http://www.dh.gov.uk/health/2012/08/health-protection-guidance/

4. The objectives are to:

- seek and receive assurance that appropriate measures are in place to protect the health of the population
- liaise with the Borough Resilience Forum to ensure proper plans are in place to respond to major incidents and emergencies
- ensure the London Borough of Havering responds appropriately to local outbreaks of infectious diseases / environmental hazard (not triggering a major incident)
- assess risks to the health of the local population as identified in the Joint Strategic Needs Assessment and Borough Risk Register and escalate as appropriate
- assess the performance of:
    - healthcare providers with regard to levels of health care associated infections
    - cancer and non-cancer screening programmes
    - immunisation programmes and to raise any issues of concern with the relevant Commissioners
- challenge the health protection delivery systems when necessary in order to protect the health of the community
- produce an annual health protection report to the Havering Health and Wellbeing Board (HWB)
- ensure health protection issues are raised in the appropriate internal and external fora including the Borough Resilience Forum
- establish task and finish groups if required

5. Governance Arrangements

The Health Protection Forum reports to Havering Health and Wellbeing Board. (See Appendix 1.)

6. Secretariat

The Committee/Forum will be supported by the Council's Public Health Team. Papers will be circulated by email one week before the meeting.

7. Regularity of Meetings

The Forum will meet quarterly

8. Review of Terms of Reference

Terms of Reference will be reviewed annually and may be subject to review more frequently if requested by a member of the Committee/Forum, and seconded by another member.

9. Membership:

Chair – Director of Public Health, LBH
Deputy Chair – Consultant in Public Health, LBH
Havering Clinical Commissioning Group, HCCG
Public Health England, PHE
NHS England, NHSE

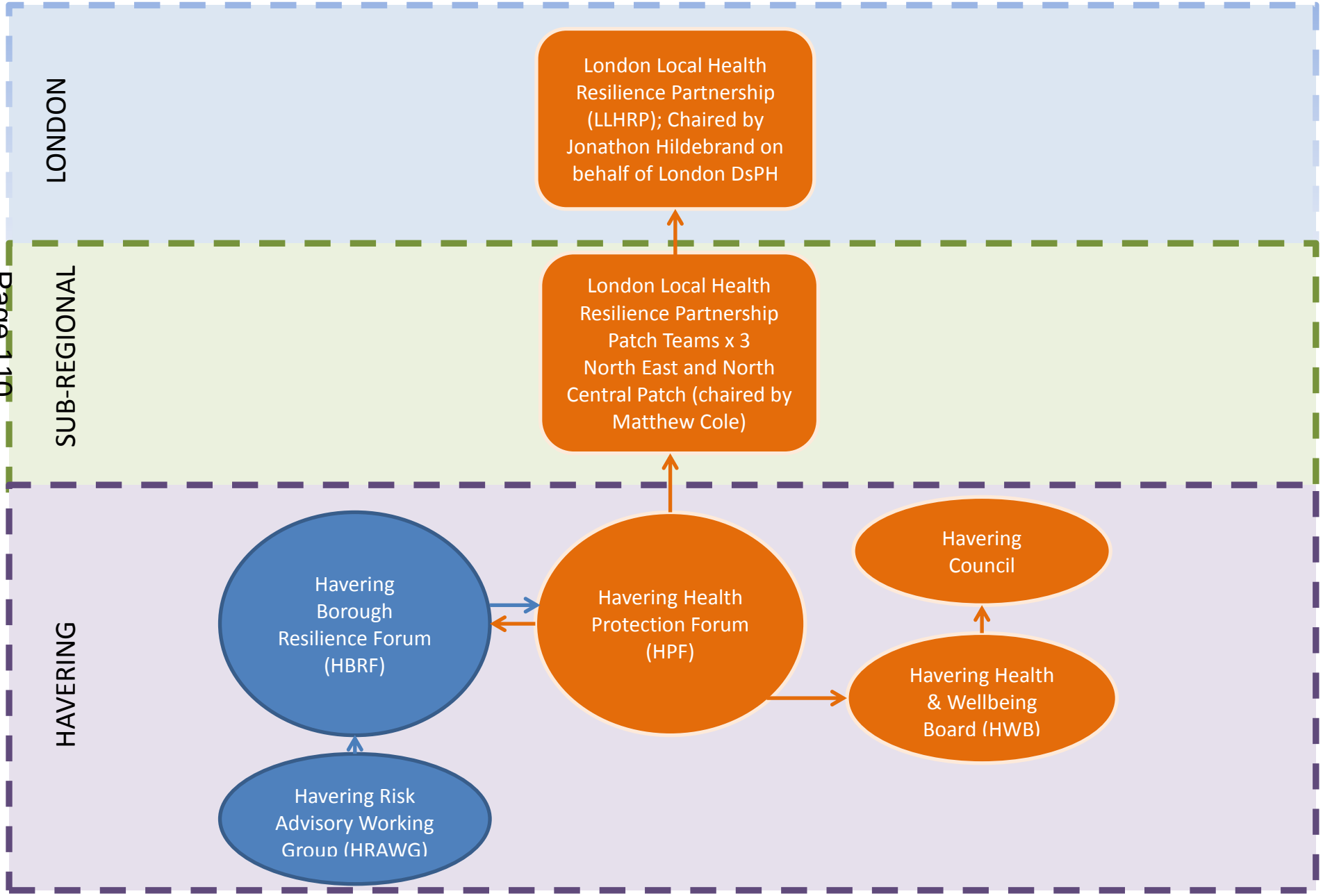
Borough Resilience Forum Chair, BRF
Environmental Health, LBH
Barking, Havering and Redbridge University Trust, BHRUT
North East London Foundation Trust, NELFT
North East London Commissioning Support Unit, NELCSU
Public Health Strategist, LBH
Public Health Information Analyst, LBH

Other directorates, services and organisations will be co-opted on to the Forum as necessary.

Terms of Reference agreed on …….. (date)

Signed …… (Chair)

Appendix 1: Governance Structure of Havering Health Protection Forum



Appendix D

Diseases notifiable to local authority proper officers under the Health Protection (Notification) Regulations 2010:

- Acute encephalitis
- Acute infectious hepatitis
- Acute meningitis
- Acute poliomyelitis
- Anthrax
- Botulism
- Brucellosis
- Cholera
- Diphtheria
- Enteric fever (typhoid or paratyphoid fever)
- Food poisoning
- Haemolytic uraemic syndrome (HUS)
- Infectious bloody diarrhoea
- Invasive group A streptococcal disease
- Legionnaires' disease
- Leprosy
- Malaria
- Measles
- Meningococcal septicaemia
- Mumps
- Plague
- Rabies
- Rubella
- Severe Acute Respiratory Syndrome (SARS)
- Scarlet fever
- Smallpox
- Tetanus
- Tuberculosis
- Typhus
- Viral haemorrhagic fever (VHF)
- Whooping cough
- Yellow fever

Report other diseases that may present significant risk to human health under the category 'other significant disease'

Appendix E

Havering Screening and Immunisation Performance compared with London and England

Target Group	Immunisation / Screening Programme	Target	Havering	London	England	Comments / What are we doing about it?
Antenatal immunisation & infectious disease screening (Pregnant Women & newborn)	Pertussis vaccination	100% of identified cohort[19]	63.8%	46.6%	57.7%	Latest available monthly data is September 2015[20]
	Seasonal influenza (flu) vaccination	75%	36.3%	39.9%	44.1%	Data 1st September 2014 to 31 January 2015[21]. NHSE have developed an action plan to achieve improvement during this year's flu season September 2015 to February 2016.
	HIV screening coverage	Acceptable ≥ 90% Achievable ≥ 95%	99.7%	99.8%	99.0%	Latest available data for BHRUT Q1 2015-16 (April to June)[22].
	HepB screening	Acceptable ≥ 70% Achievable ≥ 90%	N/A	70.2%	73.2%	Latest available data for BHRUT Q1 2015-16 (April to June)[23]. No data available specifically for BHRUT (Havering); average in both London and England are just meeting acceptable levels.
	Down's Syndrome screening	Acceptable ≥ 97% Achievable ≥ 100%	92.9%	97.6%	96.3%	Latest available data for BHRUT Q1 2015-16 (April to June)[24].
	Antenatal sickle cell & thalassaemia screening	Acceptable ≥ 95% Achievable ≥ 99%	99.7%	99.8%	99.1%	Latest available data for BHRUT Q1 2015-16 (April to June)[25].
Newborn Screening	Newborn Hearing screening	Acceptable ≥ 95% Achievable ≥ 99.5%	96.9%	97.5%	98.4%	Latest available data for BHRUT Q1 2015-16 (April to June)[26].
	Newborn and infant physical examination	Acceptable ≥ 95% Achievable ≥ 99.5%	N/A	90.5%	94.6%	Latest available data for BHRUT Q1 2015-16 (April to June)[27]. No return of data from BHRUT
	Newborn bloodspot screening	Acceptable ≥ 95% Achievable ≥ 99.9%	98.1%	96.6%	95.5%	Latest available data for BHRUT Q1 2015-16 (April to June)[28].
Routine Childhood Immunisations by 12 months old	DTaP/iPV/Hib3	95%	94.3%	90.2%	93.5%	Latest available COVER data Q2 2015-16 (July to September 2015)[29].
	Men C	95%	96.1%	92.2%	94.9%	Latest available COVER data Q2 2015-16 (July to September 2015)[30].
	PCV2	95%	93.9%	90.0%	93.5%	Latest available COVER data Q2 2015-16 (July to September 2015)[31].

Target Group	Immunisation / Screening Programme	Target	Havering	London	England	Comments / What are we doing about it?
	Rotavirus[32]	95%	N/A	85.4%	88.4%	Latest available COVER data Q2 2015-16 (July to September 2015)[33].No data available specifically for Havering
Routine Childhood Immunisations by 2 years old	DTaP/iPV/Hib3	95%	96.0%	93.0%	95.4%	Latest available COVER data Q2 2015-16 (July to September 2015)[34].
	Hib/MenC	95%	92.5%	86.4%	91.8%	Latest available COVER data Q2 2015-16 (July to September 2015)[35].NHSE have action plan to improve uptake.
	PCV2	95%	93.2%	86.5%	92.1%	Latest available COVER data Q2 2015-16 (July to September 2015)[36].NHSE have action plan to improve uptake.
	MMR1	95%	92.4%	86.0%	91.5%	Latest available COVER data Q2 2015-16 (July to September 2015)[37]. Performance in uptake of MMR2 in under 2 years improving.
Routine Childhood Immunisations by 5 years old	DTaP/iPV/Hib3	95%	96.9%	93.2%	95.9%	Latest available COVER data Q2 2015-16 (July to September 2015)[38].
	MMR1	95%	95.4%	91.2%	94.5%	Latest available COVER data Q2 2015-16 (July to September 2015)[39].
	MMR2	95%	88.7%	80.5%	87.9%	Latest available COVER data Q2 2015-16 (July to September 2015)[40].Uptake of MMR gradually improving nationally following the damage caused by the (now discredited) article by Andrew Wakefield
	DTaP/Hib booster	95%	89.6%	79.8%	87.9%	Latest available COVER data Q2 2015-16 (July to September 2015)[41].
	Hib/MenC booster	95%	95.2%	89.3%	93.3%	Latest available COVER data Q2 2015-16 (July to September 2015)[42].
Childhood Flu Vaccinations	2 Years Old	30-40%	30.7%	30.3%	38.5%	Latest published data for 2014-15 flu season 1st September 2014 to 31st January 2015[43]. Aim is for disruption in transmission of flu rather than achieving herd immunity hence target of 30-40%.
	3 Years Old	30-40%	34.8%	32.7%	41.3%	Latest published data for 2014-15 flu season 1st September 2014 to 31st January 2015[44].
	4 Years Old	30-40%	21.6%	23.6%	32.9%	Latest published data for 2014-15 flu season 1st September 2014 to 31st January 2015[45]. NHSE have included actions to improve flu vaccination amongst 4-year olds in their immunisations action plan for Havering.
Under 65	Seasonal flu	75%	47.5%	49.8%	50.3%	Latest published data for 2014-15 flu season 1st September 2014 to 31st

Target Group	Immunisation / Screening Programme	Target	Havering	London	England	Comments / What are we doing about it?
years at risk	vaccination					January 2015[46].NHSE are including this in their immunisations action plan for improvement.
	Cervical Cancer Screening programme	80%	76.3%	68.4%	73.5%	Latest available data from Public Health Outcomes Framework (PHOF) 2015[47].
	Breast Cancer Screening programme	80%	78.7%	68.3%	75.4%	Latest available data from PHOF 2015[48].
	Bowel Cancer Screening	100% of those in age range; 90% invited to be sent a test kit	50.6%	47.8%	57.1%	Latest available data from PHOF 2015[49].
Over 65 years	Seasonal flu vaccination	75%	70.2%	69.2%	72.7%	Latest published data for 2014-15 flu season 1st September 2014 to 31st January 2015[50].
	Shingles vaccination[51]	No set national target	50.8%	48.8%	59.0%	Latest available data 1st September 2014 to 31st August 2015. Data covers routine cohort only (age 70)[5253]
	Polysaccharide Pneumococcal vaccination (PPV)	No set national target	67.3%	65.0%	69.8%	Latest available data April 2014 to March 2015[54].
	Diabetic Eye Screening (DES)	Acceptable ≥ 70% Achievable ≥ 80%	78.7%	81.7%	82.8%	Latest available data Q1 2015-16 for Havering DES programme[55].
	Abdominal aortic aneurysms screening (AAA)	Acceptable ≥ 22.5% Achievable ≥ 25%	59.7%	39.0%	32.9%	Latest available data Q1 2015-16for North East London Cohort[56]. Approximately 25% of cohort is expected to be offered screening per quarter, which is aggregated annually.

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