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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD
AGENDA

1.00 pm	Wednesday, 23 March 2016	Committee Room 3B - Town Hall

BOARD MEMBERS:

Elected Members:	Cllr Wendy Brice-Thompson (Chairman) Cllr Meg Davis Cllr Gillian Ford Cllr Roger Ramsey
Officers of the Council:	Cheryl Coppell, Chief Executive Isobel Cattermole, Deputy Chief Executive, Children, Adults and Housing Dr 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 Alan Steward, Chief Operating Officer, Havering CCG Conor Burke, Accountable Officer, Barking & Dagenham, Havering and Redbridge CCGs
	Anne-Marie Dean, Chair, Havering Healthwatch John Atherton, NHS England

For information about the meeting please contact:
Anthony Clements 01708 433065
Anthony.clements@onesource.co.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 interest in any of the items on the agenda at this point of the meeting.

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

4. **MINUTES OF LAST MEETING AND MATTERS ARISING (NOT ON ACTION LOG) (Pages 1 - 4)**

To approve as a correct record the minutes of the Committee held on 27 January 2016 (attached) and to authorise the Chairman to sign them (5 minutes).

5. **ACTION LOG**

To consider the Board's Action Log (5 minutes)

To be circulated separately.

6. **HWB TERMS OF REFERENCE AND STRATEGIC PRIORITIES FOR DISCUSSION (Pages 5 - 14)**

Report attached (20 minutes).

7. **COMBINED VERBAL UPDATE ON ACCOUNTABLE CARE ORGANISATION/URGENT CARE VANGUARD AND DEVELOPMENT OF THE CCG SUSTAINABILITY AND TRANSFORMATION PLAN**

15 minutes.

8. **MARKET POSITION STATEMENT - COMMISSIONING IN ADULTS SERVICES (Pages 15 - 54)**

Report attached. (10 minutes).

9. **TRANSFORMING CARE PARTNERSHIP (Pages 55 - 62)**

Report attached (10 minutes).

10. **BETTER CARE FUNDING PLAN (Pages 63 - 114)**

Report attached (10 minutes).

11. **HAVERING SEXUAL HEALTH SERVICES RECONFIGURATION (Pages 115 - 134)**

Report attached (10 minutes).

12. **DRUG AND ALCOHOL REDUCTION STRATEGY (Pages 135 - 218)**

Report attached (10 minutes).

13. **OBESITY STRATEGY (Pages 219 - 252)**

Report attached (10 minutes).

14. **FORWARD PLAN**

To be tabled (5 minutes).

15. **DATE OF NEXT HWB MEETING**

To be agreed.

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MINUTES OF A MEETING OF THE
HEALTH & WELLBEING BOARD
Committee Room 2 - Town Hall
27 January 2016 (1.00 - 3.00 pm)

Board Members present:

Councillor Wendy Brice-Thompson, Cabinet Member Adult Social Services and Health (Chair) **(WBT)**
Councillor Roger Ramsey, Leader of the Council **(RR)**
Councillor Meg Davis – Cabinet Member, Children & Learning **(MD)**
Councillor Gillian Ford **(GF)**
Cheryl Coppell – Chief Executive, LBH **(CC)**
Isobel Cattermole, Deputy Chief Executive, Children's, Adults and Housing, LBH **(IC)**
Dr Susan Milner, Interim Director of Public Health, LBH **(SM)**
Dr Gurdev Saini, Clinical Director, Havering CCG **(GS)**
Dr Atul Aggarwal, Chair, Havering CCG **(AA)**
Alan Steward, Chief Operating Officer, Havering CCG (AS)
Anne Marie Dean, Havering Healthwatch **(AMD)**

Also Present:
Phillipa Brent-Isherwood, Head of Business and Performance **(PB)**
Elaine Greenway, Acting Consultant in Public Health, LBH **(EG)**
Dr Jacqui Lindo, Interim Consultant in Public Health, LBH **(JL)**
Keith Cheesman, Interim Head of Service for Integration, LBH **(KC)**
Lorna Spike-Watson, Interim PA to Interim Director of Public Health (minutes)

One member of the public was present.

28 **WELCOME AND INTRODUCTIONS**

The Chairman welcomed everyone to the meeting and introductions were made.

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

29 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from:

Connor Burke, Accountable Officer, BHR CCGs
John Atherton, Head of Assurance North Central and East London, NHS England

30 DISCLOSURE OF INTERESTS

No pecuniary or personal interests were disclosed.

31 MINUTES OF LAST MEETING AND MATTERS ARISING

The minutes of the meeting held on 11 November 2015 were agreed, subject to the amendment of Councillor Brice-Thompson's name being added as an attendee. The Chairman agreed to sign the minutes once this amendment had been made.

Action: SM to arrange for WBT to sign an amended set of minutes.

There were no matters arising additional to those actions recorded in the action log.

32 ACTION LOG

The action log was discussed and updated.

It was agreed that the action log would be revised to make for easier reference.

Action: SM to revise action log

33 CHANGES TO BOARD MEMBERSHIP

It was noted that Councillor Brice-Thompson has replaced Councillor Kelly as Chairman of the Board. It was also noted that Councillors Roger Ramsey and Gillian Ford had joined the Board.

The Board recorded its thanks to Councillor Steven Kelly for his past work as Chairman.

Action: WBT to write letter of thanks to Councillor Steven Kelly on behalf of the Board

34 END OF LIFE STRATEGY

JL and GS presented the End of Life Care Strategy. The following matters were discussed:

- A report is awaited from CQC on its inspection of End of Life Care in Havering.
- GS informed the Board that a 'Death Café' has been established in the Borough, which takes place at Havering College. This is a safe space

where members of the public can attend to discuss issues relating to death and dying.

- GS informed the Board that further work is being done on performance indicators to monitor progress of the strategy. There was a discussion that performance could also consider qualitative information, including audit findings.
- GF suggested that people who are homeless and lesbian, gay, bisexual and transgender communities should be specifically considered in the strategy.
- It was agreed that there would be joint governance of this strategy by the Health and Wellbeing Board and Havering CCG Governing Body.

The Board thanked GS, JL and Laidon Shapo for their work in developing the strategy.

35 **ACCOUNTABLE CARE ORGANISATION**

KC presented an update report on progress being made to develop a business case for the ACO. CC highlighted some further developments since the report was produced. KC will provide a further update on most recent developments for Board members.

Action: KC to provide update to SM for circulation to Board members

36 **HEALTH AND WELLBEING BOARD TERMS OF REFERENCE AND STRATEGIC PRIORITIES**

The Board agreed that both the terms of reference and the Board's strategic priorities needed updating. Early drafts of possible changes to both were tabled to prompt initial discussion. It was agreed that all Board members will send comments on content to SM by 10 February 2016. SM would then liaise with Board members to redraft the documents for discussion at the Board's next meeting

Action: All Board members to send comments to SM by 10 February 2016

Action: SM to collate comments for consideration at next Board meeting

37 **HEALTH PROTECTION FORUM ANNUAL REPORT**

The report was noted.

38 **FORWARD PLAN**

The following was agreed for the Health and Wellbeing Board agenda for 23 March 2016:

- CCG Planning
- Case for change for stroke services
- Vanguard report
- Draft HWB Terms of Reference and Strategic Priorities
- Obesity strategy
- Drugs and Alcohol strategy
- Accountable Care Organisation update
- Children's Services update

39 **DATE OF NEXT MEETING**

23rd March 2016, CR2, 1pm – 3pm

It was agreed that future Health and Wellbeing Board meetings will be held bi-monthly, and the duration will remain at 2 hours in length. Future dates to be agreed and circulated to members.

Chairman

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HEALTH & WELLBEING BOARD

Subject Heading:	HWB terms of reference and outline strategic priorities for 16/17
Board Lead:	Cllr Wendy Brice Thompson
Report Author and contact details:	Sue Milner, Interim Director of Public Health

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 HWB is now officially 3 years old and there have been massive changes in the local health and social economy in which the Board operates since its inception. This has led the board to reflect on its current terms of reference to ensure they are still fit for purpose. Refreshed terms of reference have been drafted for consideration, based on previous discussion at the Board. In addition the Joint Health and Wellbeing Strategy (JHWS), signed off in April 2015, needs to be reviewed to ensure it reflects the up to date strategic priorities for the Board. The board's existing strategic priorities (as currently stated in the JHWS) have been reframed and are presented for discussion. Once agreed the reframed strategic priorities will lead to a

refreshed JHWS for 16/17. The JHWS will be underpinned by appropriate actions plans and a dashboard of appropriate indicators. This will allow the HWB to be assured that its strategic priorities are being addressed and progress is being made.

RECOMMENDATIONS

The Board is asked to: -

1. Consider the refreshed Terms of Reference (ToR) and reframed strategic priorities for the Board.

2. Suggest any amendments to either.

3. Sign off the revised ToR (subject to any amendments and via Chair's action if required).

4. Agree to a refresh of the JHWS based on the revised strategic priorities and the subsequent development of an underpinning action plan and dashboard of performance indicators.

5. Agree to provide e mail feedback on the development of the JHWS, underpinning action plan and dashboard of performance indicators in sufficient time to bring a draft back to the May HWB and aim for a final sign off at the July HWB meeting.

REPORT DETAIL

1. Revised terms of reference (ToR)

The existing ToR have been amended and are attached as Appendix 1 of this report. To reflect the rapidly developing local health and social care economy it is proposed that representatives of BHRUT and NELFT are invited to join the board. This will better enable the board to consider whole system transformation.

Once the list of groups reporting to the Board has been confirmed a schedule will be drawn up for the Board to receive performance updates from these groups. This will

allow the Board to be assured that the necessary actions are being undertaken to deliver the strategic priorities as set out in the JHWS.

2. Reframed Strategic Priorities for the JHWS

Demand for health and social care services is increasing at a time when resources across the health and social care economy are diminishing. It is essential to slow the increase and then reverse the increase in demand for health and social care services. The collective resources we have across the HWB need to be deployed as efficiently and effectively as possible to provide high quality services in the right place at the right time to improve service user experience and outcomes.

There are a number of system-wide transformation programmes in place at national, regional and sub-regional levels. These are designed to promote greater integration between key partners by reducing barriers and providing enablers for these partnerships to provide localised solutions. Within BHR we are currently working on the development of an urgent care vanguard programme. In addition we are developing a business case for an Accountable Care Organisation. The NHS requirements to produce Sustainability and Transformation Plans and work jointly with local authorities to develop Better Care Fund plans further strengthen our need for partnership working and provide the contextual backdrop for the refreshed JHWS.

The Board has previously agreed that the JHWS should not attempt to cover everything that needs to be done to improve health and wellbeing. Instead it should concentrate only on those areas where the Board can add value by providing high level strategic leadership to promote system-wide transformation.

Reframed Priorities for discussion: -

Theme 1: Primary prevention to promote and protect the health of the community and reduce health inequalities. ***Healthy*** life expectancy can be increased by tackling the common socio-economic and behavioural risk factors for poor health. We could include the wider determinants of health under this theme as we already have work programmes that are not currently on the HWB's radar but are pivotal to public health, e.g. economic regeneration, learning and achievement, culture and leisure, housing etc.

We would probably want to focus on the following behavioural risk factors

- Mental health promotion

- Reduction of harm from tobacco
- Reduction of harm from alcohol
- Diet, physical activity and healthy weight management
- Increase uptake of immunisations
- Increase uptake of screening programmes

Theme 2: Working together to identify those at risk and intervene early to improve outcomes and reduce demand on more expensive services later on.

- Vulnerable children and families – identify them and intervene earlier.
- Provide effective support for children with health needs.
- Provide effective support for people with long term conditions (LTCs) and their carers so they can live independently for longer.
- Provide effective support for people with learning disabilities/dementia and their carers so they can live independently for longer
- Low level mental health issues - identify and intervene earlier.
- Secondary prevention for those with existing LTCs, e.g. identify those at risk of going on to develop CVD, diabetes, liver, renal failure etc. and clinically intervene to avoid worsening outcomes.•
- Promote earlier presentation of signs and systems, e.g. 'be clear on cancer'

Theme 3 Provide the right care/advice in the right place at the right time

- Provide improved and, where appropriate, integrated care pathways
- Reduce avoidable A/E attendances
- Reduce avoidable admissions to hospital or long term care homes
- Improve access to primary health care

Theme 4 Quality of services and user experience

- To ensure that services provided/commissioned are of good quality, are effective and provide the best possible service user's experience.
- Reduce variations in quality and practice across primary and secondary care and social care.
- Reduce variations in access to services

Should any of these NOT be in our HWB strategy because they can be dealt with elsewhere and the Board does not add value?

Is anything missing from this list of strategic priorities?

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Appendix 1

Havering Health and Wellbeing Board: Terms of Reference (Amended March 16 – Draft 2)

Purpose of the Health and Wellbeing Board

Health and Wellbeing Boards (HWBs) were established by the Health and Social Care Act 2012. Each top tier and unitary council (including London Boroughs), is required to have a board, established as a formal council committee. HWBs are strategic leaders and agents of change in the health, social care and wellbeing systems of their areas.

The Havering HWB is set up to

- improve the health and wellbeing of the residents of Havering and to reduce health inequalities.

- 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.

Responsibilities

The main responsibilities of the Board are to:

1. Agree the health and wellbeing priorities for Havering and oversee the development and implementation of a joint health and wellbeing strategy (JHWS).

2. Oversee the development of the Joint Strategic Needs Assessment (JSNA) and the Pharmaceutical Needs Assessment (PNA).

3. Provide a framework within which joint commissioning plans for the NHS, social care and public health can be developed and to promote joint commissioning.

4. 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 and social care services.

5. 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

6. Monitor the outcomes of the public health, NHS and social care outcomes framework.

7. Consider the wider health determinants such as housing, education, regeneration, employment.

Membership

- Four elected members (as per LBH constitution)
    - Lead member for adults and public health (Chair)
    - Lead member for Children's Services
    - Leader of the council
    - Additional member nominated by the Leader

- Director of Public Health
- Director of Adult Social Care
- Director of Children's Services.
- LBH Chief Executive
- CCG representatives x 4
- *Proposed for discussion BHRUT representative*
- *Proposed for discussion NELFT representative*
- Local Healthwatch representative
- NHSE (London) representative

In attendance

Head of Policy and Performance

Reporting and Governance Arrangements

- The Health and Wellbeing Board is a committee of the council.

- The Board will receive regular progress updates from all groups that report to the Board in the attached governance structure.

- 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)

- Chairing arrangements – the leader of the Council will be required to nominate the Chair of the Board. Board members will nominate a vice Chair.*(proposed)*

- All full members of the board will have voting rights. Where a vote is tied, the Chairman will have the casting vote.

- The Board is quorate when 9 members are present. (This will need to be reviewed if we add more members).

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

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

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

- These terms of reference will be reviewed 12 months from the date of formal sign off by the board.

Groups that will report to the HWBB (to be put into structure chart once confirmed)

- Joint Management and Commissioning Forum.
- End of Life Strategy Group.
- Health Protection Forum.
- Mental Health Partnership Board (?Dementia Partnership to be part of this board).
- JSNA Steering group.
- Poverty Reduction Programme Executive.
- Local Children's Safeguarding Board
- Adult Safeguarding Board
- Care Transformation Board

? what other groups should report to HWB?

Once confirmed these groups will be asked to update their respective ToR for sign off by the HWB. They will be required to report regularly to the HWB on their agreed work programmes and KPIs

Groups that have a ‘partnership relationship’ with HWB (to be put into structure chart once confirmed)

- Integrated Care Coalition and/or ACO programme board (tbc)
- Community Safety Partnership
- Primary Care Transformation Board

Any others?

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HEALTH & WELLBEING BOARD

Subject Heading:	Market Position Statement
Board Lead:	Wendy Brice Thompson
Report Author and contact details:	John Green Ext 3018

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 Draft Havering Market Position Statement (MPS) is supplied to the board for awareness and approval.

RECOMMENDATIONS

To approve formal launch of the Market Position Statement

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REPORT DETAIL

The purpose of the Market Position Statement is to support:

- Improved dialogue – primarily with social care providers
- To contribute to the stimulation of a diverse, active market of high quality.
- Information in one place about demography, trends, finances, current position of market and commissioning intentions

The key theme is a focus on supporting people in maintaining their independence, ultimately reducing the use of health and social care services.

Consultation has included:

Autumn 2014: 12 Interviews with internal colleagues to formulate the basis of the document
October 2014: Introduction to 50 different providers (with 114 attendees overall) at the Care Act / Commissioning event
February 2015: 6 follow up market shaping sessions with 24 different providers
Summer 2015: Internal MPS working group set up to produce a first draft
September 2015: Launch of the draft MPS to 36 different providers (43 attendees overall)
Winter 2015: Sign off from Lead Member and Executive brief and attendance at CMT.
Today at HWB

The Care Act 2014 establishes our duty to shape the market and presents a series of 'must dos' for local authorities:

- MUST facilitate markets that offer a diverse range of high-quality and appropriate services
- MUST work to develop markets for care and support that ensure the overall provision of services remains healthy in terms of the sufficiency of adequate provision
- MUST NOT undertake actions which undermine the sustainability of the market as a whole
- **An MPS should be central to this process**

The key messages within Havering's Market Position Statement are:

- Significant demographic and financial challenges faced
- No more Residential & Nursing Provision
- Developing sustainable & outcome focused Home Care
- Applying learning from current Reablement contract
- Building capacity & high quality LD and Autism services

- Responding to the needs of adults with autism
- Continuing to become dementia friendly
- Identifying and supporting carers
- Developing a market to better facilitate personalisation
- Re-imagining the VCS based on outcomes and demand
- Building capacity for more specialist housing
- Communication and engagement with the marketplace

What is next for the MPS?

- Finalisation of draft sent to corporate design.
- Published online
- Not a key decision but there is a need to ensure general awareness of decision makers
- Attendance at HWB – pre-empts final launch
- Communications through provider forums and service user forums
- 6 monthly updates

See attached MPS. Minor updates to the draft and its format will be made as necessary but the document is substantially complete.

IMPLICATIONS AND RISKS

Financial implications and risks:

None

Legal implications and risks:

None

Human Resources implications and risks:

None

Equalities implications and risks:

None

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BACKGROUND PAPERS

Market Position Statement

Adult Social Care
Market Position Statement
2016 – Draft

Havering
LONDON BOROUGH

Contents

Introduction

Purpose

This document is aimed at existing and potential providers of adult social care and support.

It aims to maintain and improve dialogue with providers, people who use services, carers, and others. We want to stimulate a diverse, active market of high quality.

This is a key part of shaping what kind of place Havering is, where people with care and support needs, their families and carers, are included and supported in making choices that sustain their independence.

This Market Position Statement lays out the direction of travel and future needs of Adult Social Care (ASC) in the London Borough of Havering.

The key theme is a focus on supporting people in maintaining their independence, ultimately reducing the use of health and social care services. For each group of service users the document lays out the current market place and commissioning intentions.

Strategic Direction of Travel

The joint vision for the London Borough of Havering and Havering Clinical Commissioning group is expressed in the Joint Health & Wellbeing Strategy as being:

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

The 3 key themes identified as priorities in achieving the joint vision are:

- **Preventing, reducing and delaying the need for care and support through effective demand management strategies**
- **Better integrated support for people most at risk**
- **Quality of services and patient experience**

The Health & Wellbeing Strategy for Havering, provides the platform for Adult Social Care's market position statement.

The vision for Havering's ASC service is: 'Supporting excellent outcomes for the people of Havering by helping communities to help themselves and targeting resources and interventions to encourage independence' and underpinning this vision is the understanding that the Council can only continue by enabling a communal response to the demands faced:

'Collectively, we recognise that the solutions to many people's care and support needs rest within themselves, their families, social networks, and communities. Underlying all of our commissioning intentions is our belief that it is in everyone's interests that they maximise these resources as this fosters individual and community resilience; encourages mutual aid and reciprocity and thereby helps build stronger and healthier communities.

We believe that making these values explicit will support those involved in both commissioning and delivery to make better decisions.'

Prevention and Managing Demand

The Council recognises that drivers of demand have to be recognised and addressed to prevent increasing costs.

An Early Help, Intervention and Prevention Strategy focuses specifically on demand management across Council services.[1]

Commissioning for Better Outcomes

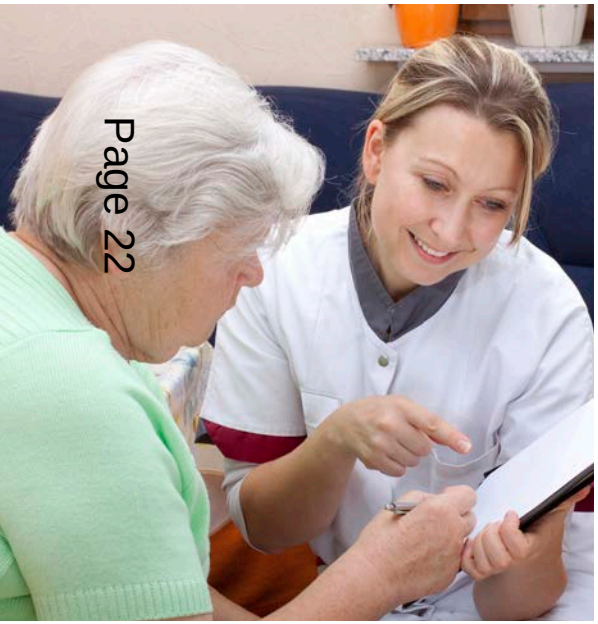
Havering wants to commission services differently, focussing on outcomes, both at a personal level and in wider service contracts that ultimately promote prevention, independence, personalisation and choice. We recognise we have a way to go on making this a consistent approach but this is our aim and intention. The approach also looks at wider benefits possible from commissioned services. For example reducing social isolation could be an additional outcome targeted within a domiciliary care contract. Improved health outcomes would also be considered as we commission services.

[1] Children, Adults and Housing Directorate Early Help, Intervention and Prevention Strategy

Working in Partnership and Co-production

For Havering to realise these ambitions we need to truly adopt the principles of partnership working and co-production.

We want to work more closely with the market, adults with care needs, carers, Health, other Council services and neighbouring local authorities.



Overview

Our direction of travel is reflected in each chapter below.

There may be differences in how we complete the journey with providers, but the outcomes required will remain consistent.

We generally want to work with partners who:

- **Adopt a whole family approach to services.**
- **Wish to innovate – we will support those to innovate where it supports prevention and increases independence.**
- **Are prepared to work closely with other organisations and partners.**
- **Have high quality standards and publish the results of their independent monitoring.**
- **Can demonstrate their understanding of demand in Havering and how this changes over time.**
- **Are able to show the impact of their activities.**
- **Can clearly demonstrate the wider social impacts of interventions and their impact on wellbeing.**
- **Do not overlap or duplicate other services**

Context

Havering operates in a wider context, influenced by legislation, national strategies and guidance. The Care Act, the Better Care Fund and the Social Value Act, are but a few, influencing significantly what and how we commission in future:

Responding to the Care Act 2014

The Care Act 2014 requires local authorities and providers to:

- **Promote wellbeing.**
- **Prevent or delay the need for care and support.**
- **Promote choice and control to help people plan their care and support.**
- **Ensure carers have an assessment in their own right.**
- **Improve information and advice, including access to independent advocacy.**
- **Shape the market to promote quality services, sustainability and choice.**
- **Manage risks in provision, including financial, safeguarding, and provider failure.**

We need to listen to providers to effectively shape service provision for those who the council support and those who fund their own care and support.

The Better Care Fund (BCF) and Integration with Health

The BCF ensures that health and social care work collaboratively to integrate services. The Council and Havering CCG have worked together to design schemes, designed to improve outcomes through integrated working. The schemes include:

- **Review of the Customer Interface**
- **Intermediate Care Pathway**
- **Developing Integrated Localities**
- **Carers and Voluntary sector development**
- **Learning disabilities**
- **Long Term conditions**
- **Integrated Commissioning**

A target for the Better Care Fund is to reduce emergency admissions by 2.5% in 2015/16. The need to develop community based solutions that prevent people from going to hospital means that providers are important in achieving these objectives.

Governance of this process is through the Joint Management and Commissioning Forum (JMCF) chaired by a Clinical director of the CCG and Corporate Director from the LB Havering, ultimately reporting to the Health and Wellbeing Board.

Social Value Act

The Public Services (Social Value) Act came into force on 31 January 2013. It requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits.

Before they start the procurement process, commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders.

The Act is a tool to help commissioners get more value for money out of procurement. It also encourages commissioners to talk to their local provider market or community to design better services, finding new and innovative solutions to difficult problems. For example the development of volunteers might be something that would be expected when a service is tendered.

The Locality and Demographics

Havering is the third largest London borough, covering some 43 square miles. It is located on the northeast boundary of Greater London.

According to the latest mid-year estimates the population of Havering is 245,974[2]. Representing a continuing increase in population, largely from migration from other local authorities.

The population is significantly older in comparison to other London Boroughs with around 43,956 residents over the age of 65 recorded in the 2011 census[3] and a mean age of 40.4 years, higher than for London (which reduced to 35.6) as well as for England (which fell to 38.6).

Most notably, growth in the 85+ age group saw the largest increase over this period (43%) and is higher than for London or England.

This is of particular importance as this age group are the most likely to require both Social Care and health services.

In addition, Havering has experienced the largest net inflow of children across all London boroughs, the majority originating from other outer London boroughs.

In the context of public sector finances, this projected increase means that Havering ASC and the Council need to think differently about the kinds of services required to meet and reduce demand in the future. It does not mean we will be planning for an increase in services that respond traditionally to an ageing population, such as care homes.

Instead preventative, health sustaining services and those designed to increase and maintain independence and keep people at home, such as telecare, are those that we will look to encourage.

The table below shows how the overall population of Havering is expected to increase.

Ethnic Composition

Havering is predominantly White British (83% from the 2011 census) and although it is one of the least ethnically diverse London boroughs, it has seen the highest percentage increase in minority ethnic groups (including non-British white groups) doubling from 8% to 17% between the 2001 and 2011 census.

Of these groups the largest is Black African, which constituted 3% of the total population. This compares to a mean of 44.9% white British population for London and 79.8% for England. In addition the Schools Census recently reported that nearly 23% of school pupils in Havering were from non-white ethnic groups.

This raises issues for the ASC market, in particular:

- **The need for – and provision of – ethnically appropriate services**
- **The incidence and prevalence of certain long term conditions varies according to ethnic background and these can give rise to an increased need for Social Care services.**

Deprivation

Overall, Havering is ranked 177th out of 326 local authorities for deprivation (where 1st on the scale is rated the most deprived)[4] but there are significant differences within Havering.

Of particular note is the measure relating to the relative affluence of the older population. Havering older people are more affluent than mean averages but some areas(one in Gooshays and another in South Hornchurch) fall into the 10% most deprived areas in England and a further 11 fall into the 20% most deprived areas in England.

	2014	*2015*	*2020*	*2025*	*2030*
Total population	244,400	247,000	261,200	276,200	291,100
Population aged 65 and over	45,600	46,200	49,400	54,400	60,700
Population aged 85 and over	6,800	7,100	8,300	9,400	10,700
Population aged 65 and over as a proportion of the total population	18.66%	18.70%	18.91%	19.70%	20.85%
Population aged 85 and over as a proportion of the total population	2.78%	2.87%	3.18%	3.40%	3.68%

Financial Context

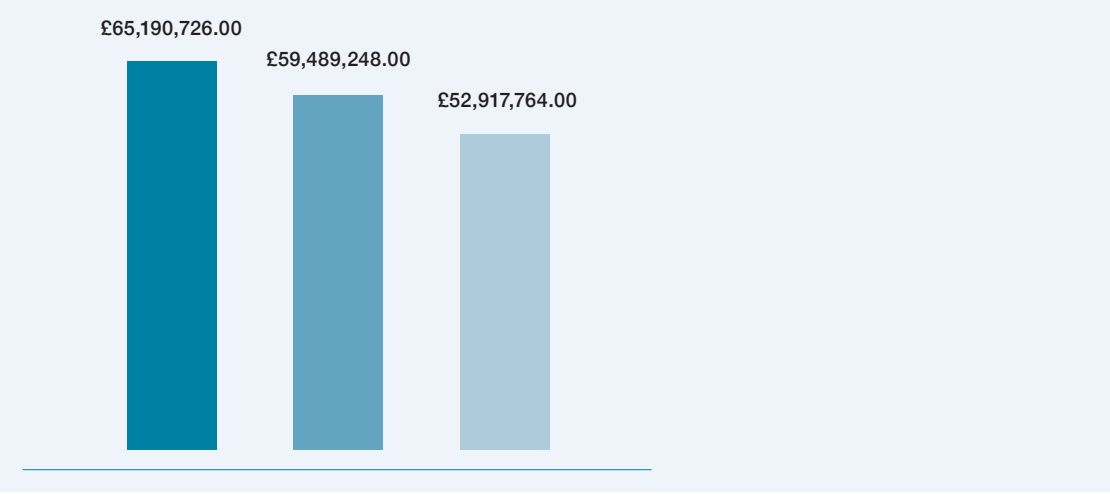
Havering, like all councils, is facing a major financial challenge. We need to reduce our overall budget by around a third over the next four years, in response to Government funding cuts, inflationary costs and a growing and ageing population.

Havering already receives the fourth lowest Government grant in London per head of population. It has saved £40 million over the past four years - so this task will not be easy.

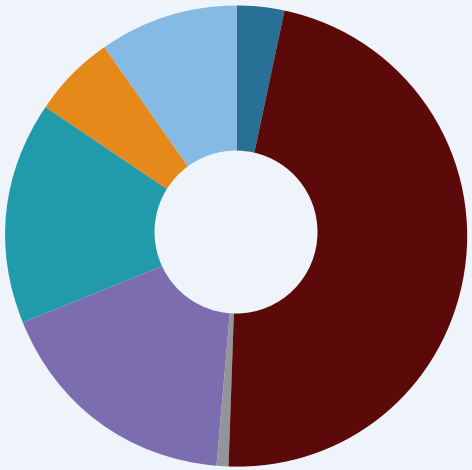
Havering Council's Adults Social Care needs to save £9,386 million over the next four years. This is on top of the £9,935 million worth of savings that the Service has delivered over the last four years. The reality of the financial position is that the Council is required to make some decisions on what services we offer to customers.

LBH Revised Budgets 2013-16

Havering Council has made a strong commitment to deliver all statutory services and improve the services being offered across the borough. We remain committed to protecting the services that matter most to the residents of Havering



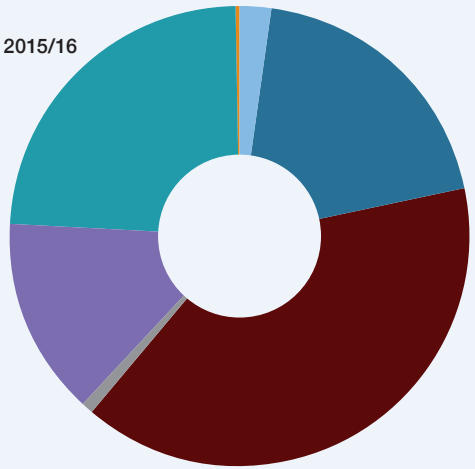
Gross Total Expenditure by Service Type 2014-15



ASC Clients 18 – 64 years

- Nursing – £882
- Residential – £11,845
- Supported Accommodation – £144
- Community: Direct Payments – £4,390
- Community: Home Care – £3,916
- Community: Supported Living – £1,495
- Nursing – £2,373

2013/14 2014/15 2015/16



ASC Clients 65+ years

- Nursing – 5,828
- Residential – £11,779
- Supported Accommodation – £223
- Community: Direct Payments – £4,162
- Community: Home Care – £7,177
- Community: Supported Living – £10
- Community: Other Long Term care – £706

Quality and Safety

For all service users and type of provision, quality and safety underpins all our intentions. Havering council is responsible for monitoring the standard of care and support services delivered, whether directly commissioned or not, to ensure services are safe and of a good quality.

The Havering Quality and Contract team works collaboratively with providers to acknowledge good practice and to ensure that services are safe, deliver high quality outcomes to service users and evidence compliance with regulatory and contract requirements.

The team work with a range of individuals and organisations including care practitioners in the community and a variety of teams and organisations within and outside the council. These include the Quality & Surveillance Group with health partners, the Joint Assessment and Discharge team at Queens, the Safeguarding Team within the Council, reporting where necessary to the cross organisational safeguarding board, Healthwatch Havering and the Care Quality Commission.

The team also regularly speak to service users and their families or advocates to obtain their views about what is positive and what improvements may need to be made.

Regular forums and meetings are held to exchange information and ensure providers are fully informed in regard to expectations. Visits to providers are conducted on a regular basis, and are unannounced; where there are concerns and additional support is needed, visits may be more frequent and additional meetings conducted to understand the improvements required.

A range of sanctions can be applied where there are continued concerns, including suspension of placements. Should a suspension or embargo be implemented, this is communicated to other Councils and authorities and kept under close review while the team work with the provider.

Where providers leave the market, by choice or where they are unable to deliver their service to the required level, Havering's Establishment Concerns and Failure Policy guidance is in place and outlines the measures that will be taken to protect the interests of service users and the council.

All providers in the Borough, whether they are regulated or not are required to fully comply with requests from the Quality and Contract team and to provide information and documents within agreed timescales. This is essential given the Council's new duties under the Care Act to facilitate a sustainable market for high quality care and support, whilst managing provider failure and service interruptions regardless of how services are funded.

Under the Care Act 2014 Local Authorities should be assured that providers are complying with National Minimum Wage legislation. This will include appropriate remuneration for any time spent travelling between appointments and recognising other elements of detail such as recognising that the premium element of overtime and shift premium pay – that is, the amount the higher pay rate exceeds the worker's basic rate – does not count towards minimum wage pay.

From April 2016 providers are required to pay Living Wage to their staff, currently £7.20 per hour.

We will be working with providers on the implications of this.

We want to hear concerns if this causes issues around sustainability and have so far issued two surveys to gather information and followed up with direct engagement.

Generally providers need to be aware and apply the Care Act principles - wellbeing, prevention, person centred care and support, being aware of how to respond to safeguarding concerns, awareness of carer situations and the general principle of partnership working that runs through the Act.

Residential & Nursing Care

The Marketplace

There are 39 care homes in Havering (21 residential and 18 with the facility to provide nursing care for OP/PSD) with a total of 1,611 beds. Of these, the London Borough of Havering currently place just a third of clients, the rest being self-funders, health placements, out of borough placements and vacancies.

Between April 2014 and March 2015 there were a total of 286 (including self-funders) new admissions in to care homes with around 88% being over the age of 75. Over a third of these new admissions came directly from the local acute hospitals (Queens and King George's), the remainder admitted from the community.

Analysis last done in 2013-14 indicated that around 45% of care homes admissions from hospital were admitted as a result of a fall. On average, 50% of those admitted to a care home had an informal carer before being admitted.

Of those new admissions to a care home, 8% had initially been self-funding but subsequently required Adult Social Care funding as their savings had fallen below the threshold. On average, adults with care needs were able to self-fund for 25 months' before presenting to Social Care.

From April 2014 to March 2015 there were, on average, 602 adults over the age of 65 (known to Adult Social Care) in a long stay placement at the end of each month.

Social Care teams have noted a general increase in the number of adults entering in to a long stay care home placement with dementia, more so than physical frailty.

The average weekly cost of a care package prior to admission in to a care home in 13/14 to 14/15 was around £215 and the average weekly cost of a long stay placement in a care home was £520.

Commissioning Approach and Intentions

The Council is clear that there is no need for more residential or nursing homes within the borough. Throughout 2014/15, of approximately 1600 available beds, 250 remained vacant each week

Our policy has been and will be to support people in remaining independent and safe at home.

For those residential and nursing care homes currently providing services in the borough we value and appreciate the services provided. We are committed to working together to balance the needs for economy in the current financial climate and the quality services we want to see provided for vulnerable older people.

Home Care

The Marketplace

There are 9 Home Care agencies on the Havering framework and 16 that are spot contracted. Of these 25 providers, 8 are based outside of the borough.

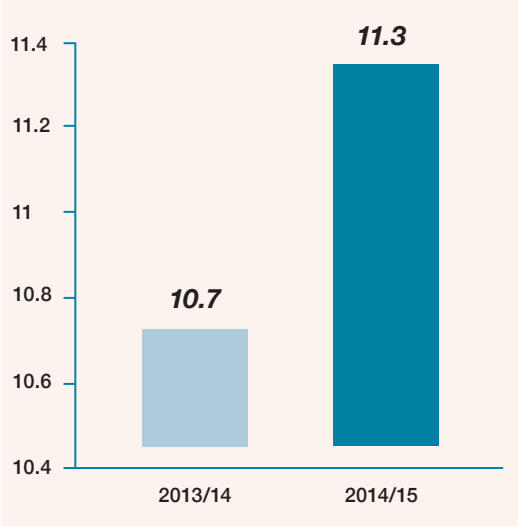
Currently there are around 1,101 adults with home care receiving 12,442 hours of care and support, equalling an average of 11.3 hours per week.

Home Care is currently contracted by hours of care and support, which can be broken down further into prescribed, timed visits (for example 30 minutes three times a day) depending on their needs.

There is capacity to bill by the minute but in general we would like to look at how we achieve outcomes rather than pursue time and task monitoring.

The graph right shows an increase in the average number of hours of home care per client commissioned during 2013/14 and 2014/15:

Average Commissioned Weekly Homecare hours per client



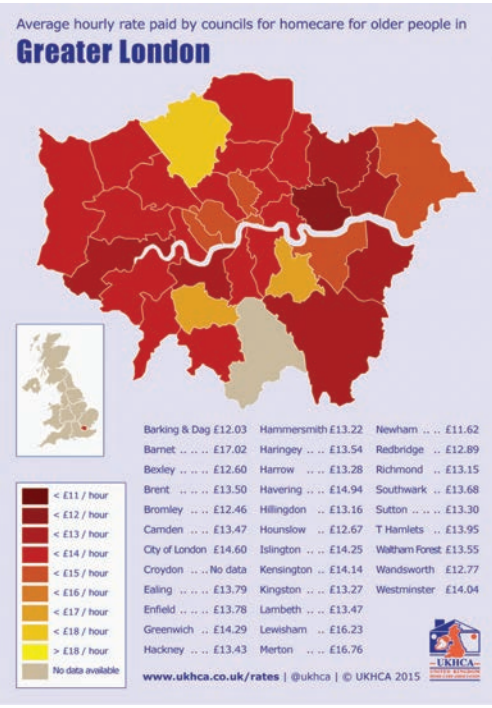
Home Care Workforce

The right infographic was supplied from the United Kingdom Homecare Association and shows comparator figures for Greater London on the average hourly rate paid by councils for homecare for older people[5].

It indicates that the homecare rate paid for by Havering is the fourth highest in London, which should allow scope for high quality services that play a role in enabling adults with care needs to be as independent as possible.

However some other indicators suggest that there is a problem in retaining employed carers in comparison to neighbouring authorities (see table next page[6]) and that providers' on the framework face issues in responding to the frequency and type of demand for home care.

We want to understand this as we proceed to more outcomes based commissioning that recognises the difficulties of providers and workers alike.



[5] United Kingdom Homecare Association: The Homecare Deficit:
A report on the funding of older people's homecare across the United Kingdom 2015

[6] United Kingdom Homecare Association: The Homecare Deficit:
A report on the funding of older people's homecare across the United Kingdom 2015

Workforce Stats	*Havering*	*Bexley*	*Thurrock*	*Barking & Dagenham*
No. of CQC registered services	112	80	67	79
No. of CQC registered services that are care homes	72	38	40	22
Estimated no. of direct care workers	3,800	4,100	2,200	2,500
Staff turnover rate	35.9%	21.4%	26.8%	11.5%
Turnover rate for direct care staff	39.4%	28.5%	31%	13.6%
Current vacancy rate	9.3%	9.8%	2.9%	16.6%
No. of direct care workers leaving their position in the last 12 months	1,500	1,170	680	340

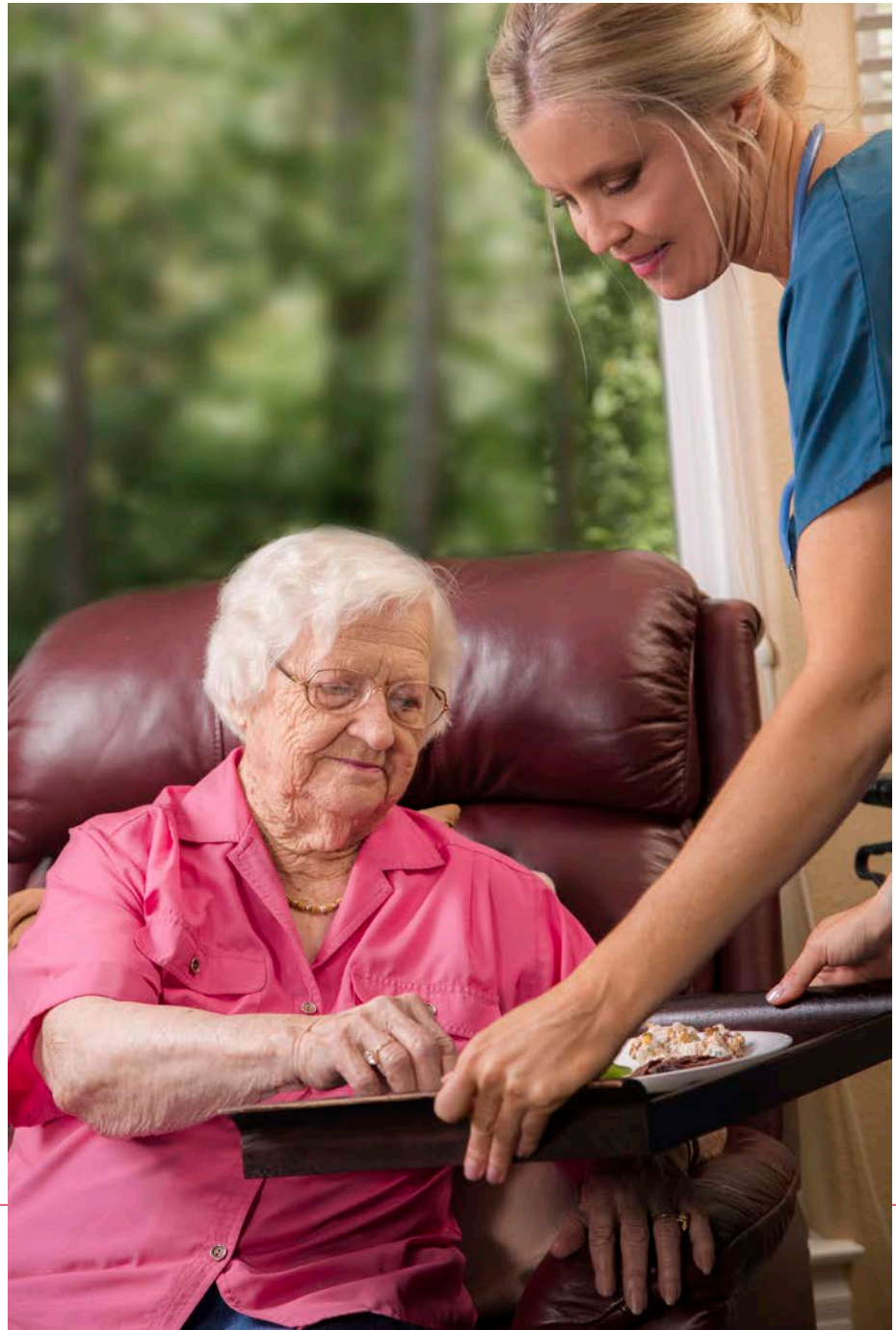
Commissioning Approach and Intentions

Although we are moving to increased personalisation there will be continued demand for contracted home care and we will commence re-commissioning of the services.

We will work with providers to develop an outcome based contracting arrangement, replacing the current framework, which recognises the need for:

- **Positive outcomes for adults with care needs in preventing the worsening of their condition, looking to reable and rehabilitate where possible**
- **Positive outcomes for the Council, particularly in regard to prevention with associated benefits related to cost**
- **A sustainable business model for providers**

We know this will mean a different dialogue between providers and the council and are committed to this in the coming months.



Reablement

The Marketplace

Reablement services are free for clients up to six weeks. The aim of reablement is to support the client to get back on their feet following a crisis, and to be as independent as possible.

Havering's reablement service is delivered via three different avenues:

- **community reablement that takes place in the clients' home;**
- **accommodation based reablement that takes place in purpose built flats at Royal Jubilee Court;**
- **reablement day service that takes place at Yew Tree Resource Centre.**

80% of reablement referrals come from the Joint Assessment & Discharge Team at Queen's Hospital with around 20% from the community.

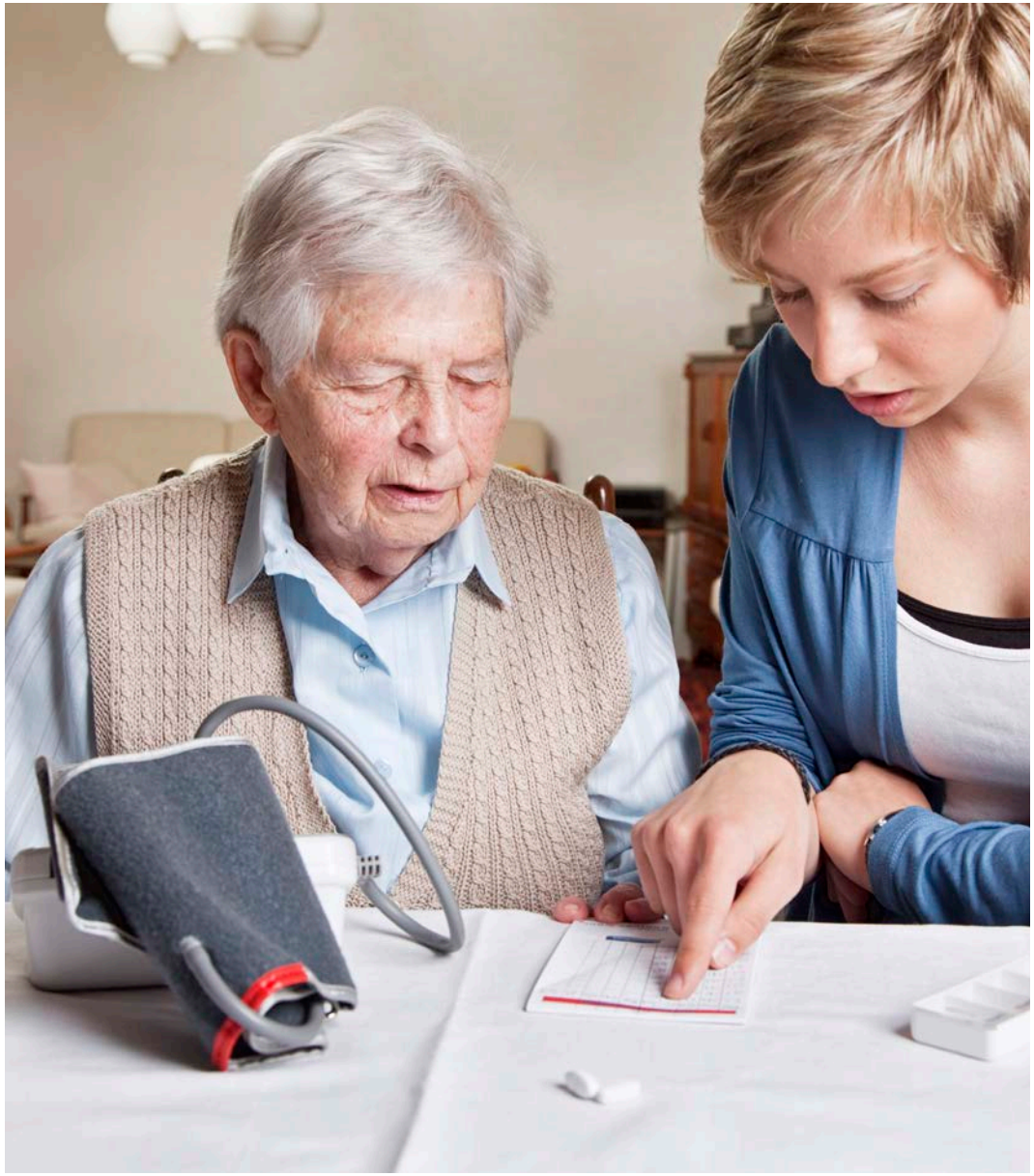
One week in January 2015 showed there were, at any one time, 130 reablement clients with 983 hours of commissioned support.

Commissioning Approach and Intentions

Havering remains committed to reablement and has learnt a lot from the current contract it has in place. The contract is scheduled to run until November 2017.

Reablement sits firmly on the intermediate care pathway and as such will be a key component of the review of the pathway as part of the Better Care Fund.

It is acknowledged that there could be more integration of services to the benefits of patients and service users. Commissioners providers and service users will be engaged with as this develops.



Respite Services

The Marketplace

There are 35 Care Homes with and without nursing provision in Havering who state they provide respite services.

For 2014/15, 266 clients used respite services totalling 638 separate episodes. There were:

- **600 respite placements:**
- **452 as planned respite (for 155 clients)**
- **148 as emergency placements (for 105 clients)**
- **38 short stays (for 14 clients) (which can sometimes be respite) with no fixed end dates.**

Commissioning Approach and Intentions

After respite, on average:

- **88% went straight in to a permanent care home placement**
- **17% had received respite up to one month before a long stay placement.**

This data would suggest that respite is leading to permanent admission to Residential Care, which is not the intention of the service.

There may be many reasons for this and the Council, in partnership with key stakeholders, including providers, would like to understand this better.

Day Services

The Marketplace

There are 10 day opportunity services in Havering, located mostly in the north of the borough. On average in 2014/15 there were 140 clients of day services over the age of 65 in any one week.

There are also other services that provide day activities commissioned directly by Havering, provided largely by the voluntary sector. These include services like:

- **'Singing for the Brain' – a service intended for dementia sufferers and their carers**
- **Neighbourhood day services**
- **Lunch clubs**

Commissioning Approach and Intentions

Havering puts significant investment into day care both across older people and learning disabilities services (see section below). Day services we require should be designed with prevention and positive outcomes in mind.

The intention is to ensure that services provided are aligned with this intention. This may provide opportunities for a review that would benefit from co-production with providers, adults with care needs and carers.

Services for People with Physical & Sensory Disabilities

The Marketplace

The physical and sensory disability market in Havering is relatively small numerically in comparison to other areas such as older people.

However, the number of people with physical and sensory disabilities (PSD) in the borough is expected to rise as health improvements support people to live longer and healthier lives.

Only two of the 39 residential care homes in the borough regularly accept PSD service users under 55 years on a permanent or respite stay basis.

In Havering these types of services are predominately older people focussed and are not appropriate for younger adults; because of this some people opt to move into small residential accommodation outside the borough with more specialist or tailored support that is more appropriate to their needs.

- **10 out of 12 PSD service users under 55 years are placed in residential accommodation outside of the borough (Feb 15)**
- **4 out of 5 PSD service users under 55 years stay in respite out of the borough (2014-15)**

Whilst the majority of people who have been diagnosed with a visual and sensory impairment are not likely to qualify for social care funding, initial support is available from occupational therapists to help with enablement and accessing equipment etc. and individuals rely heavily on support from voluntary organisations and local groups to help them access information, advice and support.

From the research of 176 PSD service users there is one provider specially supporting an individual with a sensory impairment.

There are two day opportunities in the borough for PSD service users under 55 with 105 people out of 176 receiving a personal budget.

At least 58 direct payment holders are opting to employ a Personal Assistant to meet their outcomes.

The graph right shows projections for the number of adults in Havering expected to have a physical disability in the next 15 years:

Commissioning Approach and Intentions

Support for people with physical and sensory disabilities should empower people to live as independent lives as possible.

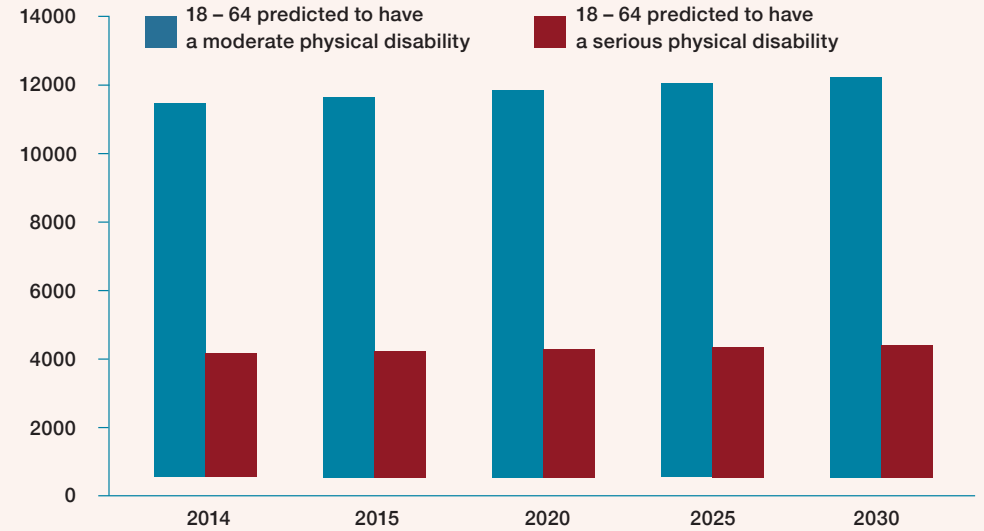
This may involve the development of local housing solutions, greater employment and education opportunities and general empowerment of individuals to lead fulfilled lives.

We anticipate that the development of provision of services in borough will ensure better choice and control for users, help ensure good value for money, and also deliver more beneficial outcomes.

Further exploration of services and costs of residential placements for physical and sensory service users under 55 years is intended.

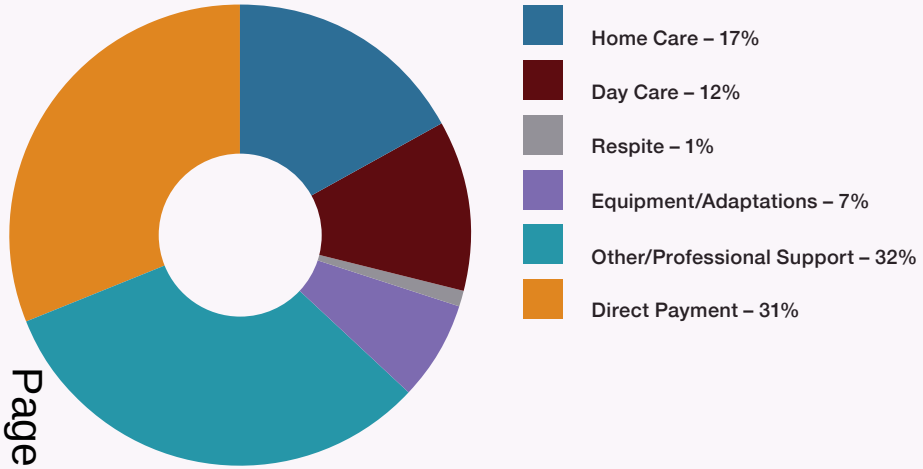
In the longer term we would like to see more supported living accommodation in Havering to enable people with physical and sensory disabilities to stay in the local community and for that provision to be consequently more cost effective.

There is a gap in the market for specialist and flexible respite services for those with a physical or sensory disability– there is currently no provision in Havering and service users must go out of borough.



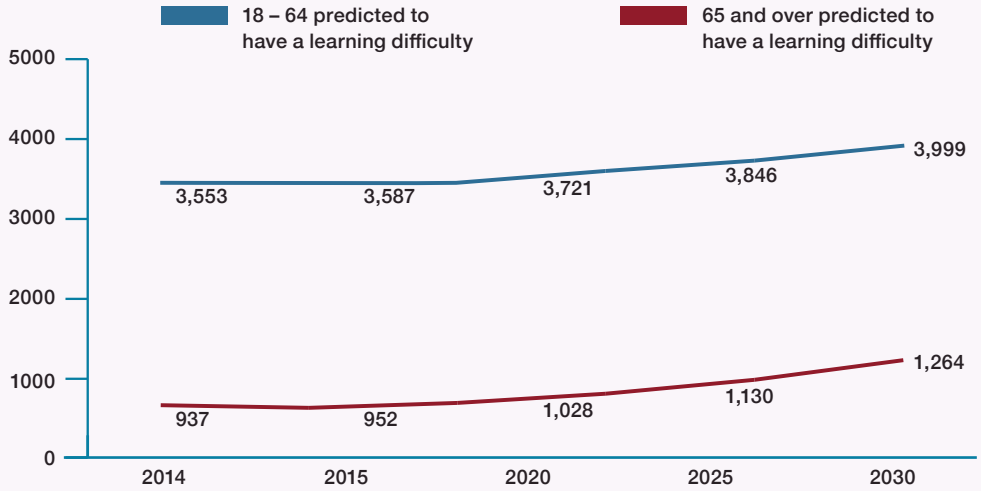
Services for People with Learning Disabilities & Autism

Community Services for Learning Disability Clients



at 31 March 2015

Learning Disabilities – Havering Projections



The Marketplace

The number of people with learning disabilities and autism is projected to increase according to projections from national data sets. There are, for example, increasing numbers of young people with learning disabilities and autism transitioning through to adulthood. Many of these will not, however, need services or meet eligibility criteria.

Adults with complex needs are also living much longer often with the associated health conditions that come with old age already present.

The graph above right gives projections for the number of residents in Havering with a learning disability over the next 15 years.

More recent local information suggests that demand in local schools is increasing rapidly. The number of children with special educational needs and disabilities is growing year on year, averaging increases of between 40 to 60% in all groups over the past 3 years. These are particularly marked in respect of children with the most severe and complex needs where there are disproportionate growths, leading to pressures and shortfalls in relation to both mainstream and special school places. The Council is facing increasing demand for specialist help and schooling for children with autism (ASD) and for those with behavioural, emotional and social difficulties (BESD), including those with mental health issues. Whilst respective increases of 40 and 62% were seen in these two groups over the past 3 years, numbers for ASD in the primary school population are expected to double over the next 5 years.

Numbers for the BESD primary school group are also expected to treble during this period, and these will add to the increases already in secondary schools.

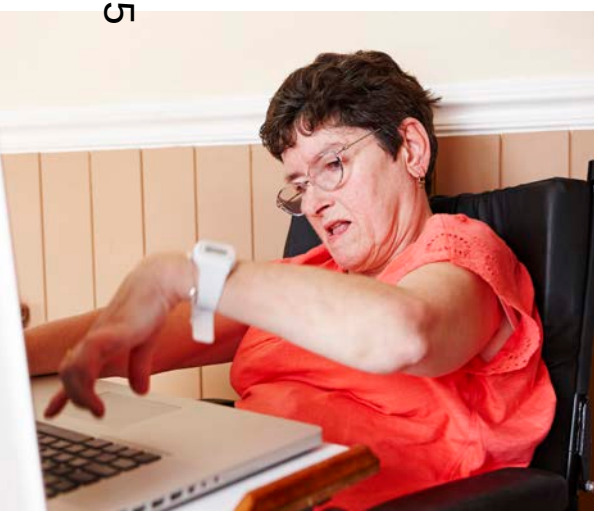
There are also increases in children with moderate learning difficulties and those with speech, language and communication needs. However, mainstream schools are increasingly making successful provision for them. Autism and behaviour difficulties remain major issues, requiring significant help and resources for schools to meet these needs.

Paid Employment

In 2014/15 there were a total of 509 people with a learning disability (known to Adult Social Care) who were of working age.

Of those, 44 were in paid employment; with 11 of these working over 16 hours per week and 33 working less than 16 hours per week.

The remainder were either in unpaid voluntary work, receipt of community services or no services at all (only two clients in residential care were in unpaid voluntary work).



Accommodation

The current commissioned housing options in Havering for people with a learning disability consist of:

- **23 commissioned residential care service providers**
- **17 commissioned supported living service providers.**

In 2014/15 there were 190 learning disability clients known to ASC considered to be in 'unsettled' accommodation. This was made up of:

- **99 clients in residential care homes**
- **3 clients in nursing care homes**
- **88 in accommodation of unknown tenure.**

In 2014/15 there were 319 learning disability clients known to ASC considered to be in 'settled' accommodation. This was made up of:

- **216 clients in mainstream housing with family or friends**
- **83 clients in supported living,**
- **7 clients in a local authority or other registered social landlord tenancy**
- **3 clients in a shared ownership scheme**
- **10 clients who were private tenants**

Commissioning Approach and Intentions

The commitment of the Council is to develop services that support people to be as independent as possible and to actively discourage long term provision that does not enable full realisation of potential for those receiving services.

For providers considering setting up in Havering the need for consultation prior to set up is paramount. In the absence of this dialogue it is likely that services will not meet requirements and, potentially, receive no Council placements.

What is wanted by the Council is specialist provision of the right sort, fully discussed in advance.

It is necessary for providers and staff of those services to be fully equipped to provide the specialist service required. If this is not the case, staff from Health and Adult Social Care services can be drawn in to supporting those services – drawing on scarce and valuable resources in an unplanned way.

Step down facilities from assessment and treatment units to facilitate the clients to move on successfully may also be beneficial but, again, would require full consultation before establishing.

In general we are looking to support and encourage services that provide imaginative supported living schemes with 'life skills' that allow clients to move on.

For both those with learning disabilities and autism we are also looking to develop increased awareness among the Havering community, particularly in regards to employment opportunities and access to key public and private services.

For example a recent initiative has established a shop in the Mercury Shopping Centre designed for people with autism, which will look to provide a safe space as well as information and advice exclusively for those with autism.

Adults with care needs in out of borough placements may benefit from more local accommodation. We will continue to look for suitable provision that is capable of accommodating those adults.

We would like to have provision that prevents the need for moving out of borough in the first place.

To support this aspiration Havering's long term vision for young people with special educational needs and disabilities post-16 is to provide high quality education and training opportunities which support young people to move smoothly into adulthood.

Havering are developing new post-16 provision that will be aspirational in supporting young people to move towards Entry Level 1 qualifications, alongside building their social and employability skills, and then onto becoming an active and contributing members of their community.

The provision will support young people and their parents to aspire to a life which is as independent as possible and which includes some form of work, whatever this might look like for each young adult, depending on their need.

We want to ensure that we are employers of disabled young people and that those organisations we work with follow our lead and offer flexible and supported employment opportunities, as well as work experience, for all of our young people to ensure a positive step into adulthood

Services for People with Mental Health Conditions

The Marketplace

There are increasing numbers of people with mental health conditions. This may, in some part, be attributed to increased recognition and diagnosis but the issue of growing demand remains.

The following graphs show projections for the number of residents in Havering with a mental health condition over the next 15 years.

Health Services

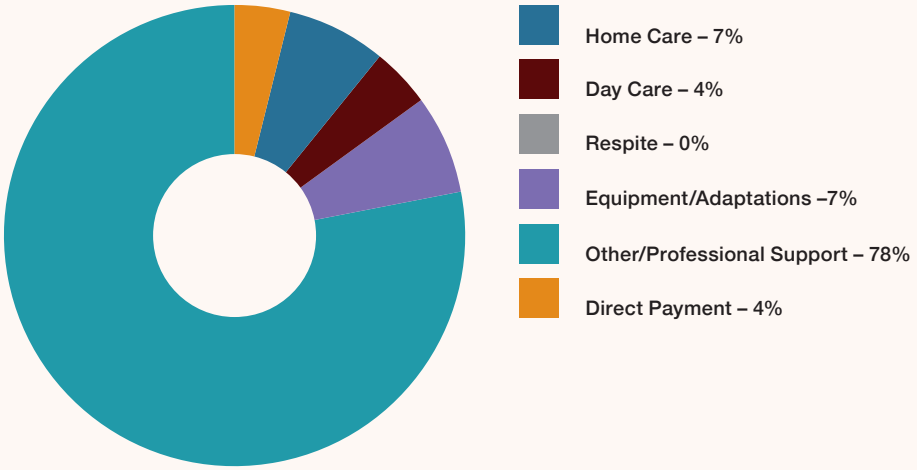
Havering's largest provider of mental health services is the North East London Foundation Trust (NELFT) who provide the following:

- **Memory clinics**
- **Older adults mental health services**
- **Psychological services and therapies**
- **Community Recovery Teams**
- **Early intervention in psychosis**
- **Access and assessment**

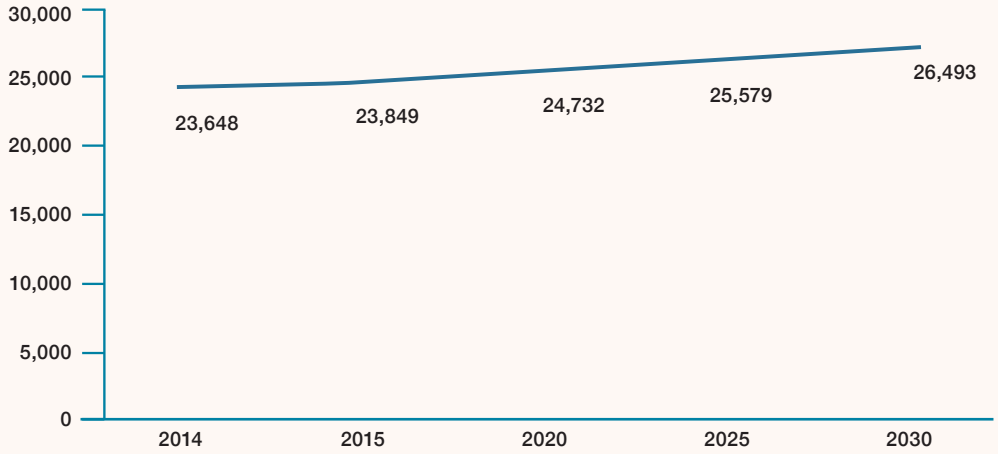
Statistical Performance

Spend in Mental Health for 2014/15 was around £30.2 Million, equivalent to 10% of all Health Commissioning spend. Mental health spend made up a further 10% of all secondary care spend[7].

Community Services for Mental Health Clients at 31 March 2015



18 – 64yr olds – Predicted to Have A Common Mental Disorder – Havering Projections



[7] BHR CCGs Mental Health Commissioning Framework 2014

Commissioning Approach and Intentions

Strategic aims for Mental Health as set out in Havering's Health & Wellbeing agenda are to support healthy lifestyles and manage risk, support vulnerable adults with mental health needs to access good quality information advice and advocacy, reduce social isolation and increase the number of adults with mental health needs in to paid employment.

We will work closer with Housing colleagues to consider development of appropriate housing and accommodation support (particularly when shared accommodation is not always considered appropriate for mental health clients).

This may include development of more supported living for mental health clients.

We recognise the associated issues of social inclusion and the development of mental health issues, looking for ways to improve engagement and involvement in the community.

- **The understanding of 'hard to reach' groups where they are isolated or feel they don't need support**
- **Developing clear pathways that are understood across health and social care so that people can be signposted appropriately by professionals within the system.**

Mental Health services are largely delivered through the Health service and the Local Authority is working closely in partnership with both the CCG and NELFT as the main provider. Plans are being developed to ensure that these services continue to provide the best support possible for adults with care needs, taking on the challenges in the national strategy 'Closing the Gap'.

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Criteria	*Rate*	*Year*	*Havering*	*National*
A&E attendances for psychiatric disorder	Per 100,000 of the population	2012/13	291.2	243.5
Emergency admissions for self-harm	Per 100,000 of the population	2012/13	113.7	191
Hospital admissions for unintentional & deliberate injuries, age 0-24	Per 10,000 of the population	2012/13	86.8	116
Detention on admissions to hospital (quarterly)	Per 100,000 of the population	2012/13	3.2	15.5
Social Care MH clients in residential care, age 18-64	Per 100,000 of the population	2012/13	17.3	32.7
Mental health readmissions to any MH trust in 3 months	% of total discharges	2012/13	11.4	15.4
Mental health readmissions to any MH trust in 6 months	% of total discharges	2012/13	13.9	18.7

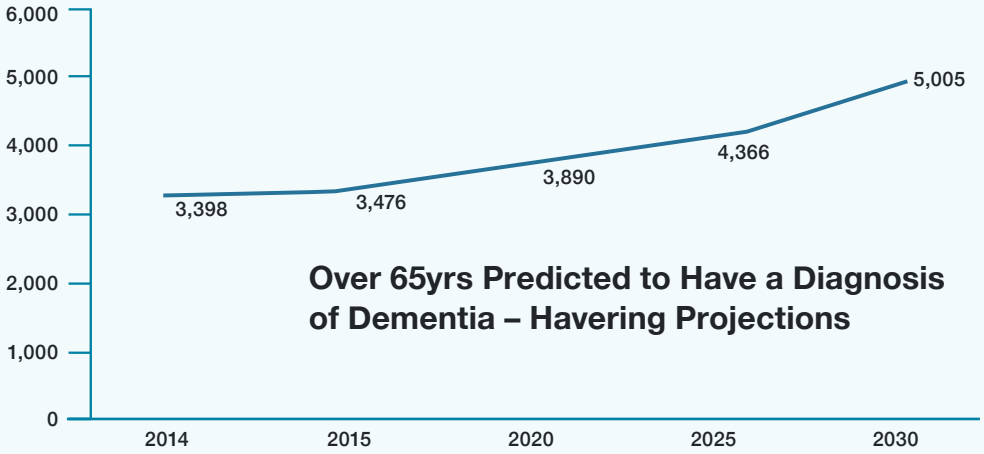
Services for People with Dementia

The Marketplace

The graph below shows the number of adults over the age of 65 in Havering predicted to have a diagnosis of dementia in the next 15 years.

The dementia diagnosis rate for Havering in August 2014 was 46.4%. Due to the efforts of the Dementia Partnership Board and strong partnership working the diagnosis rate reported to NHS England in August 2015 has risen to 64.3%.[8]

There are 37 care homes (with and without Nursing) in Havering who are listed as providing support for people living with dementia.[9]



Dementia Action Alliance

The Havering Dementia Action Alliance (DAA) was commissioned with the aim of making the lives of people living with dementia and their carers better by making changes in the community. To date, the DAA has 74 organisations signed up as members.

One of the aims of the DAA is to raise awareness of dementia within the Havering community through 'dementia friendly' training. To date, there have been 2000 organisations/teams who have received the training with a further 350 who have completed it online and 1965 clinicians who have been trained in dementia symptoms. In 2014 Havering was the second London Borough to be awarded with Dementia Friendly status.

http://www.dementiaaction.org.uk/local_alliances/4789_havering_dementia_action_alliance

Commissioning Approach and Intentions

The Havering Dementia Strategy is overseen by a joint health and social care dementia partnership board which is delivering against a clear and specific action plan. There is a commitment to prevention, enabling people to remain at home with the condition for as long as possible. Commissioning and engagement with providers will be consistently aligned with this intention.

The projected increase in dementia has implications for providers of care in all areas. Providers who have staff trained and capable of working supportively and effectively with those with dementia will be more likely to be able to respond to increased demand in this area.

The development of 'sit-in services' at home and/ or more imaginative day opportunities for people with dementia that support those with the condition and their carers would be positive.

[8] BHR CCGs Mental Health Commissioning Framework 2014
[9] Carehome.co.uk/Havering

Services for Carers

The Marketplace

A carer is someone who helps another person, usually a relative or friend, in their day-to day life. Carers are not to be confused with paid care workers, Personal Assistants, Shared Lives carers or volunteer carers.

The Government's National Carers' Strategy describes the term carer as:

"A carer is someone who spends a significant proportion of their time providing unpaid support to a family member, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems."

Becoming an unpaid carer in your 50s increases your chances of leaving the labour market for good, is associated with health problems and restricts social and leisure activities. Unpaid care is highest for both men and women aged 50-64, most likely to have an elderly parent to care for.

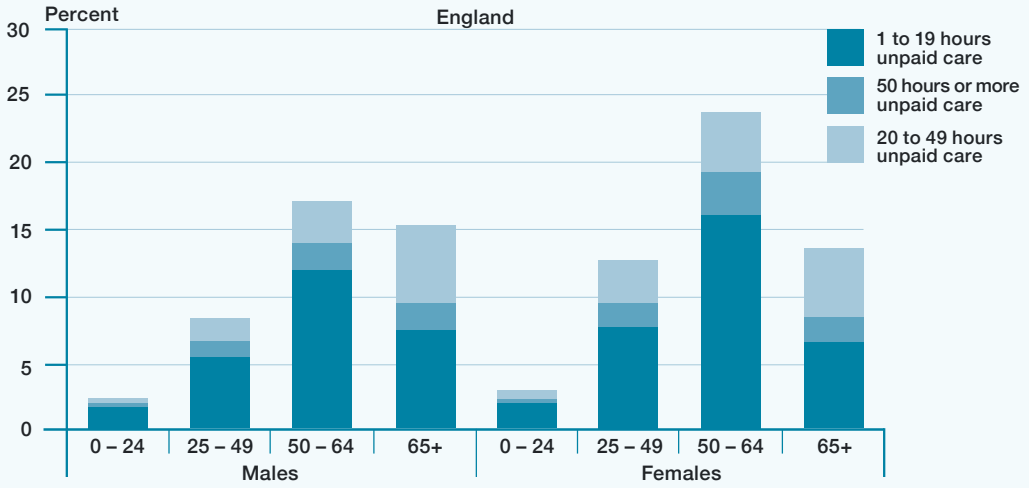
According to the 2011 Census, 25,214 people, 11% of Havering's residents identified themselves as carers, an increase from 23,253 (8.4% increase) in 2001. 5,835 said they provided more than 50 hours care per week.

There are 2,330 claimants of Carers Allowance in the borough and in the past year, 1,936 carers had an assessment of their needs carried out by Adult Social Care.

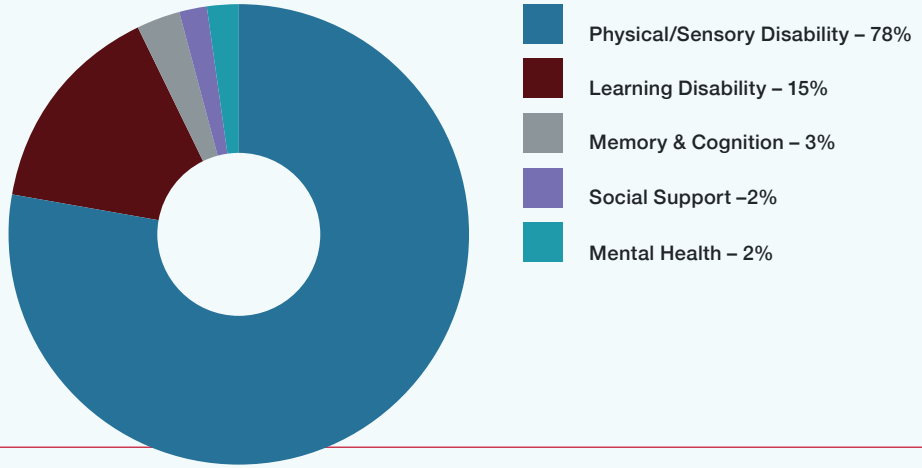
The figure right shows that in 2014-15 the majority of Havering carers supported a loved one with a physical or learning disability.

The Personal Social Services Survey of Adult Carers in England is a biennial survey that took place for the second time in 2014-15. 81% of Havering carers said the person they care for lives with them, 66% of Havering carers responding said they were retired.

Unpaid care provision:
by age and sex in England and in Wales, 2011:



Carers – Primary Support Reason of 'Cared For' Person 2014 – 15



Commissioning Approach and Intentions

The Care Act sets out carers legal rights in relation to assessments and support. It requires local authorities to shape a market that delivers a wide range of sustainable high quality care and support services. Consideration is required for how the services will promote the well-being of carers.

Although this Act gives local authorities the power to charge for the costs incurred in providing care and support to meet the needs of individuals, including carers, Havering Council will not charge for carers services in financial year 2015 to 2016. We will review our charging policy in 2016

In addition insight has been gained into Carer and provider perspectives which has and will inform future commissioning and plans going forward:

We are in the final stages of co-producing a joint Council and NHS Havering Clinical Commissioning Group 'Carers Strategy' for Havering, with carers.

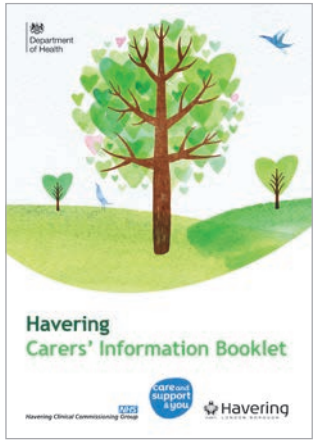
As part of co-producing the Strategy with carers and consulting with stakeholders, we will continue to identify the priorities for Havering carers which will inform needs led and outcome focused services.

Carers have told us they want:

- **To manage their own health and well-being; services available to support them to get the sleep you need and to manage their stress and anxiety levels.**
- **To balance their caring role with their day-to-day tasks and responsibilities.**
- **To have a life outside of their caring responsibilities.**
- **To feel reassured about the health and well-being of the person(s) they care for, even when they are not with them.**
- **To have the skills, tools and confidence to carry out their caring responsibilities.**
- **To feel less alone.**

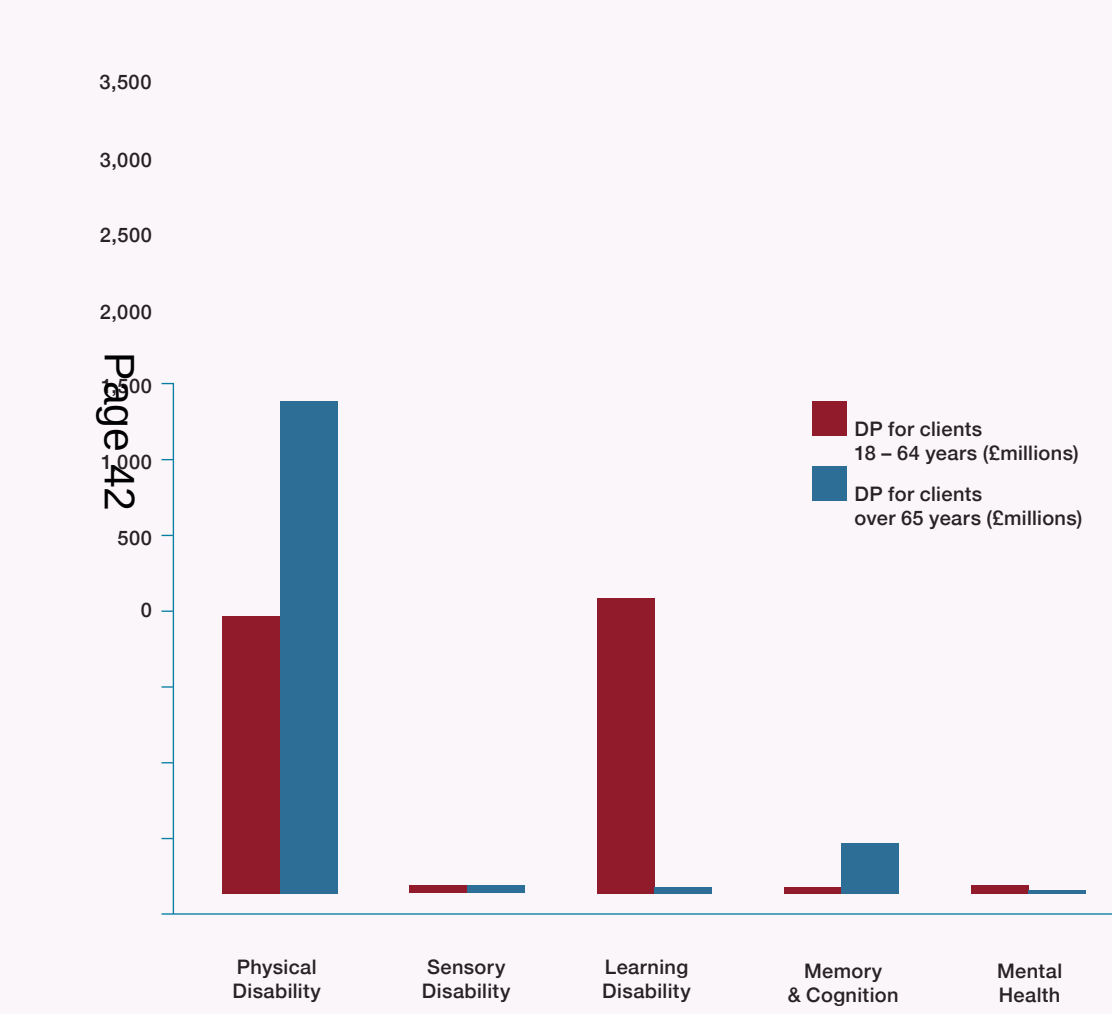
Current support for carers of Havering residents includes:

- **Havering Carers Forum –**
  These quarterly Forum meetings are facilitated jointly by the Council and Havering CCG. We are actively seeking to identify new and hidden carers who may wish to attend and also wish to work with local providers of support and to encourage their engagement and involvement with the Forum, e.g. to host information stalls, lead on workshops and deliver presentations on specific services.
- **Havering Carers Register –**
  We wish to work with funded and non funded partners, to promote awareness of the Register. Over 750 carers are currently signed up to the Havering Carers Register and receive:
  - *the Havering Carers Information Booklet (see page 39 for link)*
  - *invitations to carers events including the Havering Carers Forum*
  - *the quarterly Havering Carers Newsletter*
  - *occasional invitations to participate in surveys and/or consultations which influence commissioning.*
- **Carers events –**
  Over 250 people attended the last Carers Week event in June 2015.
- **Carers assessments and needs reviews of Havering residents –**
  We wish to work with partners across Havering, to raise awareness, support carers to access assessment and to improve their overall experience.
- **Commissioned services –**
  There are a range of services and support currently funded by the ASC's Strategy and Commissioning Team which is under formal review. This will enable us to understand if and how the services are directly and indirectly meeting the needs of carers of Havering residents and identify unmet needs



Personalisation (Self-Directed Support)

Direct Payments – Net Expenditure 2014/15 among different client groups



The Marketplace

The table left shows net expenditure in 2013/15 on direct payments among different client groups. The majority of spend is in the older people market which includes all client groups over the age of 65, however there are more registered SDS users with a physical disability as a proportion of those receiving services than any other client group.

Commissioning Approach and Intentions

Havering is committed to increasing the number of people who have self-directed support as part of its Corporate Plan. The commitment is to:

- **Increase the percentage of people using social care who receive self-directed support and those receiving direct payments to 82%**
- **Increase the percentage of direct payments as a proportion of self-directed support to 45%**

The implications for the market will be increased opportunities to respond to the demand that comes from individuals looking for choice in services that meet their outcomes.

It will also mean the development of an extended and high quality personal assistant market and we will be looking to further develop regulatory arrangements to ensure quality for service users.

Our approach to contracts will recognise that our long term aim is to increase personalisation and micro commissioning.

There are many interdependencies involved in taking personalisation forward. It is therefore intended that a programme of activities is initiated that will address some of the issues that are preventing the development of the market in Havering.

Assistive Technology

The Marketplace

There are currently 4849 residents using some form of assistive technology with 2997 (61.8%) of these jointly funded with Health as part of the Better Care Fund.

Of these 48% have the basic pendant alarm only (Careline) whilst the remaining 52% have the pendant together with additional sensors from an extensive range including a variety of falls and epilepsy monitors, medication reminders, security door alarms for bogus callers and environmental detectors such as smoke, carbon monoxide, flood and extreme temperature gauges.

The evidence base for taking such an approach is contained in a report developed within the commissioning service. It indicated the pendant and the supporting service (Havering Telecare, based in the Housing directorate of the Council) improved quality of life, delayed residential care and reduced hospital admissions.

The current weekly charge for a basic pendant alarm is £4.74 and for the pendant and two additional alarms, the weekly charge is £6.89 with a further charge of £1.14 for every additional sensor (capped at £10.31 maximum fee).[10]

Commissioning Approach and Intentions

Over the course of the coming year an update of the analysis of benefits arising from AT and a review of the funding approach is planned.

There is on-going commitment to enhance the service in place.

This year, for example, the Havering Telecare Service has partnered with Health to combine a rapid reaction vehicle with the alarm service, with skilled health practitioners getting to falls victims as quickly as possible. This will look to reduce referrals to hospital or get treatment to sufferers quicker so that consequences of the fall are mitigated.

[10] Housing Services, Havering Telecare Centre

The Voluntary Sector

The Marketplace

The approach to the Voluntary Sector mirrors and supports the wider Council approach as set out in Havering's 'Voluntary Sector Strategy 2015-18'. The strategy scoped the volume and nature of voluntary sector services in Havering (see link page 39)

It is clear from this work that the voluntary sector is a much larger and more varied provider of services than is commissioned by the Council. For example 477 charitable organisations were identified but ASC directly commissions 16 that will be included in the review of their services in the coming year.

These services apply to many of the areas referred to in the different sections of this document, for example:

- **Day services to give variety for service users and respite for carers**
- **Support for people to get home from hospital – and to prevent going into hospital**
- **Services specifically for people living with dementia and their carers**
- **Support for people with mental health conditions and their carers**
- **Specifically targeted support for carers**
- **Transport to services**
- **Befriending services**

Total expenditure in 15/16 on these preventative services is approximately £1.1m. but there is no guarantee that funding at these levels will be maintained. Neither will the type of services that are presented above necessarily be those provided in future. This is neither a criticism of the services provided nor a pre-emptive evaluation of their benefits. The services are valued as they are but will be reviewed objectively to assess outcomes and be commissioned within available funding limits.

Commissioning Approach and Intentions

The long-term vision for Havering's 'Voluntary Sector Strategy 2015-18' is to ensure that communities are resilient and supported by an effective and sustainable voluntary and community sector.

The approach being taken within ASC commissioning is aligned with the strategy. There will be a period of change in the way services are commissioned and in the approach to preventative outcomes that will impact on providers.

If services can be shown to increase independence and have a preventative approach, reducing demand and costs, from robust business cases, they are more likely to be funded.

It is recognised however that proof of tangible and cashable benefits, particularly in the short term, are difficult to evidence. There is also finite funding available so at some point even a beneficial business case may not be good enough to release funding.

This can be challenging but will also provide opportunities for incumbent and new providers who can deliver outcomes that produce benefits to service users and the council.

These outcomes will need to be preventative in nature and, for example, will look to support our intentions to achieve:

- **Reductions in hospital admissions or re-admissions**
- **Less need for residential care**
- **Delayed or reduced need for home care services**
- **Maximised independence whilst recognising the need for safety for vulnerable people, meaning they need less support from public services**
- **The creation of services attractive to individuals who have choice about what supports their independence**

This may mean a re-shaping of what is commissioned and what is marketed and provided.

The dialogue between the voluntary sector and the council about the future of commissioned services has already started and will look to re-shape the way that services are delivered in future.

Information and Advice

The Marketplace

Havering went through a tendering exercise for the provision of Care Act compliant information and advice services in 2014/15.

This led to a change of provider and the new service is now in place.

Previous provision was from a shop unit based in Romford that picked up telephone calls and face to face discussions. The service was backed by the CarePoint web site where service users could access independent advice and information about services.

Commissioning Approach and Intentions

The importance of setting up the new service in a constructive way, building positive relationships between commissioner and provider is recognised.

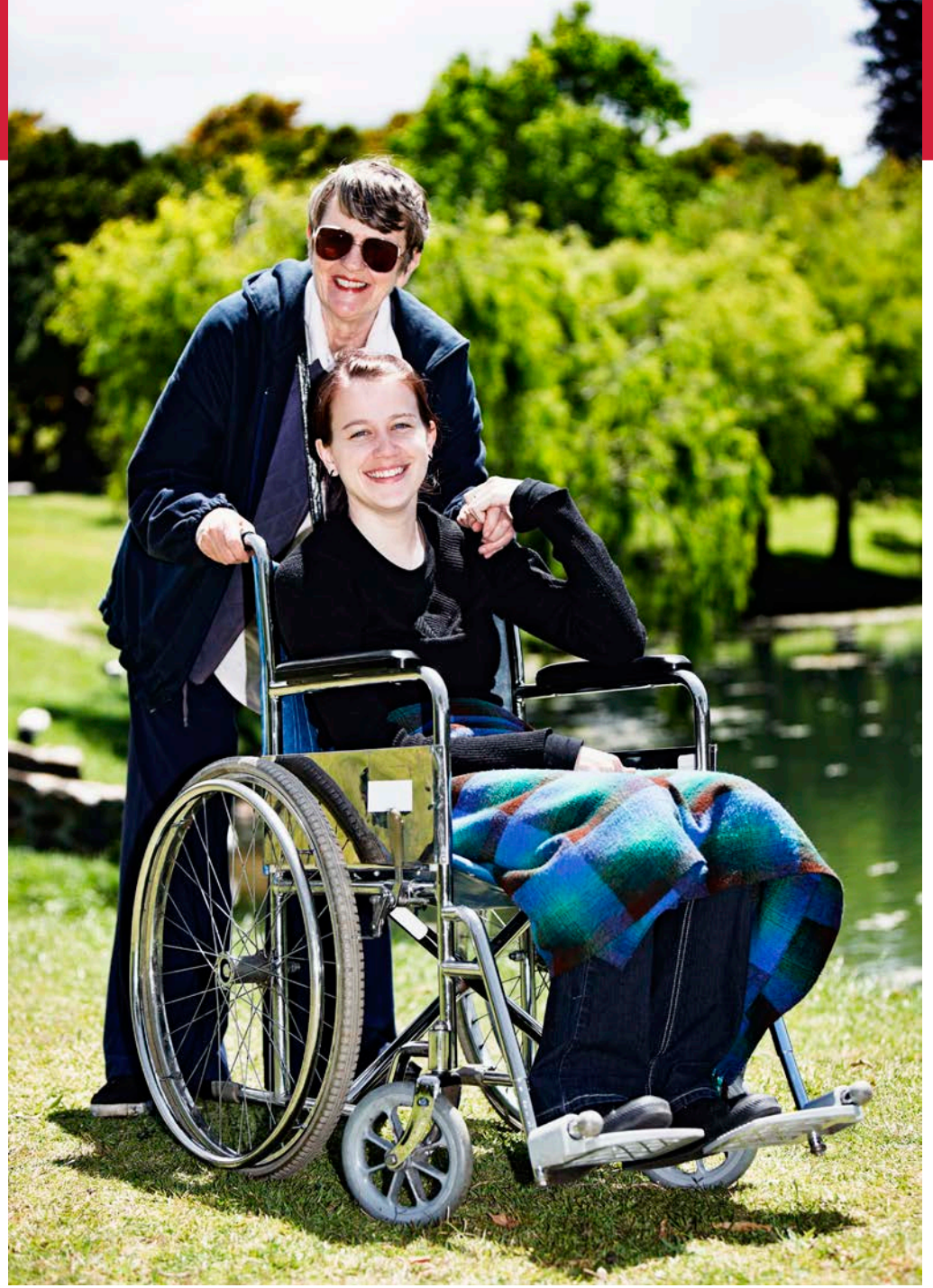
Discussions have already begun to shape a service that is outcome focused. Measures of success are being designed in a collaborative way with the new provider.

The intention is to increase the number of people and groups reached, with higher quality outcomes. This will be both from face to face engagement at physical locations and through outreach initiatives.

Understanding of the parameters around telephone access, being clear about what the council's customer services will provide and ensuring there are minimal duplications or conflicts between the provider and the council is imperative.

An updated web site is being developed, looking to improve the user experience and increase numbers of users.

Care organisations need to ensure that their information is shared with this new service so that the public get accurate and up to date advice and guidance.



Independent Advocacy

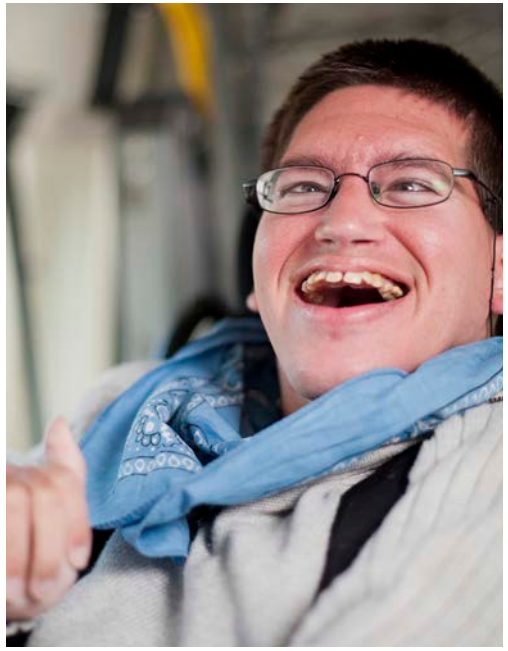
The Marketplace

The Care Act has prescribed the need for Independent Advocacy. To understand demand Havering has taken the approach of tendering a pilot service.

Commissioning Approach and Intentions

The new service is scheduled went live from December 2015. The pilot will run for 16 months and will give a full picture of expected demand and the needs of an advocacy service that delivers effective outcomes for service users.

Learning will be an essential part of the new service and will allow for a more informed and comprehensive approach to the establishment of the service in 2017.



Housing

The Marketplace

More of Havering's older population own their own homes than both nationally and regionally. The numbers of residents in social housing is substantially less than London as a whole and also nationally.

The majority of those older people who own their own home are mortgage free 73% (as per Housing Needs and demand assessment 2012), with over 85% of those responding indicating that they have equity in excess of £100,000.

The overwhelming majority of Havering's older population live in non-specialist general needs accommodation.

There are fewer than 2000 specialist housing units for older people in Havering. The vast majority of these are sheltered or retirement schemes with, in addition, 3 Extra Care schemes.

Around two thirds of the schemes are for social rent (1219 units). Of these 71.5 % are owned and managed by the council in 19 separate schemes with the remaining 28.5% being owned by Housing Associations mainly in 8 schemes.

There are approximately 700 units within 20 schemes which are in the private sector where properties are available to purchase, usually on a leasehold basis.

The council Sheltered Schemes are generally two storey properties, of which:

- **80% are one bedroom,**
- **17% are bedsits.**
- **Under 3% are 2 or 3 bed.**[11]

They are designed for people over 60 but the majority of residents are older with over 80% of tenants being over 65 and 54% being 80 or over. There is a mobile support worker who is able to give advice and general assistance.

There are visiting services that include: hairdressing, library services, health services, food services. Social activities include outings, seasonal events, music, lunches and general entertainment.

The three Extra Care schemes are owned by Housing Associations:

- **Dreywood Court has a total of 98 units (49 single and 49 double)**
- **Painsbrook Court has a total of 64 units (56 single and 8 double)**
- **St Ethelburga has 33 single units (2 units are designated for extended support where people are unable to return home immediately) with the addition of a Careline service**

St Ethelburga is 100% social rent. Painsbrook is primarily social rent but also has 5 shared ownership units. Dreywood has a greater mix of social rent and shared ownership (78 social rent, 20 shared ownership)

They are primarily for residents over the age of 55 however in some circumstances younger residents with a disability are also eligible. The extra care schemes are designed to enable those who have specific care needs to receive that care within their homes. The council has separate care contracts for each of the schemes. They are currently commissioned on the basis of providing care for tenants who, between them, have mixed dependency levels ranging from low to high. In one week in January 2015 all three schemes had a total of 105 clients with 1,332 hours of commissioned support.[12]

Housing for Older People

Tenure	*Owner Occ*	*Shared Owner*	*Local Authority*	*Other Social Rent*	*Private Rent*	*Living Rent Free*
England	74.1	0.5	10.2	8.7	4.4	2.1
London	64.5	0.5	16.6	10.8	6.0	1.6
Havering	82.9	0.2	10.6	2.6	2.5	1.2
Havering	23277	67	2968	721	711	328

[11] Sheltered Housing Schemes Information 2012

Commissioning Approach and Intentions

Older People

The council has recently undertaken a review of the need for specialist older persons housing within the borough. This review looked at both what was the current and projected need for housing for older people but also what should be the specific type(s) of specialist accommodation. The review acknowledged that the considerable majority of older people will remain in general needs accommodation but that there was a need to ensure that there was the right quantity, quality and type of specialist housing available for older people.

The review concluded that whilst there was an overall need for additional accommodation that this was predominately in the private sector rather than the affordable housing sector. As a result the council will be looking at its own schemes with the aim of ensuring that schemes are fit for purpose and meet the demand for such accommodation in future years.

The review concluded that there was a need for additional Extra Care accommodation. The schemes would preferably be mixed tenure with varying dependency levels amongst residents.

A further review of how the Extra Care provision in the schemes is delivered is taking place. Consultation with providers will be a feature of any model we develop in the future. The councils own research indicates that there is a general lack of awareness amongst residents of the benefits of Extra Care Accommodation and this can extend to some professionals when considering re-housing options which aim at maximising a client's independence.

The council is also looking at whether developing larger Retirement Village schemes are an effective way of delivering the full spectrum of specialist housing in one complex. We will be open to exploring this and more conventional extra care schemes with interested parties.

Future choices about increased levels of provision will be made in partnership with Housing, based on rigorous development of business cases based on robust data collection and the strongest possible evidence base.

Other Client Groups

As has been evidenced in the specific sections relating to both the council's responsibilities for clients with a learning disability, mental health conditions

and older looked after children there is a need for both specialist and long term housing solutions to be found for those groups within Havering.

For those clients with a special educational need and disability who have reached 16 we are developing an integrated post 16 provision which has to include effective Housing Provision. This will include the development of further supported living schemes, but also ensuring that there are suitable accommodation such as ground floor or bungalows to enable individuals to be able to live independently (with appropriate support) within the community.

The council has over 100 looked after children who are accommodated outside of the borough. As these young people reach adult hood we need to be able to assist them in finding their own accommodation, this includes adequately preparing them for being able to live independently within the community.

We are aware that with the difficult housing market and the overall shortage of social housing that long term solution for the council vulnerable clients will include the use of the private rented market. The council will actively seek solutions which provide easy access to good quality accommodation in the private sector.

Communication & Engagement

We want to work more with our key stakeholders. Effective communication from both sides is essential in achieving this aim and building better relationships.

A lot of the work between the Council and providers is productive and mutually beneficial. However there are also opportunities for improvement and the Council wants to develop these opportunities.

In recent consultations providers, too, have highlighted communication as an area where improvements could provide dividends, including:

- **Building trust between the Council, providers and adults with care needs**
- **Management of expectations between the Council and providers**
- **Improved feedback between all parties**
- **Avoidance of the duplication for requests for information**
- **Clarity on who providers should contact within the council**

Information that providers reported they wanted to receive more of included:

- **Ideas around innovation**
- **Funding opportunities**
- **Tender opportunities**
- **Training and development opportunities**
- **Specific issues that the council were facing where providers could help in identifying a resolution**
- **Data, performance and projections**
- **Information on other services within Havering that providers' clients could also access e.g. to tackle social isolation**
- **Key contact information within the council that is consistently kept up to date**

One initiative that Adult Social Care has piloted this year to address issues outlined above is the provider portal, 'Care Network', a website with log in access for providers. The site allows providers to have a page dedicated to their organisation and the services they provide.

There are opportunities for discussion through online forums and private chat facilities, details on upcoming events through an online calendar and training opportunities and tenders.

Engagement

A series of quarterly provider events will be continued. Indeed this document was launched at a provider event in September 2015. In addition specific events with particular provider groups or on specific topics will be conducted as necessary.

Business Support for the Market

The Economic Development team within the LB Havering are spending some time looking at the ASC market and what could be done to support ASC providers.

They are developing a support package which is due to be made available in the next few months but is considering:

- **1. Working with 10-15 Small to Medium Enterprises (SMEs) to provide business and workforce development support and to assess return on investment for employers before, during and after implementation and to facilitate opportunities for shared activity, learning and networking as peers.**
- **2. To contribute to a sector specific forum of social care businesses to develop leadership, support and to consider ways of working to support the changing and growing service needs.**
- **3. Research into good practice models of care and how they can be implemented and promoted in Havering.**
- **4. A wider action research project aimed at establishing and examining recruitment, retention and business performance in terms of impact of apprenticeships/ workforce development on profitability and efficiency. We also want to be able to find out about the issues faced by various sub sectors within care in adopting progression pathways in care including how the Integration of health and social care can impact on attracting staff into the sector as a result of Integration.**
- **5. Work with both Commissioning and other stakeholders, and market test the next 'generation' of contracts to identify components of sustainable business models.**

Conclusion

Havering is changing. Demand on services, as indicated in this document is set to grow. Other demographic changes suggest demand of various types impacting on public services within the borough.

If we continue to respond to this demand in ways we have done previously this will put severe pressure on our ability to meet that demand, both financially and in maintaining levels of quality.

Instead we need to change by shaping the market to be able to deliver in a new context.

The Council needs to play its part in communicating effectively with providers of services but that needs to be a mutually supportive relationship.

The commitment is to maintain and build a dialogue that supports these aspirations.

This Market Position Statement is just one part of that and gives an insight to providers to the current state of the market and what is needed.

This does not mean the end of a process but the start of one.

The document will, no doubt, have gaps and require adjustment.

To enable this there is a commitment to produce a revised document, using feedback from providers and users, to develop and refine the document.

The ways of giving that feedback are detailed below.

Contact Us

We would appreciate your feedback.

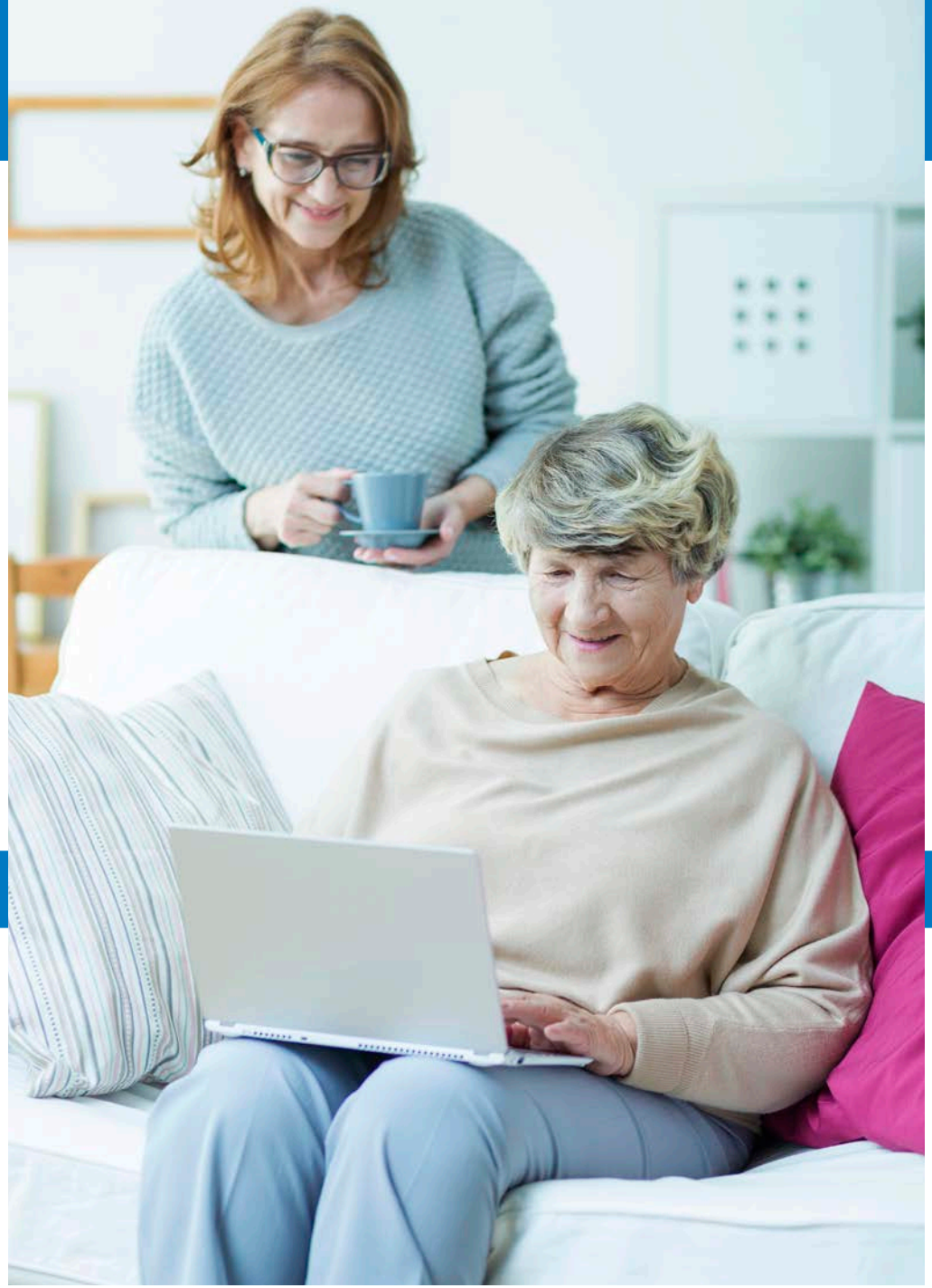
To submit your comments or enquiries regarding this document:

If you are a Havering care provider and are registered on Care Network, please submit your feedback online by visiting

www.carenetworkhavering.org.

Alternatively members of the public, colleagues, providers and other stakeholders can contact the ASC Strategy and Commissioning team via the Havering website online feedback form.

www.havering.gov.uk/Pages/OnlineForms/Market-position-statement.aspx



Key Related Documents

Local Strategies

The key local strategies that inform how Adult Social Care will respond to the legislation outlined above and the changing needs of Havering residents include:

Adult Social Care Strategic Commissioning Strategy 2015-18 (in development) – consultation to be launched November 2015.

Voluntary Sector Strategy 2015-18 –

www.havering.gov.uk/Documents/Community-Engagement/voluntary-sector-strategy.pdf

Health & Wellbeing Strategy 2015-18 (in development)

This 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.

The Better Care Fund 2014-15

The BCF supports the transformation and integration of health and social care services to ensure local people receive better care. It is a pooled budget that shifts resources into social care and community services for the benefit of the NHS and local government.

www.havering.gov.uk/Documents/Adults-and-older-people/Care-Act/better-care-fund-planning-1.pdf

Clinical Commissioning Group (CCG) Delivery Plan

This plan outlines clearly the work programme of activity that the CCG are committed to delivering and which will lead to significant improvements in the local NHS.

www.haveringccg.nhs.uk/About-us/Our-plans/Strategy/strategy-csp.htm

Pan London Safeguarding Procedures 2011 (currently being reviewed)

The procedures aim to make sure that the safety, needs and interests of adults at risk are always respected and upheld. This includes upholding human rights.

www.scie.org.uk/adults/safeguarding/policies/

Early Help, Intervention and Prevention Strategy

This strategy focuses on identifying, prioritising and addressing the major causes and triggers of demand for our services.

Corporate Public Consultation Policy & Toolkit (in development)

The policy aims to support a process of informed and transparent decision-making and planning by improving the quality and effectiveness of public consultation undertaken by or on behalf of the Council

Havering Carers Information Booklet –

www.havering.gov.uk/Documents/Adults-and-older-people/Care-Act/carers-info-booklet.pdf

Legislation & Policy

The key legislation or national strategies that will underpin and influence the direction of travel for Adult Social Care include:

The Care Act 2014

This act has been the biggest change in Adult Social Care in 60 years and the legislation focuses on the integration of health and social care services.

www.gov.uk/government/publications/care-act-2014-part-1-factsheets

Health & Social Care Act 2012

This act puts clinicians at the centre of commissioning, frees up providers to innovate, empowers patients and gives a new focus to public health.

www.gov.uk/government/publications/health-and-social-care-act-2012-fact-sheets

Children & Families Act 2014

This act will give greater protection to vulnerable children as well as a new system to help children with special educational needs and disabilities.

www.legislation.gov.uk/ukpga/2014/6/contents/enacted

Social Value Act 2012

The Act, for the first time, places a duty on public bodies to consider social value ahead of a procurement of a service.

www.gov.uk/government/publications/social-value-act-information-and-resources

National Dementia Strategy 2009

This strategy provides a strategic framework within which local services can deliver quality improvements to dementia services.

www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy

Closing the Gap: Priorities for essential change in mental health

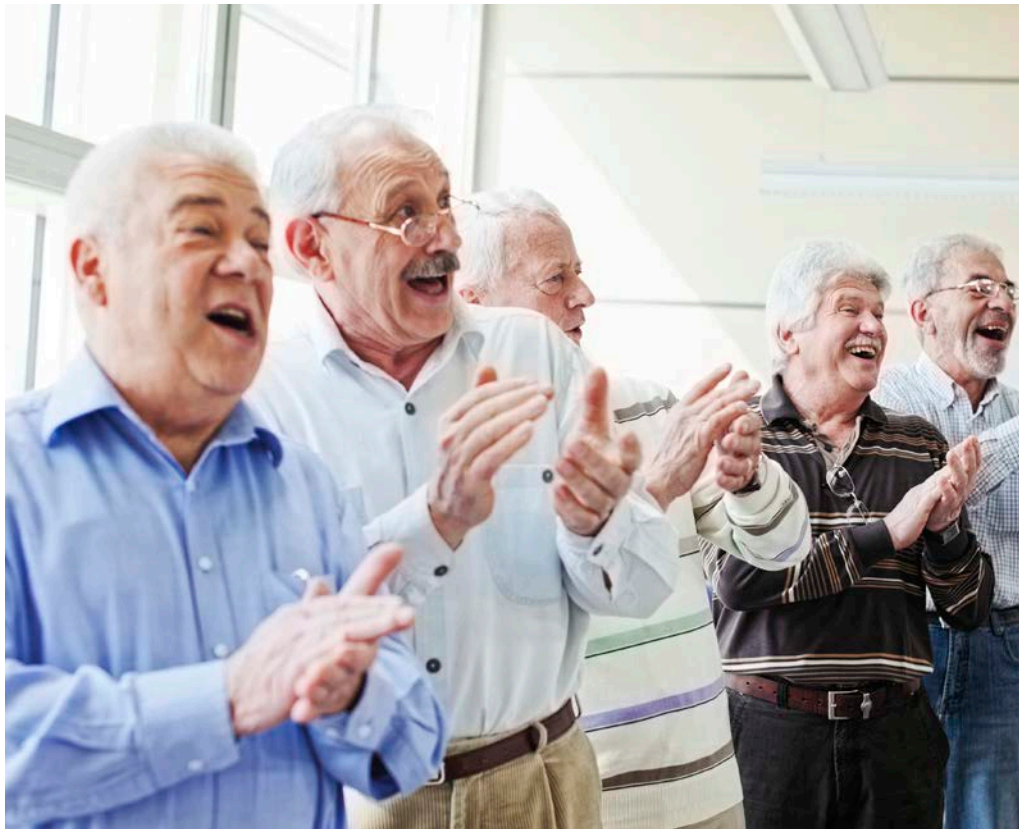
This document supports the mental health strategy implementation framework and suicide prevention strategy, published in 2012.

https://www.google.co.uk/url?url=https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014

EU Procurement Directive 2014

These new changes to regulations will support further reform by making the public procurement process simpler, faster, less costly and more effective for business and procurers alike.

www.gov.uk/government/news/eu-to-open-up-public-procurement-following-uk-government-lobbying



Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Transforming Care Partnerships
Board Lead:	Wendy Brice Thompson
Report Author and contact details:	John Green Ext 3018

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

This is a report updating the board on the developments of the newly formed Barking and Dagenham, Havering and Redbridge Transforming Care Partnership (BHR TCP) for young people and adults with learning disabilities and/or autism including those with a mental health condition.

The BHR TCP is a partnership with membership from the three Local Authorities, Clinical Commissioning Groups (CCG), Specialist Commissioning (NHS England) and North East London NHS Foundation Trust (NELFT).

In October 2015, NHS England (NHSE), the Association of Directors of Adult Social Services (ADASS) and the Local Government Association announced a national plan called *'Building the Right Support'*. The programme is an extension of the Winterbourne View programme and aims to ensure that more people are supported

in the community rather than in placements in institutional settings, namely Assessment and Treatment Units (ATUs), within the next 4 years.

In order to achieve this outcome, a number of actions have been set out for each TCP to deliver within a timeframe. This includes:

- Mobilisation: BHR TCP will need to have a solid foundation upon which to base its transformation with strong leadership and sound governance.
- Developing a vision: BHR TCP will need to develop a shared vision of how the service will change across the new TCP geographical area.
- Implementation: BHR TCP will need to clearly set out how it will deliver the outcomes of the vision and identify the resources it will need to ensure success.

BHR TCP is required to submit its vision and work plan by 11 April 2016. The submission is required to include consultation with stakeholders and approval of the vision and plan by all of the relevant Health & Wellbeing Boards (HWBB) across Barking and Dagenham, Havering and Redbridge. The BHR TCP has begun to shape the vision in preparation for 11 April submission. This report provides an outline of the initial vision for the TCP programme and the steps that will be taken to consult with stakeholders and groups over the next 6 weeks.

The report will be accompanied by a presentation at the March Health and Wellbeing Board meeting outlining the initial vision and priorities for the BHR TCP transformation plan in more detail.

RECOMMENDATIONS

- Note the progress that has been made in developing the BHR Transforming Care Partnership vision to date.
- Discuss and agree the proposed actions and consultation activity that will be undertaken to finalise the vision and plan before 11 April 2016.
- Delegate authority to the Deputy Chief executive and the Accountable Officer (BHR CCGs) to sign off the final submission before the 11 April 2016 deadline.

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REPORT DETAIL

1.1 In October 2015, NHS England, the Association of Directors of Adult Social Services (ADASS) and the Local Government Association announced a national plan called *'Building the Right Support'*. The plan, agreed by all national partners, aims to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. The programme is expected to achieve a closure of 40-65 % of inpatient facilities nationally within the next 4 years. *Building the Right Support* is the next step in the vision set down in the Winterbourne View Concordat which seeks to ensure that people with learning disabilities are given the support that they need close to home.

1.2 Transforming Care Partnerships have been set up to achieve the aims set out in the national plan. Locally, our Transforming Care Partnership includes Barking and Dagenham, Havering and Redbridge and includes the three local authorities, CCGs and North East London NHS Foundation Trust. Each TCP is expected to produce a transformation plan by 11 April 2016 setting out how it will work together to reduce the usage of institutional settings, namely Assessment and Treatment Units (ATUs), and provide more services in the community.

1.3 Transforming Care Partnerships will work alongside people who have experience of using services, as well as their families/carers, clinicians, providers and other stakeholders to formulate and implement these joint transformation plans.

1.4 It is intended that TCPs will bring commissioners together at a scale larger than most CCGs and many local authorities. It is envisaged that these wider partnerships will enable TCPs to:

- Build where possible on existing collaborative commissioning arrangements in place in the area (e.g. joint purchasing arrangements amongst CCGs, joint commissioning arrangements between CCGs and local authorities).

- Develop local health economies of services for people with a learning disability and/or autism (e.g. patient flows, the provider landscape, and relationships between commissioners and providers). Where, for instance, a number of CCGs tend to use the same hospital provider for inpatient services it makes sense for those CCGs to implement change collaboratively.

- Commission at sufficient scale to manage risk, develop commissioning expertise and commission strategically for a relatively small number of individuals whose packages of care can be very expensive.

2. Our local vision

2.1 Over the last month, representatives from Barking and Dagenham, Havering and Redbridge have been working together to produce an initial vision for the TCP. At this stage, no resources have been committed by any of the representative organisations although partners will be expected to align existing resources to achieve the vision for this cohort of individuals.

2.2 Locally across BHR our vision is consistent with the national service model and is currently (subject to further stakeholder engagement to confirm exact wording):

"People with a learning disability and/or autism, including people with complex and challenging behaviour, can lead fulfilling and rewarding lives while being part of a community that is able to support them with dignity and respect and ensure that people's individual wellbeing is at the heart of decisions."

2.3 The Partnership have stated that they are committed to achieve the vision by designing and implementing care and support services that:

- Provide support and interventions in the least restrictive manner and for the shortest time possible;
- Provide respite for families and carers that enables at home placements to be maintained with positive family relationships;
- Ensure that people who need inpatient care do not have to travel long distances to access it;
- Strengthen multi-disciplinary and multi-agency working to reduce health inequalities;
- Make better use of community provision across the three boroughs;
- Ensure that people have choice and control over their own health and care services;
- Ensure that early identification and early support is commissioned and provided;
- Enable people with learning disabilities and or autism and their family and carers to have access to the right level of information, advice and advocacy.

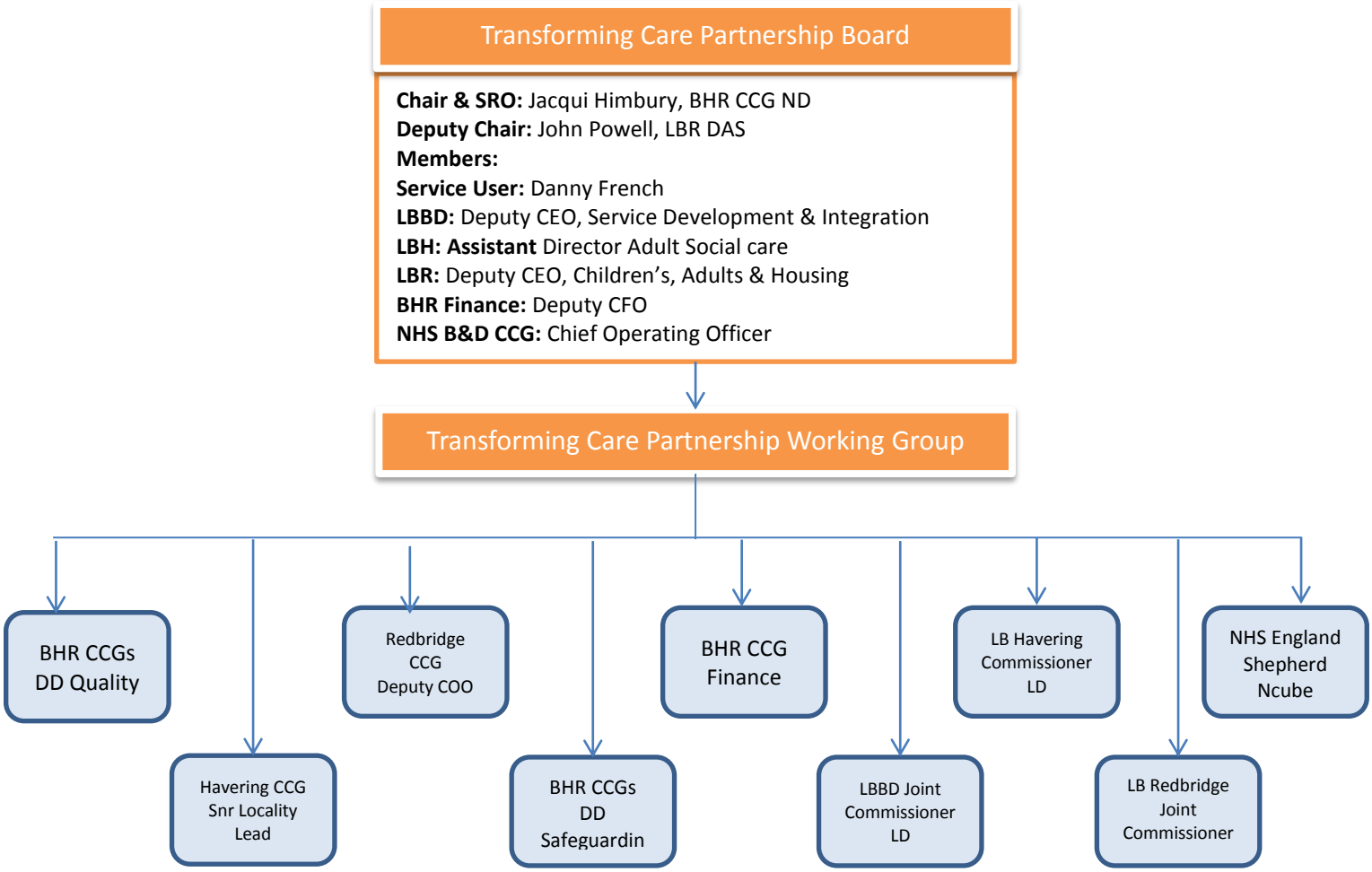
2.4 Our initial thoughts on our vision were presented to NHS England on 25 February 2016 by a panel of BHR TCP members and officers from the representative organisations. We have received formal feedback which will be used to inform the final transformation plan. An update will be given at

the Health and Wellbeing Board meeting on xx March 2016. The deadline for the final plan is 11 April 2016.

2.5 More detail on the proposed vision and priorities for the TCP transformation plan will be provided at the Health and Wellbeing Board meeting, recognising that between the drafting of this report and attendance at HWB, progress will have been made.

Governance and membership

2.6 The Havering Barking and Dagenham and Redbridge Transforming Care Partnership will provide leadership on the delivery of the TCP plan and is accountable for the delivery of the programme. The Transforming Care Programme has a working group which consists of representatives from all Boroughs, CCGs and NHS England, which is described in the diagram below:



2.7 Service users, carers and providers will also be invited to participate in the Board, as well as representatives from the community and voluntary sector.

2.8 A Project Manager is supporting the development of the transformation plan and is working closely with the TCP Board and officers within Havering, particularly the Assistant Director for ASC, Head of Commissioning for ASC, Commissioning Manager for learning disabilities and the Commissioning Manager in children's.

It should be noted that the Learning Disability Partnership Board have already taken the lead in shaping the TCP vision and objectives on behalf of the Havering Health and Wellbeing Board and an initial discussion took place at the LDPB meeting on 4 March 2016 to inform the transformation plan.

Consultation

2.9 Over the next six weeks, the Chair of the TCP, Jacqui Himbury, the Project Manager and Commissioning Manager for Learning Disabilities will consult with stakeholders in Havering to develop the final vision and priorities of the BHR TCP transformation plan.

2.10 The following groups will be consulted. The Board are asked to discuss this proposed consultation activity and comment upon whether any other groups should be consulted within the time available:

- Learning Disability Partnership Board (including service user, carer and provider forums);
- Mental Health Partnership Board;
- Safeguarding Adults Board;
- Local Safeguarding Children's Board;
- SEND Programme Board.

IMPLICATIONS AND RISKS

Financial implications and risks:

Legal implications and risks:

Human Resources implications and risks:

Equalities implications and risks:

BACKGROUND PAPERS

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HEALTH & WELLBEING BOARD

Subject Heading:	Better Care Fund Planning for 2016-17
Board Lead:	Isobel Cattermole, Deputy Chief Executive of Children, Adults and Housing
Report Author and contact details:	Caroline May, Head of Business Management, Adult Social Care Caroline.May@Havering.gov.uk t. 01708 433671

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

- ☒ Priority 1: Early help for vulnerable people
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- ☒ 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 provide the Health and Wellbeing Board with an update on the way in which the BCF will be implemented in the financial year 2016/17. This is based on the national policy framework which has recently been issued.

There is a requirement for plans to be jointly developed and approved by the Health and Wellbeing Board, in accordance with BCF technical guidance.

The BCF has been established by Government to provide funds to local areas to support the integration of health and social care. It aims to ensure a closer integration between health and social care, putting person centred care and

wellbeing at the heart of the decision making process. The BCF is a vital part of both NHS planning and local government planning.

2015/16 was the first year of the BCF nationally. Section 75 of the National Health Service Act 2006 gives powers to local authorities and health bodies to establish and maintain pooled funds out of which payments may be made towards expenditure incurred in the exerciser of prescribed local authority functions and prescribed NHS functions.

The BCF policy required the pooling of budgets and a section 75 agreement about how integration will be taken forward and the funding prioritised to support this. In Havering, the pooled fund totals £18,914m in 2015/16.

RECOMMENDATIONS

1. Delegate authority to the HWBB Chair to approve the final submission of the BCF Plan 2016/17 to NHS England for submission on 25 April 2016, subject to obtaining approval from the Council and the Havering Clinical Commissioning Group (CCG).

2. To receive, post 25 April 2016, the final submission that was made, and subsequently to receive monitoring reports at six monthly intervals.

3. Delegate authority to the HWBB Chair to approve BCF statutory reporting returns each quarter.

REPORT DETAIL

1. 2016/17 Planning

1.1 The Department of Health (DH) and the Department for Communities and Local Government (DCLG) have published a detailed policy framework[1] for the implementation of the Better Care Fund in 2016/17, developed in partnership with the Local Government Association, Association of Directors of Adult Social Services and NHS England.

1.2 For 2016/17 it has been agreed that the BCF planning and assurance process should be integrated as fully as possible with the core NHS operational planning and assurance process.

1.3 Local partners will be required to develop, and agree, through the relevant Health and Wellbeing Board (HWBB):

i. A short, jointly agreed narrative plan including details of how they are addressing the national conditions;
ii. Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes;
iii. A scheme level spending plan demonstrating how the fund will be spent;
iv. Quarterly plan figures for the national metrics.

1.4 In Havering we held a BCF planning workshop on 10 February 2016. This was independently facilitated to enable impartial review and challenge. The main outcomes that will be reflected in our 2016/17 plan were:

i. **Current Schemes** - for the coming year we should maintain the current schemes and focus on developing the 2020 integration plan (to be in place by 2017).
ii. **Governance** – the Joint Management and Commissioning Forum and the Delivery Group would both be reviewed and reorganised.
iii. There was consensus that the **Accountable Care Organisation** (whether attained or not) is the scale of integration we are strategically committed to. This is a longer term strategy and the local BCF plan needs to be delivered as initial steps towards integration at a greater scale.

2. Policy Requirements

2.1 The legal framework for the Fund derives from the amended NHS Act 2006, which requires that in each area the Fund is transferred into one or more pooled budgets, established under Section 75, and that plans are approved by NHS England in consultation with DH and DCLG. The Act also gives NHS England powers to attach additional conditions to the payment of the Better Care Fund to ensure that the policy framework is delivered through local plans. In 2016/17, NHS England will set eight conditions, which local areas will need to meet through the planning process in order to access the funding. The conditions require:

i. That a BCF Plan, covering a minimum of the pooled Fund specified in the Spending Review, should be signed off by the HWB itself, and by the constituent Councils and CCGs;
ii. A demonstration of how the area will meet the national condition to maintain provision of social care services in 2016/17.
iii. Confirmation of agreement on how plans will support progress on meeting the 2020 standards for seven-day services, to prevent unnecessary non-elective admissions and support timely discharge;
iv. Better data sharing between health and social care, based on the NHS number;
v. A joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
vi. Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;
vii. That a proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement; and
viii. Agreement on a local action plan to reduce delayed transfers of care.

2.2 New condition vii replaces the national payment-for-performance element of the Fund, linked to delivering a reduction in non-elective activity that was a condition in 2015-16. Condition viii is also a new national condition for 2016-17.

2.3 Our DTOC plan currently is effectively the Joint Access and Discharge Team and moving forward we have the Discharge to Access Pilot. These plans are being incorporated into the BCF submission.

3. Timeline

3.1 The high level timetable is below:

1) NHS Planning Guidance for 2016-17 issued 22 December 2015
2) Technical Annexes to the planning guidance issued, 19 January 2016
3) BCF Planning Requirements; Planning Return template, BCF Allocations published February 2016
4) First BCF submission agreed by CCGs and local authorities, to consist of: BCF planning return only 2 March 2016
5) Assurance of CCG Operating Plans and BCF plans March 2016
6) Second submission following assurance and feedback, to consist of Revised BCF planning return and high level narrative plan 21 March 2016
7) Assurance status of draft plans confirmed by 8 April
8) Final BCF plans submitted, having been signed off by Health and Wellbeing Boards 25 April 2016

4. Assurance and Plan Approval

4.1 There will be no national assurance process for BCF Plans for 2016-17. Instead regional teams will work with the Better Care Support Team to provide assurance to the national Integration Partnership Board (jointly chaired by DH and DCLG whose membership includes NHS England, LGA and ADASS) that the above process has been implemented to ensure that high quality plans are in place which meet national policy requirements and have robust risk-sharing agreements where appropriate. This will include offering assurance that appropriate support and assurance arrangements are in place for high risk areas.

4.2 The assurance arrangements will place plans into three categories – ‘Approved’, ‘Approved with support’, ‘Not approved’. The next steps for a HWB whose plan is placed within each category are set out below:

I. Approved – proceed with implementation in line with plans;
II. Approved with support – proceed with implementation with some on-going support from regional teams to address specific issues relating to ‘plan development’ and / or ‘risks to delivery’;
III. Not Approved – do not proceed with implementation. Work with the NHS England DCO team, Better Care Manager and LGA / ADASS representatives to put in place steps for achieving plan approval (and / or meet relevant conditions) ahead of April 2016.

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IMPLICATIONS AND RISKS

Financial implications and risks:

Funding Requirement

Under the NHS Mandate for 2016/17, NHS England is required to ring-fence £3.519 billion within its overall allocation to CCGs to establish the BCF.

BCF 2016/17 funding allocations have been announced. Havering's minimum funding allocations over 2015/16 and 2016/17 are per the table below:

Description	2015/16 £'000	2016/17 £'000	Variance
Revenue funding from CCGs	15,495	16,352	857
Disabled Facilities Grant (DFG) funding	829	1,426	597
Social Care Capital	560	-	(560)
Total	**16,884**	**17,778**	**894**

Note that Social Care Capital funding will be discontinued from 2016/17.

In 2015/16 there was also £590k Local Authority non-recurrent revenue funding and £850k contribution from base budget. The CCG also contributed £590k non-recurrent funding. This brought the total value of the pool up to £18,914m. In 2016/17 it is expected only the Local Authority £850k contribution from base budget will remain that is over and above the minimum requirement.

There is additional funding in 2016/17 financial year of £80k relating to what was previously section 256 funding for Social Care and £12k for the Care Act. This funding is not new but has been uplifted. The £135m nationally made available through the BCF in 2015/16 for a broader set of duties around the Care Act has been simplified to focus mainly on carer support.

The Disabled Facilities Grant (DFG) allocations have increased from £829k to £1.4m. This is to encourage areas to think strategically about the use of home adaptations, use of technologies to support people in their own homes, and to take a joined-up approach to improving outcomes across health, social care and housing. In 2016/17, the housing element has been strengthened through the National Conditions, which require local housing authority representatives to be involved in developing and agreeing BCF plans.

Risk Share

In 2015/16 there was a performance element totalling £857k within the pool. This was related to the non-elective admissions performance metric, which has a target activity reduction of 2.5%. The risk share was apportioned 35/65 between the local authority and the CCG respectively. The performance fund was not achieved and so this element of the pooled fund was not passed onto the council and instead was paid directly to health to offset acute pressures. Although non-elective admissions is no longer the basis of a Performance Fund, the metric is still in place, as set by the CCG Operational Plan. As per Technical Guidance Annex 4 – Better Care Fund Planning Requirements for 2016/17, Local areas are expected to consider including a risk sharing arrangement which is specifically linked to the delivery of their plan for non–elective admissions in 2016/17. There will be further discussions between the Council and the CCG to determine this level of risk and will aim to finalise this for the second and final submissions due by 21st of March and 25th of April 2016 respectively.

Better Care Fund 2016/17 First Submission - 02 March 2016

The first submission spending plan for each scheme is in line with 2015/16.This will require further approval by the Joint Management and Commissioning Forum and is subject to HWBB chair sign off for the second submission due on 21st of March 2016, and the final submission on 25th of April 2016.

Section 75

There will be a requirement to amend the s.75 to reflect the locally agreed risk share and also update the relevant schedules. As per s.75 the financial arrangements will remain the same including the invoicing processes between the two partners.

Legal implications and risks:

There are no legal implications arising directly from this report.

Human Resources implications and risks:

There are no human resources implications arising directly from this report.

Equalities implications and risks:

The Better Care Fund provides an opportunity to transform care so that people are provided with better integrated care and support. It encompasses a substantial level of funding and it will help deal with demographic pressures in the health and social care system. The Better Care Fund does not appear to have any adverse effects on people who share Protected Characteristics and no further actions are recommended at this stage.

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BACKGROUND PAPERS

Technical Guidance Annex 4: Better Care Fund Planning Requirements for 2016/17

2016/17 Better Care Fund : Policy Framework

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Technical Guidance Annex 4:

Better Care Fund Planning Requirements for 2016-17

February 2016

NHS England Publications Gateway Reference 04437

CONTENTS

INTRODUCTION

1. The Department of Health (DH) and the Department for Communities and Local Government (DCLG) have published a detailed policy framework[1] for the implementation of the Better Care Fund in 2016-17, developed in partnership with the Local Government Association, Association of Directors of Adult Social Services and NHS England. This forms part of the NHS Mandate for 2016-17 to 2017-18. It requires NHS England to issue further detailed guidance to local areas on developing Better Care Fund (BCF) plans for 2016-17.

2. For 2016-17 it has been agreed that the BCF planning and assurance process should be integrated as fully as possible with the core NHS operational planning and assurance process. This guidance, which has been developed in conjunction with the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS), is therefore included here as an annex to the core NHS planning guidance for 2016-17. This does not diminish the requirement for plans to be jointly developed with local government partners, and approved by Health and Wellbeing Boards. This guidance is also being disseminated directly to local authorities via the Local Government Association.

3. The policy framework signals the need for stability in 2016-17, and a reduction in the overall planning and assurance requirements on local areas. This includes a shorter narrative plan requirement, reduced detailed requirements on the scheme level data, and for plan assurance to be owned by NHS England and local government regional teams, rather than through the national assurance and resubmission process that existed for 2015-16.

4. Whilst the policy framework remains broadly stable in 2016-17, local areas should be mindful in developing their plans about the linkages with NHS sustainability and transformation plans which NHS partners will be required to produce in 2016, and the Government's Spending Review requirement to produce a whole system integration plan for 2017. Both planning requirements will require a whole system approach from 2017-20.

POLICY REQUIREMENTS

5. The legal framework for the Fund derives from the amended NHS Act 2006, which requires that in each area the Fund is transferred into one or more pooled budgets, established under Section 75, and that plans are approved by NHS England in consultation with DH and DCLG. The Act also gives NHS England powers to attach additional conditions to the payment of the Better Care Fund to ensure that the policy framework is delivered through local plans. In 2016-17, NHS England will set eight conditions, which local areas will need to meet through the planning process in order to access the funding. The conditions require:

    i. That a BCF Plan, covering a minimum of the pooled Fund specified in the Spending Review, should be signed off by the HWB itself, and by the constituent Councils and CCGs;

[1] https://www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2016-to-2017

ii. A demonstration of how the area will meet the national condition to maintain provision of social care services in 2016-17.

iii. Confirmation of agreement on how plans will support progress on meeting the 2020 standards for seven-day services, to prevent unnecessary non-elective admissions and support timely discharge;

iv. Better data sharing between health and social care, based on the NHS number;

v. A joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional;

vi. Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;

vii. That a proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement; and

viii. Agreement on a local action plan to reduce delayed transfers of care.

6. Conditions i - vi, above are based on policy set out in the 2013 Spending Review and were included in the 2015-16 BCF framework. They have been updated to reflect further policy developments and the 2015 Spending Review.

7. New condition vii replaces the national payment-for-performance element of the Fund, linked to delivering a reduction in non-elective activity that was a condition in 2015-16. We expect a similar local performance element will be deployed other than in those local areas that delivered their emergency admission reductions in 2015-16 and are confident that this can be repeated in 2016-17.Condition viii is also a new national condition for 2016-17. The details of each of the conditions are set out in the new policy framework.

PLANNING REQUIREMENTS

8. Local partners will need to develop a joint spending plan that is approved by NHS England as a condition of the NHS contribution to the Fund being released into pooled budgets. The process for developing plans will be simplified from the approach used for 2015-16 plans and will be aligned to the timetable for developing CCG operational plans. All national partners have agreed to minimise the amount of information that is collected and assured nationally as part of this process. In developing BCF plans for 2016-17 local partners will be required to develop, and agree, through the relevant Health and Wellbeing Board (HWB):

i. A short, jointly agreed narrative plan including details of how they are addressing the national conditions;

ii. Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes;

iii. A scheme level spending plan demonstrating how the fund will be spent;

iv. Quarterly plan figures for the national metrics.

9. The below table sets out where the information to fulfil the above planning requirements will be collected and how it will be assured:

Requirement	Collection method	Assurance approach
Narrative plans	Submitted to NHS England regional / local Directors of Commissioning Operations (DCO) teams in an agreed format	Assured by DCO teams, with regional moderation involving the LGA and ADASS
Confirmation of funding contributions	Submitted through CCG Finance Template and through a nationally developed high level BCF planning return (spreadsheet)	Collated and analysed nationally, with feedback provided to DCO teams for regional moderation and assurance process
National Conditions	Detail submitted to NHS England regional / DCO teams through narrative plans (as above), with further confirmations submitted through a nationally developed high level BCF planning return (spreadsheet)	Assured by DCO teams, with regional moderation involving the LGA and ADASS
Scheme level spending plan	Submitted to NHS England regional / DCO teams through a nationally developed high level BCF planning return (spreadsheet)	Collated and analysed nationally, with feedback provided to DCO teams for regional moderation and assurance process
National Metrics	Submitted through UNIFY and through a nationally developed high level BCF template return (spreadsheet)	Collated and analysed nationally, with feedback provided to DCO teams for regional moderation and assurance process

These will be the only planning requirements for the Better Care Fund in 2016-17.

NARRATIVE PLANS

10. There will not be a 'Nationally Consistent Assurance Review' of BCF plans for 2016-17 and therefore no national assessment of narrative plans. Local partners are still required to have in place a shared HWB level plan for integrating health and social care services through the BCF. This should build on approved plans for 2015-16 and demonstrate that local partners have reviewed progress in the first year of the BCF as the basis for developing plans for 2016-17. High level narrative plans produced for 2016-17 will therefore be expected to demonstrate incremental changes to 2015-16 plans reflecting this review of progress. As part of its assurance of CCG plans, NHS England will review BCF plans to ensure the appropriate use of risk management arrangements in the context of the BCF Condition 7.

11. In building on current BCF plans, the high level narrative plans that will need to be produced will also need to demonstrate that local partners have collectively agreed the following:

i. The local vision for health and social care services – showing how services will be transformed to implement the vision of the Five Year Forward View and moving towards integrated health and social care services by 2020, and the role the BCF plan in 2016-17 plays in that context;

ii. An evidence base supporting the case for change;

iii. A coordinated and integrated plan of action for delivering that change;

iv. A clear articulation of how they plan to meet each national condition; and

v. An agreed approach to financial risk sharing and contingency.

12. In all cases these elements can be demonstrated and referenced from existing plans or initiatives, including refreshed 2015-16 BCF plans. There will not be a need to restate information that is already satisfactorily provided in existing plans. This does not diminish the need for local areas to develop plans together and publish them in line with the requirements of their respective organisations.

13. In addition to the national condition relating to improving data sharing (see below), narrative plans are expected to demonstrate how digital or information technology is being established as an instrumental enabler to the delivery of integration, with reference to the Five Year Forward View and Personalised Health and Care 2020[2]. 90 communities have so far come together to create local digital roadmaps, with CCGs and local authorities included in each one. Where these are in place they should be referenced within BCF plans; where they are not it is expected that BCF plans will include a reference to their development. This recognises that integrated planning and delivery of the enabling information technology (including access to integrated digital records) is a vital part of the infrastructure to support improved operational performance on a number of areas that are a core focus of the BCF. These include reducing unnecessary non-elective admissions, seven day-a-week out-of-hospital services, and timely discharge.

CONFIRMATION OF FUNDING CONTRIBUTION

14. NHS England has published individual HWB level allocations of the BCF for 2016-17, and the detailed formulae used, on its website.[3] This builds upon confirmation of each CCG's contributions to the BCF in 2016-17 which is included in the core CCG allocations, also published on the NHS England website.[4]

15. All local partners will need to confirm mandatory and additional funding contributions to all plans to which they are a partner. This will include confirming that individual elements of the funding have been used in accordance with their purpose as set out in the policy framework and below. This will be collected nationally through a high level BCF Planning Return. Detailed instructions on completing this are included in the guidance section of the return template. Local

[2] https://www.england.nhs.uk/ourwork/futurenhs/nhs-five-year-forward-view-web-version/ and https://www.gov.uk/government/publications/personalised-health-and-care-2020
[3] https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/
[4] https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16.

Disabled Facilities Grant

16. Following the approach taken in 2015-16, the Disabled Facilities Grant (DFG) will again be allocated through the BCF. This is to encourage areas to think strategically about the use of home adaptations, use of technologies to support people in their own homes, and to take a joined-up approach to improving outcomes across health, social care and housing. In 2016-17, the housing element has been strengthened through the National Conditions, which require local housing authority representatives to be involved in developing and agreeing BCF plans. Again, following the approach taken in 2015-16, the DFG will be paid to upper-tier authorities in 2016-17. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Therefore each area will have to allocate this funding to its respective housing authorities (district councils in two-tier areas) from the pooled budget to enable them to continue to meet their statutory duty to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under.

Care Act 2014 Monies

17. As described in the Policy Framework, the BCF allocation to CCGs includes £138m to support the implementation of the Care Act 2014 and other policies. BCF plans should set out how informal family carers will be supported by local authorities and the NHS. This funding is not new but has been uplifted from the £135m made available through the BCF in 2015-16 for a broader set of duties around the Care Act – this has been simplified to focus mainly on carer support. Further guidance and details of the exact breakdown will be set out in the Local Authority Social Services Letter, which will be sent by the Department of Health to the Directors of Adult Social Services in due course.

Former Carers' Break Funding

18. The BCF also includes, as in 2015-16, £130m of funds previously earmarked for NHS replacement care so that carers can have a break. Local plans should set out the level of resource that will be dedicated to carer-specific support, including carers' breaks, and identify how the chosen methods for supporting carers will help to meet key outcomes (e.g. reducing delayed transfers of care).

Reablement Funding

19. The Better Care Fund also includes, as in 2015-16, £300m of NHS funding to maintain current reablement capacity in councils, community health services, the independent and voluntary sectors to help people regain their independence and reduce the need for ongoing care.

NATIONAL CONDITIONS

20. Local partners will be required to articulate a plan for meeting each national condition, as set out in the BCF policy framework and operationalised by the guidance contained in this document, through their BCF narrative plan. This

should include clear links to other relevant programmes or streams of work in place locally to deliver on these priorities. It is expected that local areas will want to provide more detailed plans for the new conditions in 2016-17. There will also be a requirement to confirm whether plans are in place to meet the conditions as part of the BCF planning return.

21. The two new national conditions and the conditions on 'Better data sharing between health and social care, based on the NHS number' and 'Maintain provision of social care services' should be read in conjunction with the additional guidance as set out in paragraphs 23 –34 below.

22. Confirmation that BCF plans meet the eight national conditions will be collected nationally through a high level BCF Planning Return and detailed instructions on completing this are included in the guidance section of the template.

FURTHER GUIDANCE ON NATIONAL CONDITIONS

Maintain provision of social care services

23. Local areas must include an explanation within their plans of how the use of BCF resources will meet the national condition to maintain provision of social care services.

24. In setting the level of protection for social care localities should ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through NHS England's regional assurance process.

25. It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf"

Better data sharing between health and social care, based on the NHS number

26. At the present time the HSCIC is not extending the NHS Number batch service to additional local authorities. We understand that for some local authorities this will be causing difficulties in meeting the condition set out in the BCF to use the NHS Number as an identifier across the health and care system. We are working closely together to resolve the issue at a national level. If a locality is currently unable to obtain the NHS Number from the HSCIC then this should be noted in the BCF plan and it will be taken into account when assessing the plan.

Agreement to invest in NHS commissioned out-of-hospital services

27. The BCF Policy Framework establishes that £1 billion of the CCG contribution to the Fund required to deliver investment to the NHS and previously linked to the performance framework will continue to be ring-fenced to deliver investment or equivalent savings to the NHS, whilst supporting local integration aims. Each

CCG's share of this funding will be set out in allocations and will need to be spent as set out in the new national condition.

28. Local areas should agree how they will use their share of the £1 billion that had previously been used to create the national payment for performance element of the fund. This should be achieved in one of the following ways:

    - To fund NHS commissioned out-of-hospital services, that demonstrably lead to off-setting reductions in other NHS costs against the 2014-15 baseline; or

    - Local areas that did not meet their 2015-16 emergency admission reduction goals are expected to consider putting an appropriate proportion of their share of the ring-fenced £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess emergency hospital activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 2015-16).

29. Specifically, where local areas successfully delivered their agreed 2015-16 emergency admission reductions and all partners are confident that the 2016-17 BCF plan can meet its objectives then they can choose to invest the full element of the £1bn linked to NHS-commissioned out-of-hospital services upfront. This could include a wide range of services, to be determined locally. CCGs and Councils should include a breakdown of planned expenditure, including the amount they identify as NHS-commissioned spend, within the scheme level spending plan.

30. However, where the local partners recognise a significant degree of risk associated with the delivery of their 2016-17 BCF plan, for example where emergency admission reductions targets were consistently not met in 2015-16, we expect them to consider using a local risk sharing agreement, given that 'the same pound cannot be spent twice' – on emergency admissions *and* on NHS-commissioned out-of-hospital activity at the same time.

31. Where local partners agree to use a risk share agreement the default approach should be to base this on the 2015-16 approach, as set out at **Appendix 2**. However, we are open to other local approaches that demonstrably achieve the same objective. The key point is that BCF investment does not cause a CCG to over extend itself in financial terms and hence put the financial balance of the health economy at risk.

32. As part of BCF planning returns, local areas will need to demonstrate that they are using their share of the NHS-ring-fenced £1 billion fund in the way described above. The template includes confirmation of the local share, and calculates the amount invested in NHS Commissioned out-of-hospital services from the spending plan. There is also an opportunity to confirm the value of additional funds that are part of appropriate risk sharing arrangements. Further details on this are set out in the guidance section of the return template.

Agreement on a local action plan to reduce delayed transfers of care (DTOC) and improve patient flow

33. In planning to meet this condition all areas should consider their performance in relation to DTOC (and patient flow) and work together to develop a proportionate plan to improve their position. The key elements that local areas should include in their action plan are set out below. These are drawn from existing best practice approaches and available mechanisms for managing effective transfers and delays, rather than introducing new ones.

- **Situation Analysis**
  In order to ensure that the plan developed is proportionate to address the local situation partners should review their current performance and assess the level of opportunity within the system for reducing delays and improving transfers. This should include:
    - Detailed analysis of current performance levels (including trend analysis) and the causes of delays;
    - An assessment of current schemes in place to reduce delays and improve transfers of care and how effective these are;
    - A gap analysis comparing local measures to the best practice interventions (see below);
    - A consideration of whether additional measures are required where rates of delay are very high, including whether a risk sharing arrangement may be appropriate.

- **Target and Action Plan**
  In developing their plan, local partners are expected to agree a target for reducing DTOC that is realistic but ambitious. There should be a clear articulation of how the target has been set, with reference to the situation analysis. The DTOC target and CCG planning assumption should be in alignment and include a trajectory for reducing the number of delays. The target should be underpinned by a set of clear actions to deliver improvement that builds both on successful local initiatives and on the nationally agreed best practice interventions. In addition, areas may also want to consider other metrics which monitor patient flow (such as average length of stay) at a local level. There are a number of metrics being used locally by the Emergency Care Improvement Programme (ECIP) which can be shared.

  Information about the best practice interventions can be found on the Local Government Association's website at http://www.local.gov.uk/adult-social-care/-/journal_content/56/10180/5516287/ARTICLE#impact-change or on the Better Care Exchange at https://bettercare.tibbr.com/tibbr/

- **Accountability Arrangements**
  All actions need to be clearly owned, so the plan should set out lines of responsibility and accountability for delivering each element of the plan, as well as an agreed process for local assurance and escalation where any issue cannot readily be resolved.

- **Using Local Capacity**
  Local partners are encouraged to include an analysis of their local capacity and requirements in their plans and to set out how that capacity can best be used across health and social care to minimise delays and meet evolving

need. A joint commissioning approach between health and care is encouraged. In capacity mapping and planning, local areas will need to consider the long-term sustainability of the market for both health and social care.

Many areas already recognise the role that the voluntary and community sector can play in supporting patients to remain in their own home or return there more quickly following a period in hospital. Local plans can consider explicitly how this sector can contribute to reductions in DTOC. Areas should consider whether other local stakeholders, such as housing providers, have a role to play in efforts to reduce delays.

- **Additional measures**
  As set out above, areas should consider as part of the situation analysis and the development of an action plan, what measures are proportionate to address local levels of performance. Where DTOC are high and rising, or there are significant issues with patient flow across the health and care system, local areas should demonstrate how they have considered all options for addressing this, including the potential use of risk sharing arrangements and broader incentives within the system.

  A local CQUIN has also been included in the NHS contract for 2016-17 which provides a mechanism for local areas to reward improvement in the proportion of patients discharged to their usual place of residence within 7 days of admission.

  If there is local agreement that a risk sharing arrangement for DTOC is appropriate then local areas should consider the use of existing mechanisms. At a national level, the Care Act 2014 sets out a discretionary system whereby the NHS can seek reimbursement from a local authority (LA) if the LA does not meet its statutory duties to assess and, where appropriate, put in place care and support arrangements to allow a patient to be discharged from acute care. These arrangements are explained in the Care and Support Statutory Guidance and reiterated in NHS England's Monthly Delayed Transfers of Care Situation Reports: Definitions and Guidance[5].

  Local areas may decide that they want to use wider mechanisms as part of a risk sharing mechanism and have the flexibility to do so. In doing so, local areas should ensure that their approach takes into account the legal framework on payments set out in the Care Act and that they are content that they are not acting in any way which goes against current legislation.[6]

  In considering the use of reimbursement under the Care Act and wider risk sharing mechanisms, local areas should agree collectively on the approach and assure themselves that it will lead to resources being spent in the best interest of the local population and with a positive impact on the performance of the local health and care system.

[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf and https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

[6] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted/data.htm and http://www.legislation.gov.uk/allTheCareandSupportDischargeofHospitalPatientsRegulations2014

SCHEME LEVEL SPENDING PLAN

34. A scheme level spending plan will be required to account for the use of the full value of the budgets pooled through the BCF. These plans will need to include:
    - Area of spend
    - Scheme type
    - Commissioner type
    - Provider type
    - Funding source
    - Total 15-16 investment (if existing scheme)
    - Total 16-17 investment.

35. Detail on scheme-level spending plans will be collected nationally through a high level BCF Planning Return and detailed instructions on completing this are included in the guidance section of the template.

NATIONAL METRICS

36. The BCF Policy Framework establishes that the national metrics for measuring progress of integration through the BCF will continue as they were set out for 2015-16, with only minor amendments to reflect changes to the definition of individual metrics. In summary these are:

    a. Non-elective admissions (General and Acute);
    b. Admissions to residential and care homes[7];
    c. Effectiveness of reablement;
    d. Delayed transfers of care.

37. The detailed definition of the non-elective admissions (NEA) metric is set out in the Planning Round Technical Definitions[8]. BCF plans will need to establish a HWB-level NEA activity plan. This will initially be established by mapping agreed CCG level activity plans to the HWB footprint using the mapping formula provided in the planning return template. Figures submitted in first draft CCG operating plan returns have been pre-populated into the template centrally and mapped accordingly. HWBs will be expected to agree CCG level activity plans for NEAs as part of the operational planning process and through the BCF to ensure broader system ownership of the non-elective admission plan as part of a whole system integrated care approach.

38. The level of non-elective activity which BCF plans seek to avoid, in addition to reductions already included within the calculation of CCG operating plan figures, should be clearly identified in the BCF planning return. This reduction should be set at a level which the CCG and local system feel can be achieved, and, in any case, the emergency admissions baseline for 2016-17 must not be set any higher than the BCF stretch ambitions used in 2015-16. This is because 'the same pound cannot be spent twice', so if emergency admissions were not prevented in 2015-16 then the funding will have had to be used to reimburse

[7] The ASCOF definition of this metric has changed. The revised definition is now used in the full specification of metric at the end of this annex.
[8] https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

hospitals for their emergency admissions.

39. The detailed definitions of the other three metrics are set out at the end of this document. HWBs will be required to set ambitious plans in relation to each metric. The national condition on DToC sets out further requirements in relation to setting targets for that metric.

40. Information on all four metrics will continue to be collected nationally. The below table sets out a summary of the information required and where this will be collected:

Metric	Collection method	Data required
Non-elective admissions (General and Acute)	• Collected nationally through UNIFY at CCG level • HWB level figures confirmed through BCF Planning Return	Quarterly HWB level activity plan figures for 2016-17, mapped directly from CCG operating plan figures, using mapping provided, against the original 2014-15 baseline and 2015-16 targets.
Admissions to residential and care homes;	• Collected through nationally developed high level BCF Planning Return	Annual target for 2016-17
Effectiveness of reablement;	• Collected through nationally developed high level BCF Planning Return	Annual target for 2016-17
Delayed transfers of care;	• Collected through nationally developed high level BCF Planning Return	Quarterly target for 2016-17

Further information on the data to be provided for each metric can be found in the guidance section of the BCF planning return template.

41. In addition the requirement for BCF plans to include a locally determined metric and a locally determined patient experience metric is again included within the requirements of the BCF planning return. It is expected that local areas will continue to use measures that allow them to effectively track the implementation of integrated care locally.

42. Work to establish a set of new integration metrics continues to be led by the Department of Health. Information collected on a number of potential new measures through the BCF quarter 2 reporting return will help inform that process. The new measures will not be used as part of the BCF framework for 2016-17. Work will continue through 2016-17 to develop them further.

LOCAL PLAN DEVELOPMENT, SIGN OFF AND ASSURANCE

43. Local partners are expected to continue working together to develop a joint, HWB level plan for integrating health and social care services. These should continue to build on plans delivered in 2015-16, and also look forward to longer

term strategic plans. There may be flexibility for devolution sites to submit plans over a larger footprint if appropriate.

44. The Better Care Support Team will provide a range of resources to help local areas develop their plans, including signposting to existing support and advice available on integrated care, technical support on the BCF planning requirements, and continuing to share examples of good practice. Information on planning support requirements collected through the BCF Q2 quarterly returns will also be used to develop further planning specific support. A self-assessment process is also being conducted as part of the main NHS planning approach to identify areas which feel they need more targeted support.

45. The first stage of the overall assurance of plans will be local sign-off by the relevant local authority and CCG(s). In line with the NHS operational planning assurance process, plans will then be subject to regional assurance and moderation. Assurance and judgements on potential support needs through the planning process will be 'risk-based' (based on a planning readiness self-assessment pooled with other system level intelligence) with the level of assurance of an areas plan being proportionate to the perceived level of risk in a system.

46. BCF plans will be submitted and assured through the following steps:-

- The first submission will be of the high level BCF Planning Return only, detailing the technical elements of the planning requirements, including funding contributions, a scheme level spending plan, national metric plans, and any local risk sharing agreement.
- Then brief narrative plans will be submitted to regional teams from HWBs, setting out how the plan will meet the national conditions and the other planning requirements.
- At the same point HWB partners will be required to submit a second version of the completed BCF Planning Return.
- CCGs will also be submitting further versions of their operational planning returns during this period, using central UNIFY and Finance return templates. This will include some of the same data – including funding contributions and NEA figures. There will be a national reconciliation process to ensure the data provided matches in all cases.
- The assurance process, including reconciling any data issues, will happen within NHS England's Directors of Commissioning Operations' (DCO) teams, in alignment with the process for reviewing CCG operating plans. Better Care Managers will work with these teams to ensure they have the knowledge and capacity required to review and assure BCF plans. A set of consistent 'Key Lines Of Enquiry (KLOE) will be produced to support the assurance process and will be available to local areas as a guide in developing plans.
- The assurance process will check specifically that the requirements of Condition 7 have been satisfied, i.e. that planned investment in the Better Care Fund is affordable to CCGs, and contains adequate performance/risk management schemes in respect of emergency hospital admissions.

- To support this, local government regional leads for the BCF (LGA lead CEOs and ADASS chairs) will be part of the moderation process at a regional level (supported with additional resource to contribute to both assurance and moderation) and will be consulted by DCO teams when making recommendations about plan approval;
- As part of that regional moderation process an assessment will then be made of the risk to delivery of the plan due to local context and challenges, using information from NHS England, the Trust Development Authority, Monitor and local government;
- These judgements on 'plan development' and 'risks to delivery' will help inform the placing of plans by NHS England into three categories – 'Approved', 'Approved with support', 'Not approved'. The next steps for a HWB whose plan is placed within each category are set out below:
    - Approved – proceed with implementation in line with plans;
    - Approved with support – proceed with implementation with some ongoing support from regional teams to address specific issues relating to 'plan development' and / or 'risks to delivery';
    - Not Approved – do not proceed with implementation. Work with the NHS England DCO team, Better Care Manager and LGA / ADASS representatives to put in place steps for achieving plan approval (and / or meet relevant conditions) ahead of April 2016.

47. The overall assurance process is illustrated in the schematic at **Appendix 3**.

NATIONAL ASSURANCE AND PLAN APPROVAL

48. There will be no national assurance process for BCF Plans for 2016-17. Instead regional teams will work with the Better Care Support Team to provide assurance to the national Integration Partnership Board (jointly chaired by DH and DCLG whose membership includes NHS England, LGA and ADASS) that the above process has been implemented to ensure that high quality plans are in place which meet national policy requirements and have robust risk-sharing agreements where appropriate. This will include offering assurance that appropriate support and assurance arrangements are in place for high risk areas.

49. In accordance with the legal framework set out in section 223GA of the NHS Act 2006, final decisions on approval will be made by NHS England in consultation with DH and DCLG. These decisions will be based on the advice of the moderation and assurance process set out above. Where plans are not initially approved NHS England will implement a programme of support to help areas to achieve approval (and / or meet relevant conditions) ahead of April 2016.

50. NHS England has the ability to direct use of the CCG contribution to a local fund where an area fails to meet one of the BCF conditions. This includes the requirement to develop a plan that can be approved by NHS England. If a local plan cannot be agreed, any proposal to direct use of the fund and / or impose a spending plan on a local area, and the content of any imposed plan, will be

subject to consultation with DH and DCLG (as required under the 2016-17 NHS Mandate), with the decision then taken by NHS England.

HIGH LEVEL TIMETABLE

51. The submission and assurance process will follow the following timetable:

NHS Planning Guidance for 2016-17 issued	22 December 2015
Technical Annexes to the planning guidance issued,	19 January 2016
BCF Planning Requirements; Planning Return template, BCF Allocations published	February 2016
First BCF submission (following CCG Operating Plan submission on 8 Feb), agreed by CCGs and local authorities, to consist of: • BCF planning return only All submissions will need to be sent to DCO teams and copied to england.bettercaresupport@nhs.net .	2 March 2016
Assurance of CCG Operating Plans and BCF plans	March 2016
Second submission following assurance and feedback, to consist of: • Revised BCF planning return • High level narrative plan All submissions will need to be sent to DCO teams and copied to england.bettercaresupport@nhs.net	21 March 2016
Assurance status of draft plans confirmed	By 8 April
Final BCF plans submitted, having been signed off by Health and Wellbeing Boards	25 April 2016
All Section 75 agreements to be signed and in place	30 June 2016

52. This timetable should be read alongside the timetable of page 16 of the NHS shared planning guidance.[9]

STATUTORY FRAMEWORK AND ALLOCATIONS[10]

53. The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund. It allows for the NHS Mandate to include specific requirements relating to the establishment and use of an integration fund.

54. Under the NHS Mandate for 2016-17, NHS England is required to ring-fence £3.519 billion within its overall allocation to CCGs to establish the BCF. The remainder of the £3.9 billion fund will be made up of the £394 million Disabled Facilities Grant, which is paid directly from the Government to local authorities.

[9] https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/
[10] As set out in the policy framework for the BCF in 2016-17: https://www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2016-to-2017

55. Of the £3.519 billion BCF allocation to CCGs, £2.519 billion will be available upfront to HWBs to be spent in accordance with the local BCF plan. The remaining £1 billion of Clinical Commissioning Group Better Care Fund allocation will be subject to the requirement of the new national condition vii set out in paras 27 to 32 above.

56. Within the BCF allocation to CCGs is £138m to support the implementation of the Care Act 2014 and other policies (£135m in 2015-16). Funding previously earmarked for reablement (over £300m) and for the provision of carers' breaks (over £130m) also remains in the allocation. Further information on this can be found in paragraphs 14-19 above.

57. For 2016-17, the allocations have been based on a mixture of the CCG allocations formula, the social care formula, and a specific distribution formula for the Disabled Facilities Grant element of the Better Care Fund. Full HWB level allocations have been published on the NHS England website.[11]

[11] https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

APPENDIX 1- SPECIFICATION OF BETTER CARE FUND METRICS

Metric 1: Non-Elective Admissions (General and Acute)

The baseline for measurement continues to be 2014-15, as incorporated into the local 2015-16 targets.

The definition of this metric is published as part of the technical definitions for NHS planning in 2016-17, which can be found here:

https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

Metric 2: Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population

Outcome sought	Reducing inappropriate admissions of older people (65+) in to residential care
Rationale	Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the framework supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some client groups that admission to residential or nursing care homes can represent an improvement in their situation.
Definition	**Description**: Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes. **Numerator**: The sum of the number of council-supported older people (aged 65 and over) whose long-term support needs were met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care). This data is taken from Short- and Long-Term Support (SALT) collected by HSCIC **Denominator**: Size of the older people population in area (aged 65 and over). This should be the appropriate ONS mid-year population estimate or projection.
Source	Adult Social Care Outcomes Framework: (HSCIC - SALT: http://www.hscic.gov.uk/socialcarecollections2016) Population statistics (Office for National Statistics, http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html)
Reporting schedule for data source	Frequency: Annual (collected Apr-March) Timing: Final data for 2014-15 was published in October 2015 Baseline: This will be 2014-15 data as published by the HSCIC (note that for the published data the 2014, not the 2015 ONS population estimate has been used for the population denominator)

Historic	Data first collected 2014-15 following a change to the data source. The transition from ASC-CAR to SALT resulted in a change to which admissions were captured by this measure, and a change to the measure definition. Previously, the measure was defined as "Permanent admissions of older adults to residential and nursing care homes, per 100,000 population". With the introduction of SALT, the measure was re-defined as "Long-term support needs of older adults met by admission to residential and nursing care homes, per 100,000 population."

Metric 3: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Outcome sought	Increase in effectiveness of these services whilst ensuring that those offered service does not decrease
Rationale	Improving the effectiveness of these services is a good measure of delaying dependency, and the inclusion of this measure in the scheme supports local health and social care services to work together to reduce avoidable admissions. Ensuring that the rate at which these services are offered is also maintained or increased also supports this goal.
Definition	The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. **Numerator:** Number of older people discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. This should only include the outcome for those cases referred to in the denominator. The numerator will be collected from 1 January to 31 March during the 91-day follow-up period for each case included in the denominator. This data is taken from Short- and Long-Term Support (SALT) collected by HSCIC **Denominator:** Number of older people discharged from acute or community hospitals from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting). The collection of the denominator will be between 1 October and 31 December. This data is taken from Short- and Long-Term Support (SALT) collected by HSCIC Alongside this measure is the requirement that there is **no decrease** in the proportion of people (aged 65 and over) offered rehabilitation services following discharge from acute or community hospital.
Source	Adult Social Care Outcomes Framework: (HSCIC - SALT: http://www.hscic.gov.uk/socialcarecollections2016)

Reporting schedule for data source	Frequency: Annual (although based on 2x3 months data – see definition above) Timing: Final data for 2014-15 was published in October 2015 Baseline: This should be 2014-15 data as published by the HSCIC.
Historic	Data first collected 2011-12 (currently four years data final available (2011-12, 2012-13, 2013-14 and 2014-15)

Metric 4: Delayed transfers of care from hospital per 100,000 population

Outcome sought	Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.
Rationale	This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care.
Definition	Total number of delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both)* A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when: (a) a clinical decision has been made that the patient is ready for transfer AND (b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND (c) the patient is safe to discharge/transfer. **Numerator:** The total number of delayed days (for patients aged 18 and over) for all months of baseline/payment period* **Denominator:** ONS mid-year population estimate (mid-year projection for 18+ population) *Note: this is different to ASCOF Delayed Transfer of Care publication which uses 'patient snapshot' collected for one day each month.
Source	Delayed Transfers of Care (NHS England http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/) Population statistics (Office for National Statistics, http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html)
Reporting schedule for data source	Frequency: Numerator collected monthly (aggregated to quarters for monitoring). (Denominator annual) Timing: 2 month lag. Baseline: 2014/15 quarterly rates
Historic	Data first collected Aug 2010

APPENDIX 2 – REQUIREMENTS FOR RISK SHARE AGREEMENTS

1. Paragraph 30 sets out circumstances in which local areas are expected to consider including a risk sharing arrangement which is specifically linked to the delivery of their plan for Non-Elective Admissions in 2016-17. Where this is the case the arrangements should be described within narrative plans in line with the requirements set out in paragraph 31 to include an agreed approach to financial risk sharing and contingency.

2. In addition, the finance and activity data underpinning the arrangements should be detailed within the BCF planning return template on the metrics tab. Further guidance on how to complete this is included within the guidance tab of the template itself.

3. As a minimum, a risk sharing arrangement that is put in place in this way should:

    a) Create a maximum risk share fund which is equal to the value of non-elective admissions that original BCF plans aimed to avoid.

    The reference point below which reductions can be credited to the BCF is the LOWER of the 14/15 outturn used as the baseline for 15-16 BCF plans, or the activity levels included in CCG Operating Plans for 16-17 after accounting for efficiency measures to reduce non-elective admissions (but before adjusting for the impact of actions taken in the context of 16-17 BCF plans). This is how the BCF risk fund meets the principle that "the money follows the patient" and "the same pound can't be spent twice" – on the emergency admission not avoided, and on other services.

    b) Ensure the value of this fund is withheld by CCGs from their BCF allocation which is paid into the pooled budget at the beginning of the year (recognising that CCG allocations have been set to take account of a number of efficiency measures to reduce non elective admissions which will need to be taken account of when setting the baseline against which the impact of BCF initiatives will be measured);

    c) Make payments into the pooled fund on a quarterly basis equivalent to the value of admissions avoided, up to the maximum risk share fund;

    d) Ensure that unreleased funds are retained by the CCG to cover the cost of additional non-elective activity.

4. If the planned levels of activity are achieved and, as such, value is delivered to the NHS in that way, then this funding may be released to be spent as agreed by the HWB. Otherwise it is retained as a contingency fund to cover the cost of any additional activity which results from BCF schemes not having the expected impact in reducing demand. Arrangements will need to demonstrate how and when it will be agreed to release this funding from the contingency into the pooled budget if it is not required.

5. In addition to this specific guidance, the assurance of overall risk sharing arrangements and contingency plans will look at the management of risk in each plan, with reference to key metrics. This will be consistent with the approach set out in guidance for 2015-16, focusing on whether each plan includes:

a) A quantified pooled funding amount that is ‘at risk’;

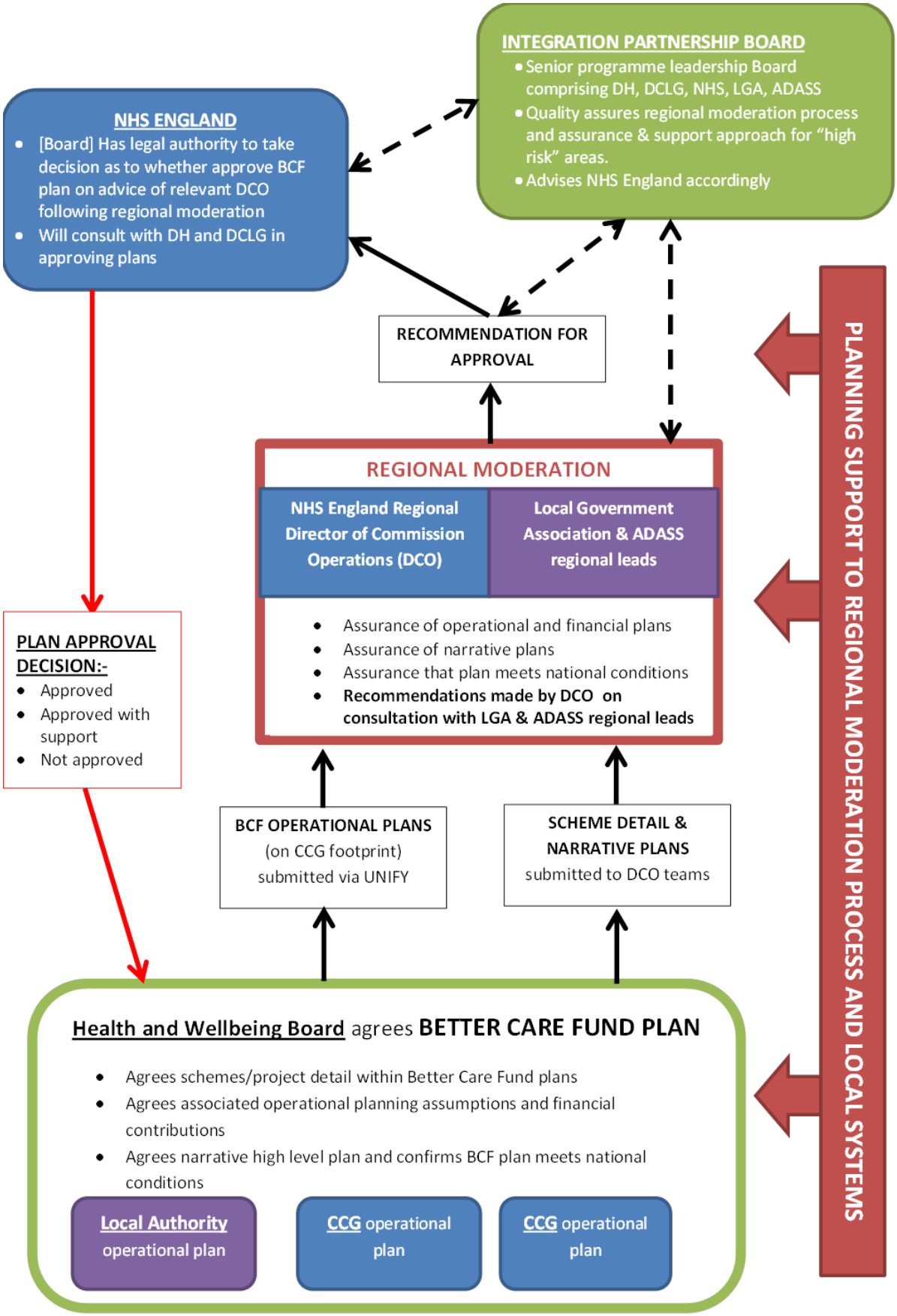
b) Demonstration that this has been calculated using clear analytics and modelling;

c) An articulation of any other risks associated with not meeting BCF targets Non-Elective Admissions and Delayed Transfers Of Care in 2016-17;

d) An articulation of the risk sharing arrangements in place across the health and care system, and how these are reflected in contracting and payment arrangements;

e) An articulation of the proportion of the financial risk will be borne by each party, and how these are reflected in contracting and payment arrangements.

APPENDIX 3 - ASSURANCE DIAGRAM



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Department of Health

Department for Communities and Local Government

2016/17 Better Care Fund

Policy Framework

January 2016

Title: Better Care Fund, Policy Framework 2016/17
Author: SCLGCP/ SCP/ Integrated Care Policy / 11120
Document Purpose: Policy
Publication date: **01/2016**
Target audience: This document is intended for use by NHS England and those responsible for delivering the Better Care Fund at a local level (such as, clinical commissioning groups, local authorities and health and wellbeing boards).
Contact details: Edward Scully Richmond House Whitehall London SW1A 2NS Edward.scully@dh.gsi.gov.uk

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2016/17 Better Care Fund

Policy Framework

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

Contents

Background

The Better Care Fund 2016/17 Policy Framework

The Better Care Fund is the biggest ever financial incentive for the integration of health and social care. It requires Clinical Commissioning Groups and local authorities in every single area to pool budgets and to agree an integrated spending plan for how they will use their Better Care Fund allocation. In 2015-16, the Government committed £3.8 billion to the Better Care Fund with many local areas contributing an additional £1.5 billion, taking the total spending power of the Better Care Fund to £5.3 billion.

Current health and care approaches have evolved to respond reactively to changes in an individual's health or ability to look after themselves, and they often do not meet people's expectations for person-centred co-ordinated care. Greater integration is seen as a potential way to use resources more efficiently, in particular by reducing avoidable hospital admissions and facilitating early discharge.

We recognise that local areas are at different points in their integration journey and in supporting them to achieve their ambitions for integrated care, we will need to prioritise progress on known barriers to change to ensure the key factors associated with successful integration are embedded and shared across the system. The Better Care Fund and other drivers of integrated care such as New Care Models pave the way for greater integration of health and social care services.

In 2016-17, the Better Care Fund will be increased to a mandated minimum of £3.9 billion to be deployed locally on health and social care through pooled budget arrangements between local authorities and Clinical Commissioning Groups. The local flexibility to pool more than the mandatory amount will remain. From 2017-18, the government will make funding available to local authorities, worth £1.5 billion by 2019-20, to be included in the Better Care Fund. In looking ahead to 2016-17, it is important that Better Care Fund plans are aligned to other programmes of work including the new models of care as set out in the NHS Five Year Forward View and delivery of 7-day services.

This document sets out the policy framework for the implementation of the fund in 2016-17, as agreed across the Department of Health, Department for Communities and Local Government, Local Government Association, Association of Directors of Adult Social Services, and NHS England. In developing this policy framework, the strong feedback from local areas of the need to reduce the burden and bureaucracy in the operation of the Better Care Fund has been taken on board, and we have streamlined and simplified the planning and assurance of the Better Care Fund in 2016-17, including removing the £1 billion payment for performance framework.

In place of the performance fund are two new national conditions, requiring local areas to fund NHS commissioned out-of-hospital services and to develop a clear, focused action plan for managing delayed transfers of care (DTOC), including locally agreed targets. The conditions are designed to tackle the high levels of DTOC across the health and care system, and to

ensure continued investment in NHS commissioned out-of-hospital services, which may include a wide range of services including social care.

Further detailed guidance will be issued by NHS England, working with the partners above, on developing Better Care Fund plans for 2016-17. The guidance will form the Better Care Fund section of the NHS technical planning guidance, which will be available on NHS England's website. Local areas are asked to refer to and follow this guidance.

Beyond the 2016-17 Better Care Fund

The Spending Review sets out an ambitious plan so that by 2020 health and social care are integrated across the country. Every part of the country must have a plan for this in 2017, implemented by 2020. Areas will be able to graduate from the existing Better Care Fund programme management once they can demonstrate that they have moved beyond its requirements. Further details will be set out shortly in guidance.

1. The Statutory and Financial Basis of the Better Care Fund

The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund. It allows for the mandate to NHS England to include specific requirements relating to the establishment and use of an integration fund.

Under the mandate to NHS England for 2016-17, NHS England is required to ring-fence £3.519 billion within its overall allocation to Clinical Commissioning Groups to establish the Better Care Fund. The remainder of the £3.9 billion fund will be made up of the £394 million Disabled Facilities Grant, which is paid directly from the Government to local authorities.

Of the £3.519 billion Better Care Fund allocation to Clinical Commissioning Groups, £2.519 billion of that allocation will be available upfront to Health and Wellbeing Boards to be spent in accordance with the local Better Care Fund plan. The remaining £1 billion of Clinical Commissioning Group Better Care Fund allocation will be subject to a new national condition.

NHS England and the Government will allocate the Better Care Fund to local areas based on a framework agreed with Ministers. For 2016-17, the allocation will be based on a mixture of the existing Clinical Commissioning Group allocations formula, the social care formula, and a specific distribution formula for the Disabled Facilities Grant element of the Better Care Fund.

Within the Better Care Fund allocation to Clinical Commissioning Groups is £138m to support the implementation of the Care Act 2014 and other policies (£135m in 2015-16). Funding previously earmarked for reablement (over £300m) and for the provision of carers' breaks (over £130m) also remains in the allocation. Further information on this can be found in the Better Care Fund Planning Requirements.

Individual allocations of the Better Care Fund for 2016-17 to local areas and the detailed formulae used will be published on NHS England's website in early January.

2. Conditions of Access to the Better Care Fund

The amended NHS Act 2006 gives NHS England the powers to attach conditions to the payment of the Better Care Fund. In 2016-17, NHS England will set the following conditions, which local areas will need to meet to access the funding:

- A requirement that the Better Care Fund is transferred into one or more pooled funds established under section 75 of the NHS Act 2006
- A requirement that Health and Wellbeing Boards jointly agree plans for how the money will be spent, with plans signed-off by the relevant local authority and Clinical Commissioning Group(s)
- A requirement that plans are approved by NHS England in consultation with DH and DCLG (as set out in section 3 below)
- A requirement that a proportion of the areas allocation will be subject to a new condition around NHS commissioned out of hospital services, which may include a wide range of services including social care.

NHS England will also require that Better Care Fund plans demonstrate how the area will meet the following national conditions:

- Plans to be jointly agreed;
- Maintain provision of social care services;
- Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate;
- Better data sharing between health and social care, based on the NHS number;
- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
- Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;
- Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care;
- Agreement on local action plan to reduce delayed transfers of care.

Detailed definitions of these national conditions are set out at Annex A.

Conditions of Access to the Better Care Fund

Under the amended NHS Act 2006, NHS England has the ability to withhold, recover or direct the use of funding where conditions attached to the Better Care Fund are not met. The Act makes provision at section 223GA(7) for the mandate to NHS England to include a requirement that NHS England consult Ministers before exercising these powers. The 2016-17 mandate to NHS England confirms that NHS England will be required to consult Ministers before using these powers.

NHS England's power to set conditions on the Better Care Fund applies to the £3.519bn that is part of Clinical Commissioning Group allocations. For the £394m paid directly to local government, the Government will attach appropriate conditions to the funding to ensure it is included in the Better Care Fund at local level. As set out in Better Care Fund technical guidance, for 2016-17 authorities in two-tier areas will have to allocate Disabled Facilities Grant funding to their respective housing authorities from the pooled budget to enable them to continue to meet their statutory duty to provide adaptations to the homes of disabled people.

3. The Assurance and Approval of the Local Better Care Fund Plans

Local Better Care Fund plans will be developed in line with the agreed guidance, templates and support materials issued by NHS England and the Local Government Association. For 2016-17, we have set out a more streamlined process that is better integrated into the business-as-usual planning processes for Health and Wellbeing Boards, Clinical Commissioning Groups and local authorities.

The first stage of the overall assurance of plans will be local sign-off by the relevant Health and Wellbeing Board, local authority and Clinical Commissioning Group(s). In line with the NHS operational planning assurance process, plans will then be subject to regional moderation and assurance. The key aspects of the process for the planning, assurance and approval of Better Care Fund plans are:

- Brief narrative plans will be developed locally and submitted to regional teams through a short high level template, setting out the overall aims of the plan and how it will meet the national conditions
- A reduced amount of finance and activity information relating to local Better Care Fund plans will be collected alongside Clinical Commissioning Group operational planning returns to submitted to NHS England, to ensure consistency and alignment
- Better Care Managers will work with NHS England Directors of Commissioning Operations teams to ensure they have the knowledge and capacity required to review and assure Better Care Fund plans. To support this local government regional leads for the Better Care Fund (LGA lead CEOs and ADASS chairs) or their representatives will be part of the moderation process at a regional level (supported with additional resource to contribute to both assurance and moderation)
- There may be flexibility permitted for devolution sites to submit plans over a larger footprint if appropriate
- An assessment will then be made of the risk to delivery of the plan due to local context and challenges, using information from NHS England, the Trust Development Agency, Monitor and local government
- These judgements on ‘plan quality’ and ‘risks to delivery’ will contribute to the placing of plans into three categories – ‘Approved’, ‘Approved with support’, ‘Not approved’.

A diagram of the above assurance and approval process is included in Annex B. The full details will be set out in the Better Care Fund section of the NHS technical planning guidance, which will be available on NHS England’s website.

Assurance and judgements on potential support needs through the planning process will be ‘risk-based’ (based on a planning readiness self-assessment pooled with other system level intelligence) with the level of assurance of an area’s plan being proportionate to the perceived level of risk in a system. Recommendations of approval for Better Care Fund plans for high risk areas will be made by the regional moderation process but those decisions will be quality assured by the Integration Partnership Board (which is a senior programme leadership board comprising DH, DCLG, NHS England, Local Government Association and the Association of Directors of Adult Social Services). Final decisions on approval will be made by NHS England, based on the advice of the moderation and assurance process, in accordance with the legal framework set out in section 223 GA of the NHS Act 2006.

Where plans are not initially approved, or are approved with support, NHS England will implement a programme of support to help areas to achieve approval (and / or meet relevant conditions) ahead of April 2016.

NHS England has the ability to direct use of the fund where an area fails to meet one of the Better Care Fund conditions. This includes the requirement to develop a plan approved by NHS England and Ministers. If a local plan cannot be agreed, any proposal to direct use of the fund will be subject to consultation with DH and DCLG (as required under the 2016-17 mandate to NHS England).

4. National Performance Metrics

Under the 2015-16 Better Care Fund policy framework, local areas were asked to set targets against the following five key metrics:

- Admissions to residential and care homes
- Effectiveness of reablement
- Delayed transfers of care
- Patient / service user experience
- A locally-proposed metric

In the interests of stability and consistency, areas will be expected to maintain the progress made in 2015-16. The detailed definitions of these metrics are set out in the Better Care Fund section of the NHS technical planning guidance.

5. Implementation 2016-17

The implementation of local Better Care Fund plans will formally begin from 1 April 2016. As part of its wider planning process, NHS England will require local areas to produce a multi-year strategic plan, showing how local services will get from where they are now to where the Five Year Forward View requires them to be by 2020. This will set out the actions and specific deliverables that NHS England will take forward to deliver the objectives set out in the multi-year mandate to NHS England – including those relating to the integration of health and social care and the continuation of the Better Care Fund.

In implementing the Better Care Fund in 2016-17, NHS England will continue to:

- Provide support to local areas to ensure effective implementation of agreed plans;
- Work with partners to identify and remove barriers to service integration;
- Promote and communicate the benefits of health and social care integration;
- Monitor the ongoing success of the Better Care Fund – including delivery against key national performance metrics;
- Prepare as necessary for the continuation of the Better Care Fund over the next Parliament.

Annex A: Detailed Definitions of National Conditions

CONDITION	DEFINITION
Plans to be jointly agreed	The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Care Fund will contribute to a longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences. The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.
Maintain provision of social care services	Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16. The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund. In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process. It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14: https://www.gov.uk/government/uploads/system/uploads/attac

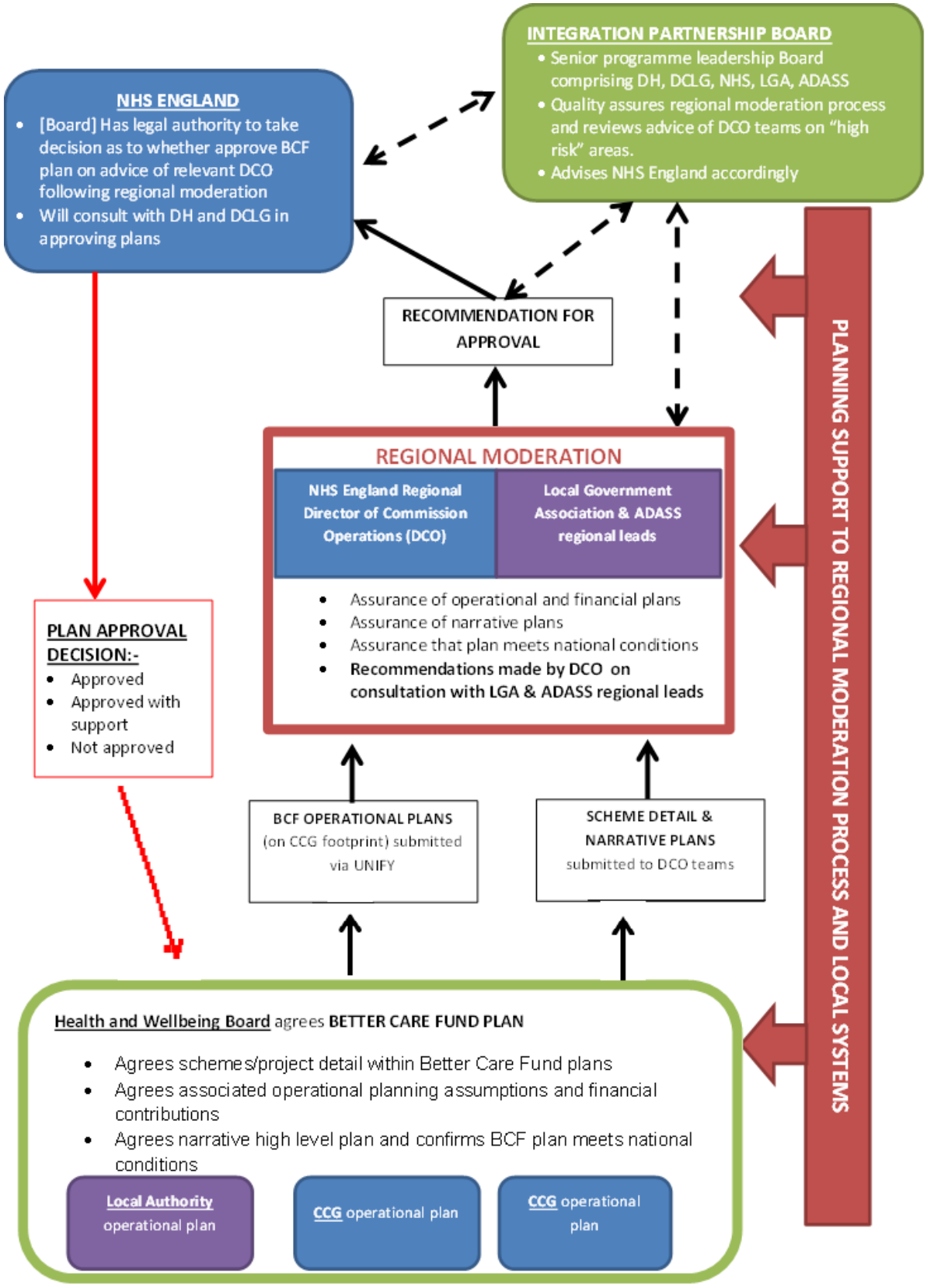
	hment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf"
Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.	Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order: • To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week; • To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why. The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf). By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made against Standard 9. This standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.
Better data sharing between health and social care, based on the NHS number	The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. Local areas should: • confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to; • confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary

	security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and • ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place. • ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review. The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access to a central repository guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by care coordinators, for example dementia advisors.
Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.
Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care	Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund. This should be achieved in one of the following ways: • To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better

	Care Fund plan; or • Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16); This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.
Agreement on local action plan to reduce delayed transfers of care (DTOC)	Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue. As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target. All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month. As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising. In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue. We would expect plans to: • Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring; • Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and

	best practice with regards to reducing DTOC from LGA and ADASS; • Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance; • Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity; • Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies; • Demonstrate engagement with the independent and voluntary sector providers.

Annex B: Assurance and Approval of Better Care Fund Plans



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HEALTH & WELLBEING BOARD

Subject Heading:	Redesign of sexual health services
Board Lead:	Sue Milner, Interim Director of Public Health
Report Author and contact details:	Mark Ansell, Consultant in Public Health

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

Effective action to improve sexual and reproductive health: -

- improves personal and population wellbeing
- saves more than it costs in terms of the overall public purse
- provides opportunities to tackle wider social ills such as domestic violence, child sexual exploitation and drug and alcohol dependency
- is an essential element in comprehensive plans to narrow health inequalities.

An effective approach to improving sexual health requires multiple commissioners and providers to coordinate their actions to ensure residents benefit from evidence based, seamless pathways of care that work to prevent problems occurring wherever possible and minimise the harm resulting when they do.

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Councils are mandated to provide key elements of the overall sexual health offer ensuring people in their area have open access to services for prevention, testing and treatment of sexually transmitted infections. These form part of the genitourinary medicine (GUM) services. Councils must also ensure access to a broad range of contraception (family planning services).

BHRUHT provides GUM and family planning services in Barking and Dagenham and Redbridge as well as Havering.

The Trust is currently incurring a significant and unsustainable loss in so doing. Planned developments across London will reduce attendances at GUM services in the future and the gap between provider income and the cost of services will grow still further.

GUM activity could be accommodated more cost effectively at one site. Barking Hospital would be preferable as Barking and Dagenham has poorer sexual health; co-location with HIV services there would yield additional benefits and the clinic space freed up at Queens Hospital would enable further improvements to urgent care across the whole health economy.

Travel times, particularly in Havering would be increased but the number of people inconvenienced will fall when home testing is made available for suitable patients and if testing and treatment for uncomplicated STIs were to be provided from level 2 services in Romford.

Level 2 services currently only offer contraceptive care. Contraception clinics are provided at multiple sites for short periods as a result considerable clinician time is wasted. Consolidation on fewer, ideally one site in each borough would be much more cost effective. Again this would result in some increase in travel times. However, general practice is accessible and is the preferred provider of contraception for the majority of women.

Recommendations are made regarding the future location of sexual health services in the borough and the suggested approach to implementing change.

RECOMMENDATIONS

The Board is asked to: -

- Discuss the proposal
- Suggest any amendments and additions felt needed to the recommendations made.

- Subject to those amendments being made, agree that the Council holds a public consultation regarding the proposals to:-
  - Consolidate local level 3 GUM services at Barking Hospital. The new service will offer dedicated Young Persons clinics and clinics in the evening and on Saturday morning.

  - Limit the inconvenience caused by increased travel times to access GUM services by;
    - Modifying level 2 services to include the offer of testing and treatment of uncomplicated STIs
    - Commission home-testing for asymptomatic low risk patients.

  - Provide level 2 contraception services at one or at most two sites per borough. More specialist family planning services, required by a small number of patients, will be provided via the Level 3 hub at Barking Hospital. There should be dedicated YP clinics and clinics in the evening and on Saturday mornings. Level 2 sites will be accessible and located to best serve the whole borough i.e.
    - In Havering, in Romford – clinic space will be provided at Queens until a suitable site in the community is identified
    - In Barking and Dagenham, at Barking Hospital
    - In Redbridge, at the 2 existing sites until and unless a single site is identified that better serves the whole borough.

- Subsequently receive a report about the views of public and professionals submitted to the consultation and the final decision regarding the location of sexual health services.

- Further endorse the recommendation to:

  - Work to establish a single board with representation from the 3 Councils, BHRCCGs, NHSE , BHRUHT and other stakeholders to oversee the further development of local sexual health services

  - Work with NHS England, local CCGs and GP representatives to maintain and improve the contraception services provided by GPs to local residents.

REPORT DETAIL

See appended paper regarding the redesign of sexual health services

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IMPLICATIONS AND RISKS

Financial implications and risks:

Any significant decisions arising from this paper have or will be subject to normal governance processes within the relevant individual organisations.

Legal implications and risks:

Ditto

Human Resources implications and risks:

Ditto

Equalities implications and risks:

Ditto

BACKGROUND PAPERS

None

Proposals for the relocation of sexual health services

1. Context

Effective action to improve sexual and reproductive health: -

- improves personal and population wellbeing
- saves more than it costs in terms of the overall public purse
- provides opportunities to tackle wider social ills such as domestic violence, child sexual exploitation and drug and alcohol dependency
- is an essential element in comprehensive plans to narrow health inequalities[1].

Local authorities are mandated [2] to provide, or commission open access sexual health services i.e.: -
services for

i) preventing the spread of sexually transmitted infections;
ii) for treating, testing and caring for people with such infections; and
iii) for notifying sexual partners of people with such infections.

And —

i) advice on, and reasonable access to, a broad range of contraceptive substances and appliances; and
ii) advice on preventing unintended pregnancy.

These services are only a part of the overall system. An effective approach to improving sexual health requires multiple commissioners and providers to coordinate their actions to ensure residents benefit from evidence based, seamless pathways of care that work to prevent problems occurring wherever possible and minimise the harm resulting when they do.

Table 1: Overview of commissioning and provider arrangements relevant to sexual health

Service	Commissioner	Provider
HIV prevention and sexual health promotion	Local authorities	Specialist provider(s)
C card (free condom distribution)	Local authorities	Many pharmacists and CYP services
Long Acting Reversible Contraception (LARC)	Local authorities	Some GPs
Contraception services including LARC	Local authorities	Specialist family planning provider
Contraception services (including EHC but excluding LARC)	NHS England /CCGs	All General Practitioners
Emergency hormonal contraception (EHC)	Local authorities	Some pharmacists
Testing and treatment of STIs including chlamydia screening	Local authorities	Specialist GUM provider
Sexual health aspects of psychosexual counselling	Local authorities	Specialist GUM provider
Non- sexual health aspects of psychosexual counselling	CCGs	Specialist GUM provider
HIV treatment and care	NHS England	Specialist provider
Sexual assault referral centres	NHS England	Specialist provider
Cervical screening	NHS England	General Practitioners
Community gynaecology	CCGs	Specialist provider
Vasectomy and sterilisation services	CCGs	Specialist provider
Abortion services	CCGs	Specialist provider

Adapted from Commissioning Sexual Health Services and Interventions: Best Practice Guidance for Local Authorities, Dept of Health 2013.

2. Description of need at borough level

Most if not all of us are likely to have need for advice and / or care from sexual health services at some point in our lives; but some groups notably young people, men who have sex with men, black ethnic groups and disadvantaged communities are at higher risk of poor sexual health and likely to have greater need to care. As a result, the need for sexual health services will vary between boroughs and between communities within boroughs reflecting the size and make-up of their population.

STI rates are highest in urban areas, especially in London, reflecting the distribution of the population groups at greatest risk of infection. Locally, rates of STI and HIV infection are significantly higher in Barking and Dagenham than in Redbridge, Havering and England as a whole. Likewise, rates of teen conception are high in Barking and Dagenham and similar to the national average in Havering and Redbridge. But abortion rates and rates of repeat abortion are high in all 3 boroughs whereas provision of long acting reversible contraception (LARC) – the most effective form – is relatively low.

Table 2: Indicators of sexual and reproductive health

	Barking and Dagenham	Havering	Redbridge	England
Rate of new STIs excluding chlamydia diagnoses / 100,000 15-24 year olds	1099	800	791	829
Chlamydia detection rate per 100,000 young people aged 15-24 years	2173.7	1374.0	1319.1	2012.0
Rate of HIV cases per 1000 aged 15-59 years	6.1	1.9	2.9	2.1
% of HIV diagnoses made at a late stage of infection	48.8%	41.7%	49.0%	42%
Rate per 1,000 women of long acting reversible contraception (LARC) prescribed in primary care	19.6	13.9	12.0	32.3
Rate of LARCs prescribed in sexual and reproductive health (SRH) services per 1,000 women aged 15 to 44 years	35.7	24.2	20.3	31.5
Total abortion rate per 1,000 females population aged 15-44 years	31.2	22.5	24.5	16.5
% of those women under 25 years who had an abortion in that year, who had had a previous abortion	33.0%	31.5%	35.5%	27.0%
Under 18 conception rate per 1,000 females aged 15 to 17 years (2013)	40.1	26.2	16.9	24.3

Source: PHE Sexual and Reproductive Health Profiles

The need for services is likely to increase in suburban areas like Havering and Redbridge as a result of continued population flows from inner London.

3. Current arrangements for the provision of sexual health services

Responsibility for commissioning sexual health services transferred to local government in April 2013 at which time the London Boroughs of Havering (LBH), Barking and Dagenham (LBBD) and Redbridge (LBR) agreed separate but essentially identical contracts with Barking, Havering and Redbridge University Hospitals Trust (BHRUHT), elapsing September 2015, for the provision of integrated GUM and family planning services.

In summary the contract specifies: -

- That the provider is paid via a simple Payment By Results (PBR) arrangement for both arms of the service.
- And services are provided via two level 3 hubs (Queens Hospital and Barking Hospital) providing a full range of GUM and family planning services and eight spokes providing 'uncomplicated' contraception services – including in most, but not all, the fitting of LARC.

3.1 GUM services

Currently there are 34 level three GUM services in London including Queens and Barking Hospitals. Their distribution is more a matter of historical chance than purposeful planning. Currently six boroughs, including Redbridge, do not have a service within their own borders but this is not necessary for Councils' to meet their duty to provide services for people in the area.

NB. This number will increase as Councils across London reconfigure services to complement the London Sexual Health Transformation Programme (see section 4.1).

As services are open access, residents can attend any they wish. Nonetheless in 2014 around 75% of all GUM attendances for Barking and Dagenham (n ≈ 5700) and Havering residents (n ≈ 4900) were at one of the two GUM services operated by BHRUHT, falling to under 40% (n ≈ 3200) for Redbridge residents.

Taking the two sites together, BHRUHT holds GUM clinics 6 days a week, with one evening clinic and one dedicated young person clinic.

3.2 Family planning services

Nationally, it's estimated that about 80% of all contraceptive care is provided by GPs.[3] Prescribing data suggest that the situation locally is similar.

The responsibilities of GPs regarding contraceptive care cover the great majority of methods but not the fitting of Long Acting Reversible Contraception (LARC) which is specifically excluded from the relevant GMS Additional Services specification. However some GPs with additional skills are separately commissioned by Councils to provide LARC in the community.

Hence, there is a significant overlap between the contraceptive services offer in general practice and specialist family planning services – ¾ of the interventions provided by BHRUHT could have also been provided by a GP. Hence the specialist family planning services commissioned by the Council can be viewed as a complement to the general practice offer - for women with specialist needs or who are otherwise unable or unwilling to attend their GP rather than a substitute as GPs remain the preferred provider for the majority of women.

As with GUM services, residents can attend specialist family planning services elsewhere but BHRUHT is the largest provider for all 3 boroughs; responsible for 90% of LBH contacts (n≈6900), 85% of LBBD contacts (n≈5800) and 60% of LBR contacts (n≈4000).*

BHRUHT provides family planning services from 10 sites. Barking and Queens Hospitals offer a full level 3 service including uncomplicated contraception and LARC as well as catering for women with complex needs. Clinics at the other 8 sites provide uncomplicated contraception, in most cases including the fitting of LARC devices.

Table 2: Breakdown of BHRUHT family planning activity by site, 2014-15

	LBBD		LBH		LBR		All BHRUHT activity*	
Barking Hosp	1065	16.5%	82	1.1%	260	4.9%	1465	7.2%
Vicarage Fields HC	967	15.0%	26	0.4%	141	2.6%	1170	5.8%
Oxlow Lane HC	2105	32.6%	236	3.2%	94	1.8%	2510	12.4%
Queens Hosp	1311	20.3%	2826	38.1%	563	10.5%	4912	24.3%
Myplace, Harold Hill	10	0.2%	330	4.5%	4	0.1%	355	1.8%
Harold Hill HC	66	1.0%	1401	18.9%	45	0.8%	1591	7.9%
St Kildas	206	3.2%	1136	15.3%	34	0.6%	1448	7.1%
South Hornchurch	58	0.9%	1100	14.8%	14	0.3%	1212	6.0%
Loxford	488	7.5%	58	0.8%	2670	50.0%	3438	17.0%
Hainault HC	189	2.9%	219	3.0%	1512	28.3%	2154	10.6%
Total	6465	100.0%	7414	100.0%	5337	100.0%	20255	100.0%

* 5% of total activity is for patients resident in another non-local borough.
Source: BHRUHT

There are a number of evening and Saturday clinics and dedicated provision for young people.

4. The case for change

4.1 New technology and models of care

Commissioners across London have been working together on the London Sexual Health Services Transformation Programme (LSHTP) having concluded that innovative approaches are needed if high quality care is to be put on a sustainable financial footing.

These plans have been developed in liaison with relevant professional bodies, NHS England, Public Health England, and Health Education England, as well as service providers.

The proposed new model of care is based on a single web-based front-end for GUM services across London as a whole which, based on information provided by service user, would assess their needs and sign post to the most appropriate source of support. For asymptomatic, low risk patients this would mean the offer of a home testing kit. People testing positive for an STI will receive their results and the offer of an appointment with a clinician for treatment. Where physical attendance is required, patients will be able to book appointments on-line with local sexual health services at a

* SHRAD 2014

convenient time and location. Partners of people testing positive will be notified by a central team and invited to attend for testing themselves. Estimates of the proportion of patients that might be suitable for home testing vary between 10 and 50% of service users[†] suggesting that the needs of large numbers of patients will be met effectively, more conveniently and at lower cost.

A competitive procurement is planned to identify a provider for these London wide services to be in place by April 2017.

The corollary of adopting such a model of care is that local GUM service providers will need to reduce costs and take out surplus capacity as activity and hence their income diminishes. To facilitate the adoption of the new model, and ensure providers remain financially viable, commissioners will need to reconfigure local services to complement the London wide offer through competitive procurement or negotiation with their current provider. Given that a recent procurement failed to identify a new provider of sexual health services, reconfiguration through negotiation with the current provider is the obvious course of action locally. The recommendations contained in this paper to relocate local services are the first outputs from that negotiation.

4.2 Financial drivers

Sexual health services are crucial to the health of local residents and highly cost effective in terms of minimising overall costs to the public purse. Moreover, local authorities have a statutory duty to ensure adequate provision. Nonetheless, they represent a significant charge against the Public Health Allocation provided by central Government to meet the cost of all the health improvement responsibilities transferred to local government in 2013. Moreover, central Government has announced plans to cut the Public Health allocation in 2016/17 and 2017/18. As money spent on sexual health cannot be spent on other equally important priorities such as obesity or giving every child the best start in life, sexual health services must be as cost effective as possible.

Table 3: Spend[‡] (£000s) on sexual health services as a % of Councils' Public Health Allocations

	2015/16							2016/17	2017/18
	Projected spend on								
	GUM services Total	GUM services with BHRUHT	Contracptn services with BHRUHT*	All sexual health services with BHRUHT	Total spend on sexual health services	PH allocatn **	Total spend as % of PH allocatn	PH allocatn	PH allocatn
LBB&D	1641	1152	426	1578	2067	19200	10.80%	17800	17400
LBH	1464	1016	483	1499	1947	12500	15.60%	11500	11200
LBR	1792	636	308	944	2100	15600	13.46%	14500	14100
3 borough total	4897	2804	1217	4021	6114				

*As most contraception services on block contract other providers don't cross charge and only spend is with BHRUHT
**Adjusted as if 0-5 services included for full year

[†] A waiting room survey undertaken by BHRUHT suggests a figure of 15%

[‡] Estimated by each borough in Jan 2016 based on year to date spend on specialist GUM and contraception services (including the cost of LARC devises). This is not the totality of Council spending on sexual health which also includes the commissioning of other contraceptive services e.g. LARC from some GPs; targeted sexual health promotion, the C-card scheme etc.

Notwithstanding the sum earned under the current PBR arrangements, BHRUT has reviewed the Sexual Health service and notified Commissioners that is a loss making at a level that cannot be sustained by the Trust.

The uncertain financial viability of the service as it is currently configured is consistent with the disappointing outcome of a procurement exercise begun by the 3 boroughs in 2014. Despite considerable effort on the part of both commissioners and potential providers, it proved impossible to award a contract for the desired service at an affordable cost.

As noted, providers are currently paid using a simple PBR mechanism. All commissioners in London are planning to introduce a more sophisticated integrated sexual health tariff (ISHT). Introduction of the ISHT will see providers being paid via a larger set of tariffs that better reflect the actual cost of the care provided in each contact rather than an average cost as is the case currently. Moreover, these tariffs have been based on the cost incurred in delivering the specific intervention in the most cost effective way possible rather than the actual costs incurred by the current local provider. An initial analysis based on 2013/14 data suggests that current income to providers across London as a whole is significantly greater than the income they could expect if the ISHT is adopted. Moreover, it appears that the impact across the BHR patch would be greater than average.

NB. All providers in London, including BHRUHT have undertaken an audit of the recording practice ahead of a further analysis of 2015/16 activity to confirm the likely impact of adopting the ISHT.

Aims of local transformation programme

To summarise the preceding discussion, the income generated by local sexual health services is less than the cost of their provision and planned changes (LSHTP and adoption of the ISHT) are likely to reduce that income. Innovative models of care provide the opportunity to maintain quality, improve convenience and increase cost-effectiveness but only if services are redesigned.

In the circumstances, both commissioner and provider are agreed that action is needed now to ensure that: -

- The totality of services commissioned for residents, locally and London wide level, continue to meet their needs, all relevant quality standards[§] and discharge the Council's legal duty to commission open-access sexual health services
- The cost of providing local services is significantly reduced, initially to a level consistent with the income generated now and then to the lower amount likely in the medium term.

[§] in accordance with:
o Standards for the Management of Sexually Transmitted Infections, MedFASH 2014 (MedFASH, 2014 (revised and updated)) (http://www.medfash.org.uk/uploads/files/p18dtqli8116261rv19i61rh9n2k4.pdf); and
o the clinical service standards of the Faculty of Sexual and Reproductive Health Care with particular reference to Service Standards for Sexual and Reproductive Health Care, Faculty of Reproductive Health Care 2013 (FSRH, 2013b) (http://www.fsrh.org/pdfs/All_Service_standards_January_2013.pdf); and
o any, new, additional or updated national guidance and standards relating to the services contained within this specification and provision of sexual health services generally; and
o those relevant supplied elements of service defined by "Effective Commissioning of Sexual Health and HIV Services" (DH, 2003 (archived)) and "Commissioning Sexual Health services and interventions. Best practice guidance for local authorities" (DH, 2013a) (www.doh.gov.uk/publicationsandstatistics/publications/PublicationsPolicyAndGuidance/DH_407355)

5. Proposals

5.1 Regarding the location of local GUM services

BHRUHT has advised that relocating GUM services to one site and the resulting reduction in premises costs would significantly reduce the gap between current income and the cost of providing the service.

The obvious choice is to consolidate GUM services at Barking Hospital as LBBD has the poorest sexual health and co-location with HIV treatment services there would yield additional productivity and clinical benefits. Closure of the GUM clinic at Queens would also free up space for improvements to A&E services.

On the downside, it would increase travel times such that 17% of Havering residents would be more than an hour away from GUM by public transport; 1% would be more than 70 minutes away; no one would be more than 1 ½ hours away. The longest travel times would be in the north of the borough (see maps provided as Appendix 1).

Table 4: Travel times (mins) from stated % of output areas to nearest level 3 GUM service, any form of public transport, morning peak time period.

	Travelling time (mins)	LBBD		LBH		LBR		3 borough total	
		pop'n	% of pop'n	pop'n	% of pop'n	pop'n	% of pop'n	pop'n	% of pop'n
GUM - current model	0-15	12711	7%	6996	3%	0	0%	19707	3%
	16-30	139844	75%	81820	34%	65959	24%	287623	41%
	31-45	33356	18%	120056	51%	177283	64%	330695	47%
	46-60	0	0%	28360	12%	35728	13%	64088	9%
	> 60	0	0%	0	0%	0	0%	0	0%
GUM - Barking Hospital only	0-15	12711	7%	0	0%	0	0%	12711	2%
	16-30	104359	56%	10861	5%	62253	22%	177473	25%
	31-45	59033	32%	88750	37%	172447	62%	320230	46%
	46-60	9808	5%	96108	41%	44270	16%	150186	21%
	> 60	0	0%	41513	17%	0	0%	41513	6%

Data provided by TfL; analysis by LBH PHS

The advent of home testing in 2017/18 will reduce the number of residents that have to travel at all.

In addition, the development of a community based level 2 sexual health clinic in Havering and Redbridge that offers testing and treatment of uncomplicated STIs as well as contraceptive services, in line with the national definitions of level 2 services, would reduce the number of patients who are required to travel out of the borough to access level 3 GUM services.

Such a clinic would have the additional benefit to the provider of minimising any loss of activity and hence income to out-of- area providers that is likely if access to local services significantly worsens.

The relocation of GUM services to one site would also provide an opportunity to increase the number of evening clinics and dedicated young person clinics.

6.2 Regarding the location of family planning services

The use of multiple sites and 'pop' up clinics results in additional premises costs and the loss of considerable staff time to travelling and setting up / taking down clinics.

Consequently BHRUHT initially suggested consolidating all contraceptive services at Barking Hospital to maximise the reduction in operating costs. However, commissioners were concerned that this would unnecessarily inconvenience patients. Subsequently, BHRUHT has agreed that taken together with the closure of one GUM site; reducing the number of family planning sites to one per borough (2 in LBR, see below), with clinics provided as more or less complete days would serve to close the gap between current income and the cost of providing the service.

The impact of relocating to individual sites in each borough in various combinations has been modelled. It's evident that: -

- Barking Hospital is as well placed as any of the existing sites in Barking and Dagenham - and relocation to the site of GUM services has the additional benefit of minimising overall premises costs.
- Romford is best placed to serve Havering residents; relocation to any of the existing peripheral sites would increase travel times by significantly more.
- There's not much to choose between the 2 existing sites in Redbridge in terms of accessibility - but neither could accommodate all the clinic hours necessary to allow the other to close.

Nonetheless, adopting a 4 site model would also increase travel times for residents. Residents in the periphery of Havering would have the longest journey (see Appendix 1).

Table 4: Travel time (mins) to nearest family planning clinic under stated scenarios

	Travelling time (mins)	LBBD		LBH		LBR		3 borough total	
		pop'n	% of pop'n	pop'n	% of pop'n	pop'n	% of pop'n	pop'n	% of pop'n
FP - current model	0-15	57665	31%	41074	17%	38518	14%	137257	20%
	16-30	116818	63%	148020	62%	132029	47%	396867	57%
	31-45	11428	6%	48138	20%	108423	39%	167989	24%
	46-60	0	0%	0	0%	0	0%	0	0%
	> 60 mins	0	0%	0	0%	0	0%	0	0%
FP - Barking Hospital only	0-15	12711	7%	0	0%	0	0%	12711	2%
	16-30	104359	56%	10861	5%	76452	27%	191672	27%
	31-45	60650	33%	95285	40%	168911	61%	324846	46%
	46-60	8191	4%	107297	45%	33607	12%	149095	21%
	> 60 mins	0	0%	23789	10%	0	0%	23789	3%
FP - preferred 4 site model	0-15	22180	12%	6996	3%	38518	14%	67694	10%
	16-30	137882	74%	83393	35%	132029	47%	353304	50%
	31-45	25849	14%	123215	52%	108423	39%	257487	37%
	46-60	0	0%	23628	10%	0	0%	23628	3%
	> 60 mins	0	0%	0	0%	0	0%	0	0%

Data provided by TfL; analysis by LBH PHS

A four site model appears to be practicable and offer the best balance between reducing service costs and maintaining accessibility.

BHRUHT with assistance from LBH is looking for a suitable site in Romford for a stand-alone level 2 service. As yet, none has been identified. Until one has been found, the new model of service (i.e. contraception services plus testing and treatment of uncomplicated STIs) would be sited at Queens.

6. Care pathways, models of care and implications for staffing.

This paper outlines proposals for the redesign of services in terms of location. Of equal, if not greater importance, are the care pathways employed and the clinical team required to deliver them cost effectively and to a consistently high standard. A parallel process to review and redesign the pathways and models of care employed is essential if the service is to be put on a sustainable financial footing in the longer term as salaries make up more than half of the overall costs of service provision. This process will be led by senior clinicians within the service itself drawing on the work previously undertaken to inform the development of the ISHT[**].

7. Summary of current status and recommendations for change

BHRUHT currently incur a significant and unsustainable financial loss in providing local sexual health services. Planned developments across London will reduce attendances at GUM services and the gap between provider income and the cost of services will grow still further. GUM activity could be accommodated more cost effectively at one site. Barking Hospital would be preferable as need in LBBD is higher; co-location with HIV services there would yield additional benefits and the clinic space freed up at Queens Hospital would enable further improvements to urgent care. Travel times would increased but the number of people inconvenienced will fall when home testing is made available for suitable patients and if testing and treatment for uncomplicated STIs were to be provided from level 2 services.

Level 2 services currently only offer contraceptive care. Clinics are provided at multiple sites for short periods as a result considerable clinician time is wasted. Consolidation on fewer, ideally one site in each borough would be much more cost effective. Again this would result in increased travel times. However, general practice is very accessible and is the preferred provider of contraception for the majority of women.

Given the above, it is recommended that LBBD, LBH and LBR as commissioners of local sexual health services and BHRUHT as provider take the following steps: -

[**] http://www.pathwayanalytics.com/sexual-health/231

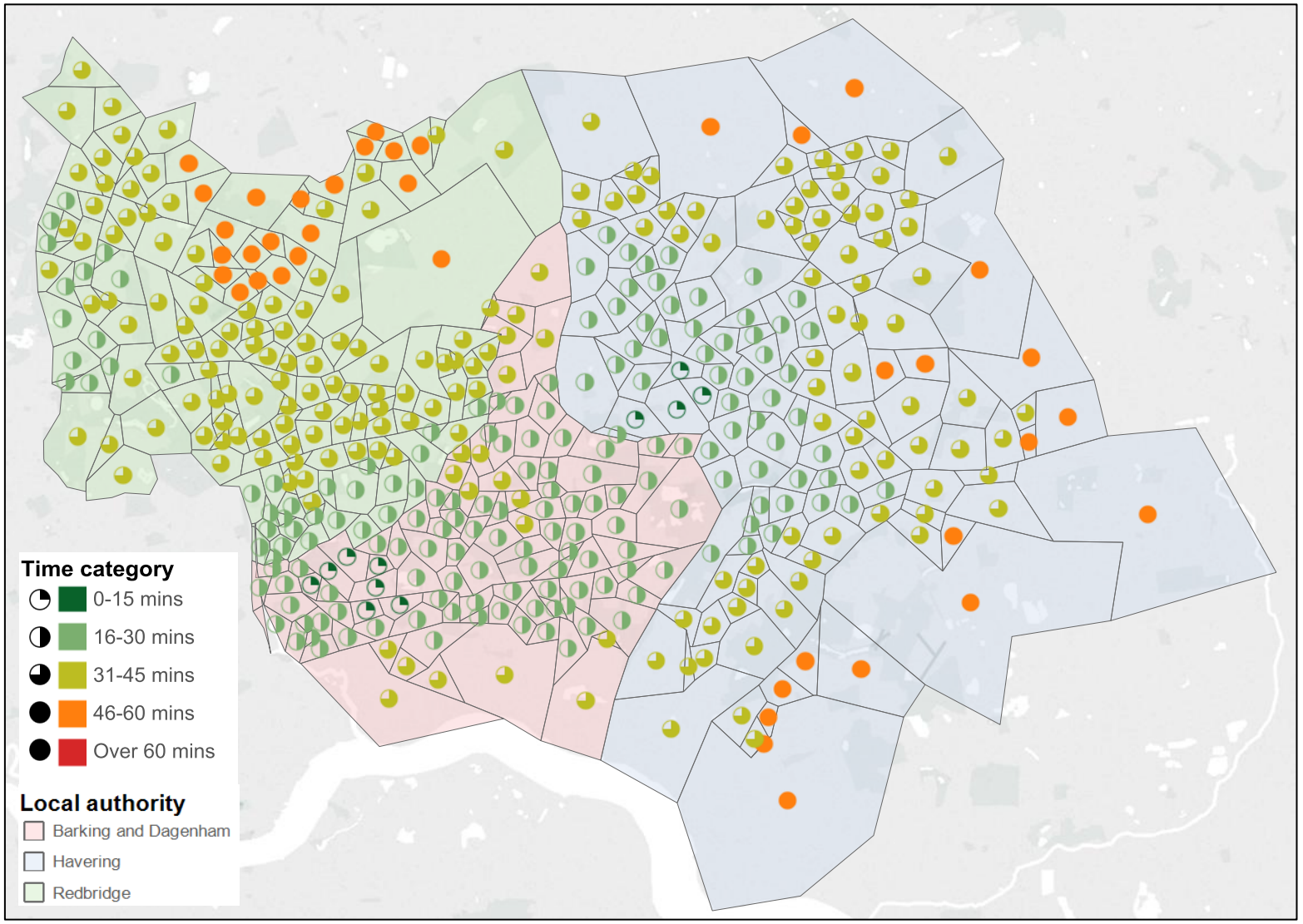
1. Consolidate local level 3 GUM services at Barking Hospital and increase provision for Young Persons and out of normal working hours.
2. Limit the inconvenience caused by increased travel times by ;
    a. Offer testing and treatment of uncomplicated STIs at level 2 services
    b. Commission home-testing for asymptomatic low risk patients.
3. Provide a full range of contraception services from one or at most two level 2 sites per borough. The level 3 hub at Barking Hospital will cater for the small proportion of patients with complex contraceptive needs. The service as a whole will continue to offer clinics for young people and out of normal working hours. Level 2 sites will be accessible and located to best serve the whole borough i.e.
    a. In Havering, in Romford – clinic space will be provided at Queens until a suitable site in the community is identified
    b. In Barking and Dagenham, at Barking Hospital
    c. In Redbridge, at the 2 existing centres until and unless a single site is identified that better serves the whole borough
4. In addition, the 3 Councils and BHRUHT should work
    a. to establish a single board with representation from other relevant stakeholders including BHRCCGs to oversee the continued redesign of local sexual health services
    b. with GPs and community pharmacists to maintain and improve the provision of contraceptive services in primary care.

References

[1] Department of Health. A Framework for Sexual Health Improvement in England. 2013. https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england
[2] The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 http://www.legislation.gov.uk/uksi/2013/351/regulation/6/made
[3] All Party Parliamentary Pro-Choice and Sexual Health Group, A report into the delivery of sexual health services in general practice, October 2007.

GUM Scenario 1 (current model – Barking and Queens Hospitals)

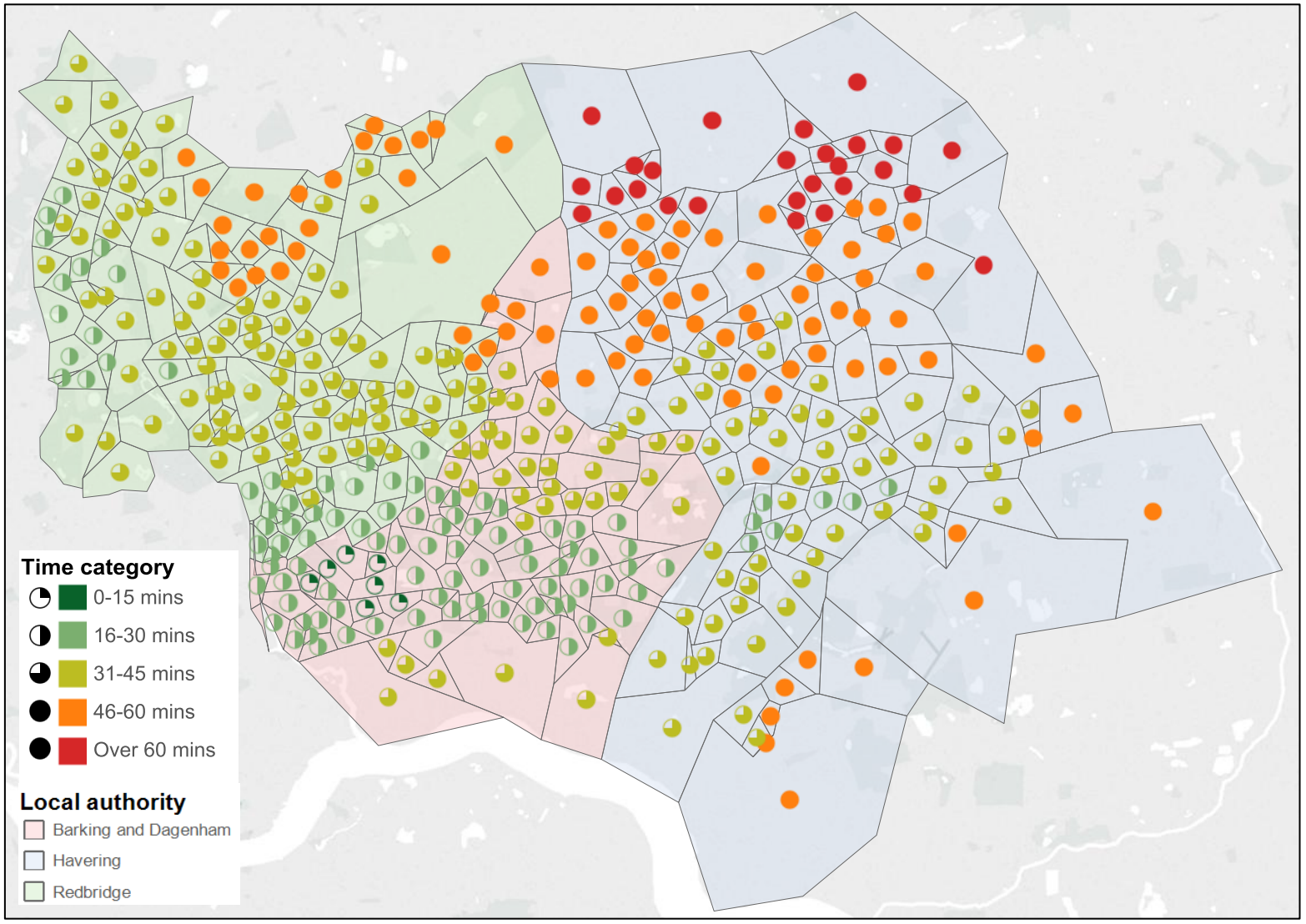
Map showing average fastest time (by time category) for persons living in lower super output areas (LSOA) to reach a GUM service (by public transport), based on GUM current scenario (including all current in-BHR and surrounding GUM centres)



Data source: Transport for London (TfL); Produced by Public Health Intelligence

GUM Scenario 2 (Barking Hospital only)

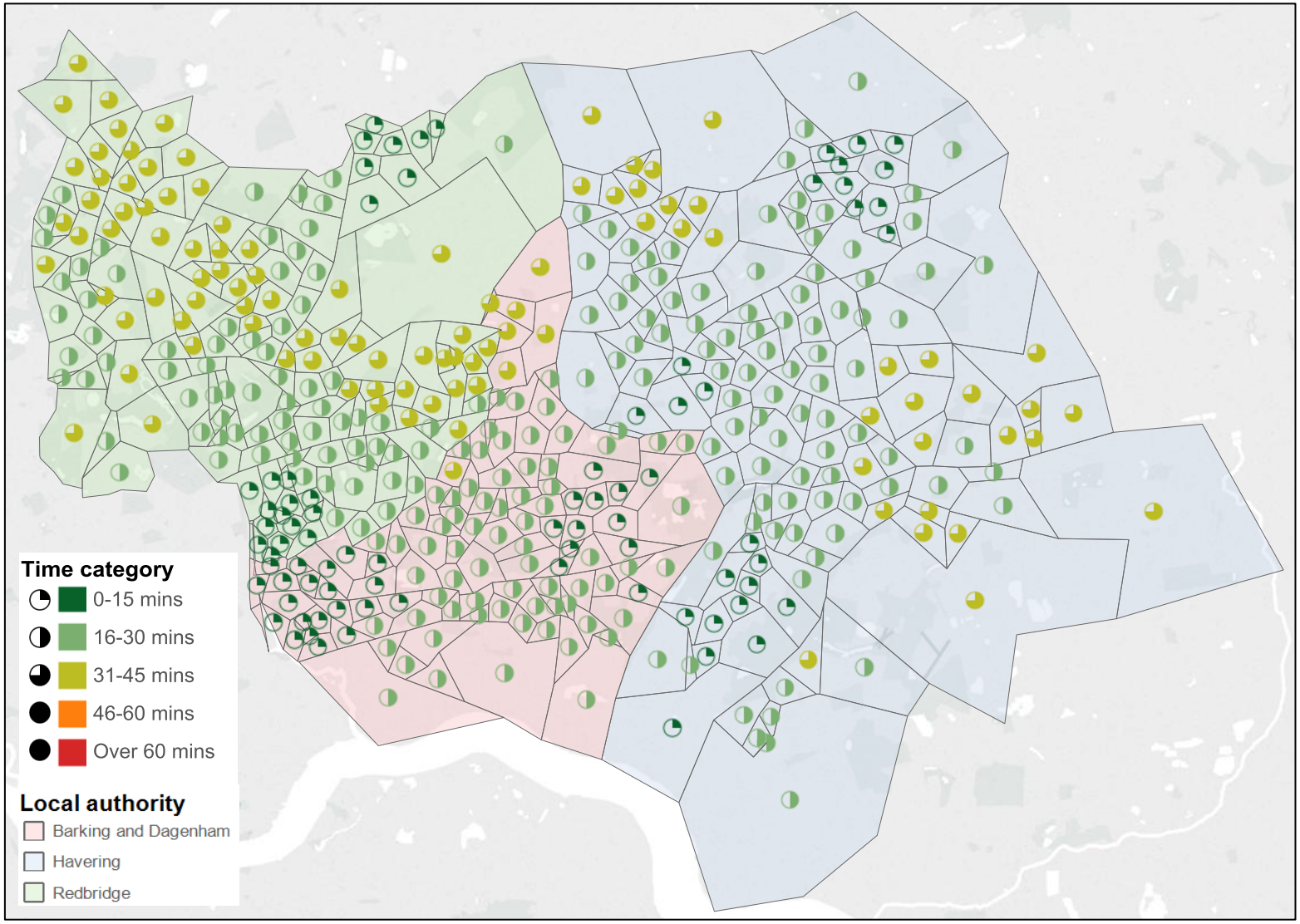
Map showing average fastest time (by time category) for persons living in lower super output areas (LSOA) to reach a GUM service (by public transport), based on GUM proposed scenario (excluding Queens Hospital)



Data source: Transport for London (TfL); Produced by Public Health Intelligence

Family Planning (FP) Scenario 1 (current – 10 site model)

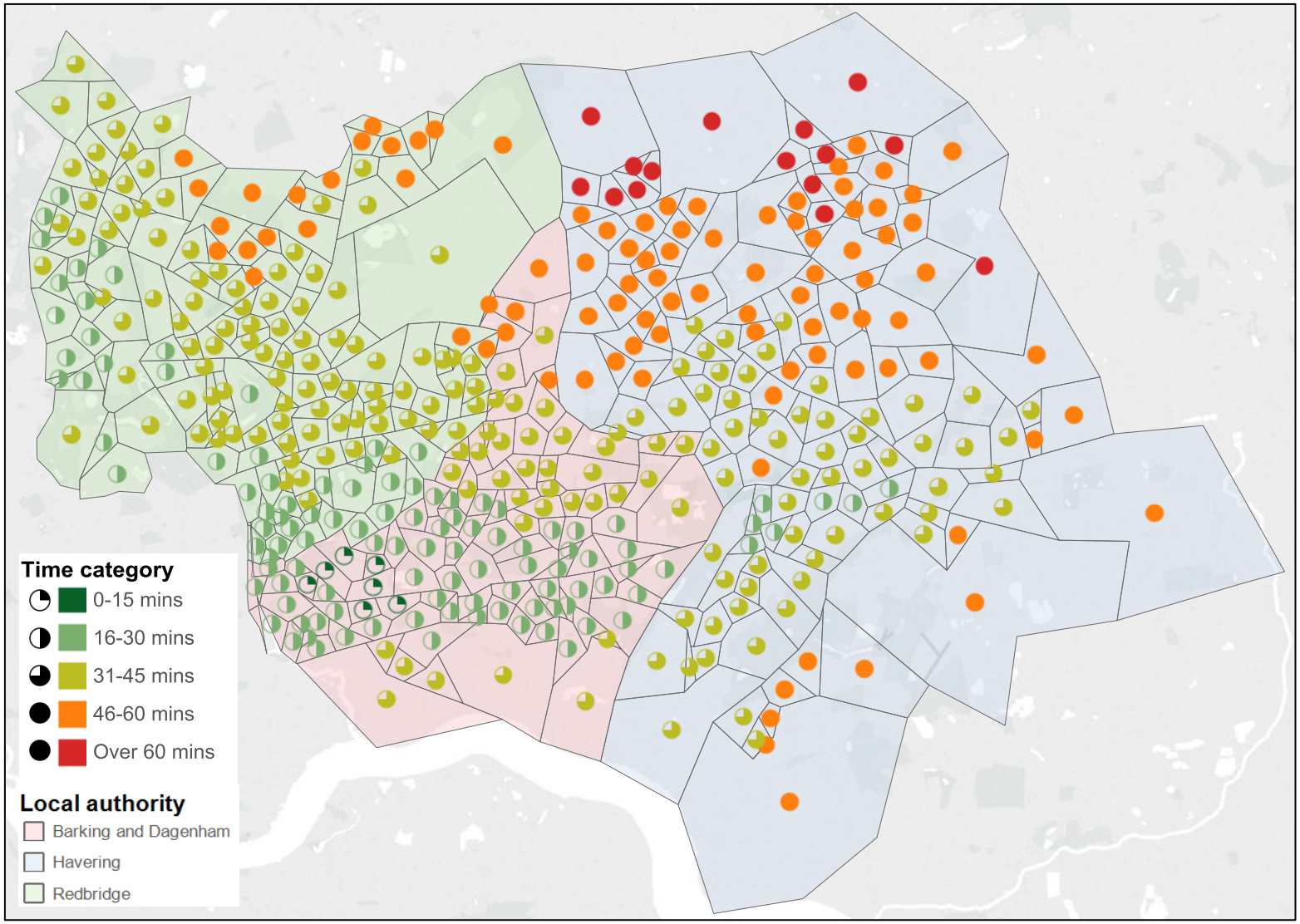
Map showing average fastest time (by time category) for persons living in lower super output areas (LSOA) to reach a family planning service (by public transport), based on FP current scenario (including all current in-BHR and surrounding FP centres)



Data source: Transport for London (TfL); Produced by Public Health Intelligence

FP Scenario 2 (Barking Hospital as the only local site)

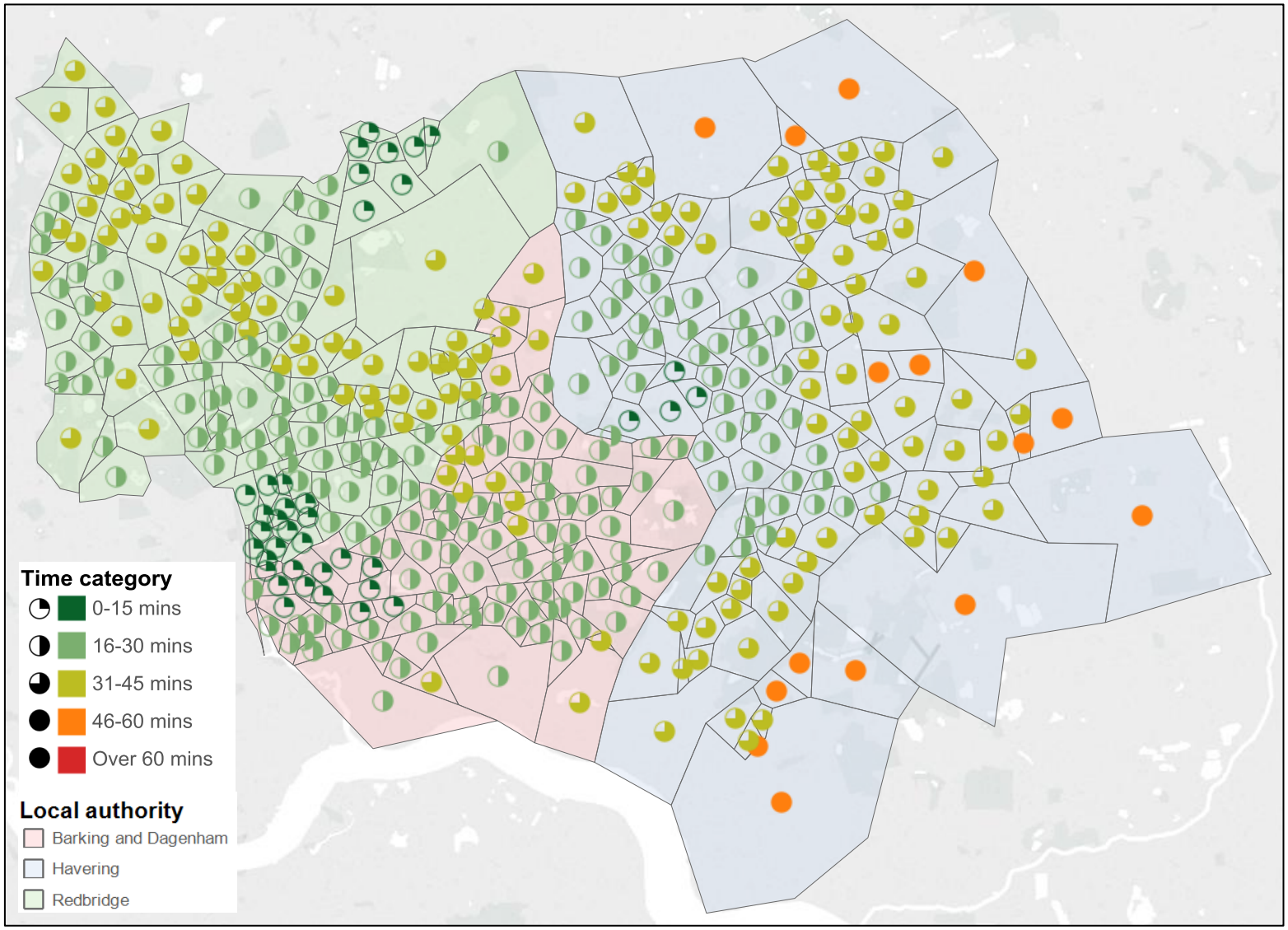
Map showing average fastest time (by time category) for persons living in lower super output areas (LSOA) to reach a family planning service (by public transport), given only local site is at Barking Hospital.



Data source: Transport for London (TfL); Produced by Public Health Intelligence

FP Scenario 3 (recommended 4 site model)

Map showing average fastest time (by time category) for persons living in LSOAs to reach a family planning service (by public transport), given services located at Romford (shown as Queens Hospital), Barking Hospital, Loxford and Hainault


Time category
0-15 mins
16-30 mins
31-45 mins
46-60 mins
Over 60 mins
Local authority
Barking and Dagenham
Havering
Redbridge

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Havering drug and alcohol harm reduction strategy
Board Lead:	Sue Milner, Interim Director of Public Health
Report Author and contact details:	Elaine Greenway, Acting Consultant in Public Health Elaine.greenway@havering.gov.uk 01708 431835

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

This strategy has been produced for the Health and Wellbeing Board and the Havering Community Safety Partnership.

The majority of people in Havering do not misuse alcohol, illegal drugs or any other substances. However, for the small number who do, the harm caused to them as individuals, their families and the wider community is significant.

The overarching aim of the strategy is to reduce the harm caused to Havering residents by substance misuse. It has been produced in partnership with a range of agencies and organisations, in recognition that there is a need to work together to address the problems.

This strategy sets out the approach that organisations will take to achieve this aim over the next three years.

The strategy is organised in two main sections:

Section 1 summarises the problem (see the Joint Strategic Needs Assessment chapter on drugs and alcohol for a detailed account).

Section 2 describes how the problems will be tackled under three main objectives:

- Preventing harm to individuals, which is primarily concerned with the damage caused to individuals as a result of personal misuse of substances.
- Preventing harm to family life, children and vulnerable adults, which considers the harm caused to families, children and vulnerable adults, particularly where substance misuse co-exists with domestic violence and mental ill-health.
- Preventing harm to the wider community, which focuses on the impact of illegal drugs and binge drinking on community safety and wellbeing.

A set of KPIs is suggested to monitor progress over time.

A detailed action plan with milestones and timescales is provided for year 1. This encompasses many broad areas of work, many of which are already being managed through existing work programmes.

RECOMMENDATIONS

The Board is asked to: -

- Consider the Strategy
- Suggest any amendments and additions needed
- Subject to there being general agreement with the approach proposed, and that any changes suggested by members are made, agree that the Chair of the Health and Wellbeing Board can approve a final draft of the Strategy without further reference to the Board
- Discuss the governance arrangements
- Subsequently receive an annual report describing progress made.

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REPORT DETAIL

Drug and Alcohol Harm Reduction Strategy including a detailed action plan is attached.

Havering
LONDON BOROUGH

IMPLICATIONS AND RISKS

Financial implications and risks:

Any significant decisions arising from this strategy have or will be subject to normal governance processes within the relevant organisation. There are no additional significant implications arising from adoption of this strategy.

Legal implications and risks:

As above

Human Resources implications and risks:

As above

Equalities implications and risks:

As above

BACKGROUND PAPERS

Havering drug and alcohol harm reduction strategy 2016-2019
Havering drug and alcohol harm reduction action plan year 1 2016-17

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Havering drug and alcohol harm reduction strategy 2016-19

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DOCUMENT CONTROL

Document details

Title	
Version number	
Status	
Author	
Lead Officer	
Approved by	
Review date	

Version history

Version	Status	Date	Dissemination change
V0.1	Initial draft		
V0.2	Updated		Additional content included: impact of drugs and alcohol on families and community

Approval history

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ACKNOWLEDGEMENTS

This strategy was developed under the direction of a steering group, comprising Council Community Safety, Adult Social Services, Children's services and Licensing, and Havering Clinical Commissioning Group, through a process led by the Public Health Service. It was produced in collaboration with a wider stakeholder group, including the police, health services and the voluntary sector and informed by service users of drug and alcohol services. The steering group would like to thank all those who gave their time and expertise to the development of this strategy, and especially the task and finish group who wrote the content and action plan:

Elaine Greenway, Acting Consultant in Public Health
Diane Egan, Community Safety and Development Manager
Jane Eastaff, Community Safety Partnerships Officer
Iain Agar, Community Safety Analyst
Patricia Riley, Havering Clinical Commissioning Group
Trudi Penman, Licensing and Health and Safety Divisional Manager
Oge Chesa, Pharmacist, BHR CCG
Syed Rahman, Senior Public Health Analyst
Jonathan Taylor, Service Manager, Early Help and Youth Offending Service
Yvonne Powell, Substance Misuse Officer

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Contents

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FOREWORD

The majority of people in Havering do not misuse alcohol, illegal drugs or any other substances. However, for the small number who do, the harm caused to them as individuals, their families and the wider community is significant. Illegal drug taking fosters criminal behaviour. The supply of illegal drugs is in itself a criminal activity and, as drug users must fund their drug taking habit, they often resort to acquisitive crime to do so.

The misuse of drugs and alcohol can harm the wellbeing of families, particularly when this is combined with mental ill-health and domestic violence. This combination is often described as the "toxic trio". We are particularly concerned about the impact of drug and alcohol misuse on the most vulnerable members of our community; especially those children who live in a family where there are such problems. Drug and alcohol misuse can also lead to acute and chronic mental and physical health problems, blighted communities and lost socio-economic productivity.

This strategy sets out our approach to reducing the harm caused by drug and alcohol misuse in Havering. It has been produced in partnership with a range of agencies and organisations, as it is widely recognised that there is a need to work together to address these problems. Our vision, set out in the documents is that

- children and young people are informed and supported in their early years so that there is less risk of them misusing substances in later life.
- young people who do develop problems have treatment and support so that their lives are not blighted by substance misuse.
- adult residents understand individual health risks associated with alcohol and so manage their drinking within safer limits.
- residents and visitors are free from the harms caused by other people's substance abuse.
- there is a halt to the demand for, and supply of drugs, which fuels criminal behaviour.
- where people have serious problems with substance misuse, they receive specialist treatment to recover – and remain in recovery.

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INTRODUCTION

It is good news that over recent years there has been a fall in the numbers of people who are using illegal drugs, and that the number of people overall who misuse alcohol is low. However, individuals who do misuse drugs and alcohol risk their own health (short and long term) and can negatively impact the health and wellbeing of their families and communities. Alcohol plays a significant part in almost half of all violent assaults, more than half of domestic violence incidents, marital/relationship breakdown, and road traffic accidents. Furthermore, episodes of heavy drinking – often described as "binge drinking" – contribute towards town centre crime and disorder. Alcohol features in around a quarter of serious case reviews of at risk children, while drugs are implicated in 20%. Drug harms also include the crime and community safety issues associated with the buying/selling and use of drugs.

For the minority of Havering residents who do have severe problems with illegal drugs, including those who are in contact with the criminal justice system, it is essential that they access high quality specialist treatment services. Where there are families that are affected by substance abuse, particularly where this co-exists with poor mental health and domestic violence[1], it is imperative that agencies work together to keep children in the family and other vulnerable groups safe from harm. Where there are problems with alcohol-related crime and disorder, this requires effective community safety measures.

Not everyone who drinks alcohol above recommended limits will be causing problems to their families or their communities, and the majority of people who are drinking alcohol above the recommended guidelines are unlikely to be taking illegal drugs. However people who are drinking above recommended limits are risking their own health, with the potential to place additional burdens on health and social care services in the future. For these groups of people it is important that they understand what constitutes safer levels of drinking and that they have access to appropriate low level support that helps them to do so. Similarly, many people who have problems with over the counter and prescription only drugs have unintentionally found themselves in this position, including older people who are problematic users of prescription drugs. In these circumstances, GPs and substance treatment services can advise, support and signpost, as appropriate.

Box 1: Groups disproportionately affected by substance misuse, include:

- **Families, children and vulnerable adults:** particularly where substance misuse co-exists with mental ill-health and domestic violence
- **Looked After Children**, especially those who go missing
- **Veterans** are more likely to misuse alcohol: The London-based charity Veterans' Aid reported that in 2009-2010, of the 105 veterans referred for substance misuse treatment, alcohol misuse was the primary diagnosis for two-thirds of these clients and research by the Ex-Service Action Group on Homelessness found that homeless veterans were more likely to misuse alcohol than other homeless people.
- **Lesbian, Gay, Bisexual and Transgender**
- **Young People not in Education, Employment or Training**
- **Ageing drug users:** Although there has been a decline in prevalence of drug use, there is a cohort of ageing drug-users in Havering who have been using opiates during most of their adult life.

[1] This "toxic trio" of issues can be described as the complex inter-relationships between mental ill health, drug or alcohol abuse and domestic violence

AIM

The overarching aim of this strategy is to reduce the harm caused to Havering residents by substance misuse (objectives described below). This document sets out the approach that organisations in Havering will take to achieve this over the next three years.

STRUCTURE

This document is set out in two main sections:

- **Section 1: Overview of the key facts and figures about the use of alcohol, illegal drugs and other substances, and over the counter and prescribed medication.**

- **Section 2: Objectives**
    - **Objective 1: Preventing harm to individuals**
    - **Objective 2: Preventing harm to family life, children and vulnerable adults**
    - **Objective 3: Preventing harm to the wider community**

This strategy is underpinned by a separate action plan for the period Apr 2016- Mar 2017 which explains how the objectives will be achieved during year one. This will be refreshed annually.

To keep the main body of the document concise a number of appendices have been included which contain further information on a range of relevant topics. The reader is referred to these appendices throughout the key sections of the document. For ease and brevity the term 'substance' is used to collectively describe alcohol, illegal drugs, psychoactive substances, over the counter drugs and prescription only medicines. However 'substance misusers' do not form one homogenous group. Therefore, where there are specific aspects of alcohol or drugs to be considered, more precise terminology will be used, e.g. alcohol misuse, drug use, problematic use of over the counter drugs and prescription only medicines.

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SECTION 1: SUBSTANCES – AN OVERVIEW

All substances considered in this strategy whether they are used legally or illegally, for recreation or for medical purposes, have effects and side effects. This section provides a brief overview of alcohol and drugs by outlining the law for different categories of drugs, a brief description of the more common drugs and a snapshot of the prevalence of drug use in the borough, the law on alcohol, national guidelines and prevalence. The main health impacts are summarised in Appendix 5 including the association between mental health and substance misuse. There is a more detailed description in the Havering Joint Strategic Needs Assessment chapter on drugs and alcohol (www.havering.gov.uk) and other key documents as described in the Reference section. The impacts on family life and vulnerable groups and on community safety are described in Sections 3 and 4 respectively.

(a) Drugs

- **Different categories of drugs**

Illegal drugs are those listed in the Misuse of Drugs Act 1971. Legal drugs are those that are prescribed by a doctor or other prescriber or medicines that are bought over the counter. New Psychoactive Substances[2] are substances not intended for human consumption and often marketed as plant food, bath salts or incense and frequently described by the unfortunate term "legal highs"; unfortunate because the term "legal" may imply a level of safety - however just because they may be legal to possess, they are largely untested for human consumption.

- **The Law on drugs**

Under the **Misuse of Drugs Act 1971**, drugs are categorised into three classes; A, B and C with different penalties for possession, supply and production, as described in Appendix 2.

The **Psychoactive Substances Act 2016** is expected to come into force in April 2016 which will make it an offence to produce and supply any substance for human consumption that is capable of producing a psychoactive effect[3].

The key legislation governing the control of medicines for human and veterinary use, categorised as prescription only medicines, pharmacy, general sales list and controlled drugs (including their manufacture and supply) is the **Medicines Act 1968**. The regulatory body for medicines in the UK is the Medicines and Healthcare Products Regulatory Agency, which ensure the authenticity of the medicines available to the public.

[2] See glossary for further description of New Psychoactive Substances
[3] Nicotine, alcohol and caffeine are exempt

- **Types of drugs**

Table 1: Brief description of the more common types of drugs as relate to this strategy

Heroin and Cocaine	The drugs that cause the most harm to the individual, families and the community are heroin and crack cocaine. These drugs account for most of the costs of drug treatment and drug enforcement and are those most likely to generate crime in order to fund drug purchase. Heroin is a drug made from morphine, which is extracted from the opium poppy. Like many drugs made from opium (called opiates), heroin is a very strong painkiller. Powder cocaine (also called coke), freebase (powder cocaine that has been prepared for smoking) and crack are all forms of cocaine. Freebase cocaine and crack cocaine can be smoked which means they reach the brain very quickly. Snorted powder cocaine gets to the brain more slowly.
Cannabis	There are many myths about cannabis; including that it is safe because it is natural. Cannabis affects how the brain works and can make an individual feel very anxious and even paranoid, and can affect concentration, the ability to learn, worsen memory and make someone feel less motivated. Smoking cannabis has been linked to lung diseases and, in some people, has led to serious, long-term mental health problems.
New Psychoactive Substances	These substances are predominantly untested for human consumption, and are often marketed as plant food, bath salts or incense. One such substance, nitrous oxide, is an aerosol used in food production such as producing whipped cream, but which is being used to produce psychoactive effects. . When inhaled, nitrous oxide can cause feelings of euphoria, dizziness and hallucinations. It is becoming popular in bars and nightclubs as a 'party drug'.
Anabolic steroids	Anabolic steroids are prescription-only medicines that are sometimes taken illegally to increase muscle mass and improve athletic performance. If used in this way, they can cause serious side effects and dependency. Anabolic steroids are manufactured drugs that mimic the effects of the male hormone testosterone. They have limited medical uses and are not to be confused with corticosteroids, a different type of steroid drug that's commonly prescribed for a variety of conditions. If anabolic steroids are misused by adolescents, they can cause premature ageing of the bones as well as restricted growth.
Over the counter and prescription only medicines	Over the counter drugs can be bought without a prescription. Some are addictive, particularly Codeine-based analgesics, and if taken regularly over long periods, can produce a physical dependence that can result in withdrawal symptoms if ceased. Prescription only medicines are drugs which are legally available only with a valid prescription and include high-strength painkillers. Whilst these may bring comfort to many people suffering a wide range of ailments, there has been growing recognition of the problematic use of these medicines.

- **Prevalence of drug use in Havering**

A range of sources helps to build a local picture of prevalence, trends and patterns of drug use. Local figures are not always available; by its very nature, much drug use is hidden and so unreported. The Joint Strategic Needs Assessment chapter on drugs and alcohol describes in detail what is known about the local issue – the following is a snapshot.

- **Illegal drugs**

Nationally there has been a decline in the prevalence of use of illegal drugs in recent years, including among young people[4] . Overall, there are estimated to be 12,060 users of illegal drugs in Havering based on national prevalence figures[1] applied to ONS population estimates.

[4] Health & Social Care Information Centre (2013). *Statistics on Drug Misuse: England 2013*. London, HSCIC.

The drugs that cause the most harm to the individual, families and the community are heroin and crack cocaine. These drugs account for most of the costs of drug treatment and drug enforcement and are those most likely to generate crime in order to fund drug purchase. The prevalence of heroin and crack cocaine use in Havering is 5.68 per 1000 population aged 15-64, compared with London (9.62) and England (8.67)[5]. There are estimated to be 888 heroin and crack cocaine users in Havering[6]. In February 2016 there were 183 heroin and crack cocaine users in treatment[7].

According to a national survey[8] of 15 year olds in 2014, cannabis is the main drug being used by young people in Havering, with 8.1% of 15 year olds in the borough saying they had ever tried cannabis (compared to England 10.7% and London 19.9%). 1.1% of 15 year olds in the borough said that they had taken drugs other than cannabis during the previous month (compared with England 0.9% and London 1.0%)

- **New psychoactive substances[9]**

There is a perception that the use of such drugs is widespread, although there are no reliable statistics that help to understand how many people are using them. Home Office Statistics for the 2012-13 Crime Survey for England and Wales (CSEW) showed that 6.1% of 16-24 year olds had taken nitrous oxide in the last year, and 2% of adults aged 16-59[10]. Havering Council's Streetcare Service has reported a visible presence of cannisters and balloons being collected with street litter. It is suspected by some that the reduction in use of illegal drugs has been supplanted by "legal highs" and that the UK has a drug scene "in transition" rather than a genuine decline.

- **Legal drugs**

The problematic use of prescription and over-the-counter medication is becoming more widely recognised. The exact size of the problem is largely unknown, but nationally where people are reporting to drug treatment services, 12% of new clients in 2009-10 reported problems with prescription-only or over-the-counter medicine[11]. It is suspected that these figures seriously underestimate the problem, as people who have problems with these medicines may be more likely to seek help from their GP and not access specialist substance misuse centres. Locally, of the 520 clients in drug treatment in Havering in 2011/12, 11.5% cited problematic use of over the counter and prescription only medicines, slightly lower than the London average (12.6%).

In terms of misuse of steroids, it is suspected that there has been an increase in intravenous use, and that there are a significant number of individuals using the needle exchange service that are injecting anabolic steroids.

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[1] Home Office (2015)
[5] Home Office (2015)
[6] Based on Office for National Statistics mid-year 2014 population estimates published June 2015.
[7] Local service level data
[8] Health and Social Care Information Centre (2015)
[9] See glossary
[10] Home Office (2013)
[11] Royal College of General Practitioners

- **Substance misuse in families**

According to 2011 Census data, there were 29,241 households in Havering with a child aged under 16 years[12]. Drug and alcohol addiction is more likely in families where drug and alcohol addiction is already present[13]. In addition, children from lone parent families are more likely than those in two-parent families to engage in risky behaviour, including drug and alcohol misuse or smoking[14]. Single parents often have lower incomes, greater degree of social isolation, fewer resources to help them cope with the stresses of daily life and in some cases find it harder to maintain discipline in the home. There were 7,224 lone parent households in Havering in 2011 with children under 16 years. In the thirteen month period 1 Dec 2014-31 December 2015, there were 74 families referred to the Council's Early Help Service where one of the problems was substance misuse. Of those 74 families, 17 also had problems with domestic violence and mental health. (Subsequently, once the practitioner gets to know the families, this number does increase.) In addition to the general risks described above, there are added concerns about the safety and wellbeing of children and vulnerable adults who are living in a household where substance abuse is present, and further concerns where there is the co-existence of domestic violence and mental health. Appendix 4 describes the safeguarding concerns. Section 2b continues with a focus on preventing harm to families where there is added description of substance misuse in families.

- **Substance misuse and crime**

The Drug Intervention Programme (DIP), probation assessment and police crime data reveals that alcohol and drugs are significant drivers of crime in Havering. For example, police data for the twelve months to November 2015, recorded 4,000 serious acquisitive crimes, 447 of these led to arrests with drug tests, of which 220 tested positive for Class A drugs, which is 50% of offenders who were arrested. Section 2c continues with more description.

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[12] London Borough of Havering (2015). *This is Havering: a demographic and socioeconomic profile*
[13] Substance Abuse and Mental Health Services Administration (2004)
[14] Blum et al (2000)

(b) Alcohol

• Benefits and disadvantages of alcohol

Alcohol brings mixed fortunes to the local environment. On the one hand, the jobs and revenue generated by on and off-trade sales of alcohol can stimulate a local economy, such as in Hornchurch and Romford, whereby well-run community pubs and other businesses, provide employment and social venues for the community. Alcohol consumption is generally socially acceptable, and is enjoyed by many, including during times of celebration. On the other hand, excessive consumption of alcohol has a strongly negative influence on individual health, impacts on community wellbeing including as a result of antisocial behaviour, and on families and children. Alcohol (along with drugs), is often implicated as one of the three major issues in the Troubled Families agenda, along with domestic abuse and mental ill-health, which together, are commonly described as the "toxic trio". Furthermore, alcohol plays a part in more than half of domestic violence incidents and relationship breakdowns.

Figure 1: What does a unit of alcohol look like?

Source: www.nhs.uk

• The law on alcohol

The Licensing Act 2003 and its regulations sets out the law on alcohol licensing. It is illegal to sell alcohol to anyone under the age of 18[15] or to someone who is drunk. Anyone who wishes to sell alcohol must have a licence to do so, which is issued by the Licensing Authority[16] (part of the Council).

• Guidelines

New guidelines for alcohol consumption were produced by the UK Chief Medical Officers in January 2016 following a review of the evidence on harm caused to health by alcohol (see also Appendix 3). The new guidelines say that

- men and women should not drink more than 14 units of alcohol each week, which should be spread out over 3 or more days, and include several alcohol free days a week
- pregnant women should not drink alcohol at all

Calculating the units of alcohol in a drink depends on the percentage of alcohol in each drink by volume (alcohol by volume, or ABV measure). Figure 1 illustrates the number of units in a range of alcohol drinks.

[15] Beer, cider or wine can be bought by someone over the age of 18 for someone who is 16 or 17 to drink with a meal on licensed premises.

[16] See glossary Licensing Objectives and Licensing Policy

- **Prevalence: adults**

As figure 2 illustrates, of the drinking population (persons aged 16 and over):

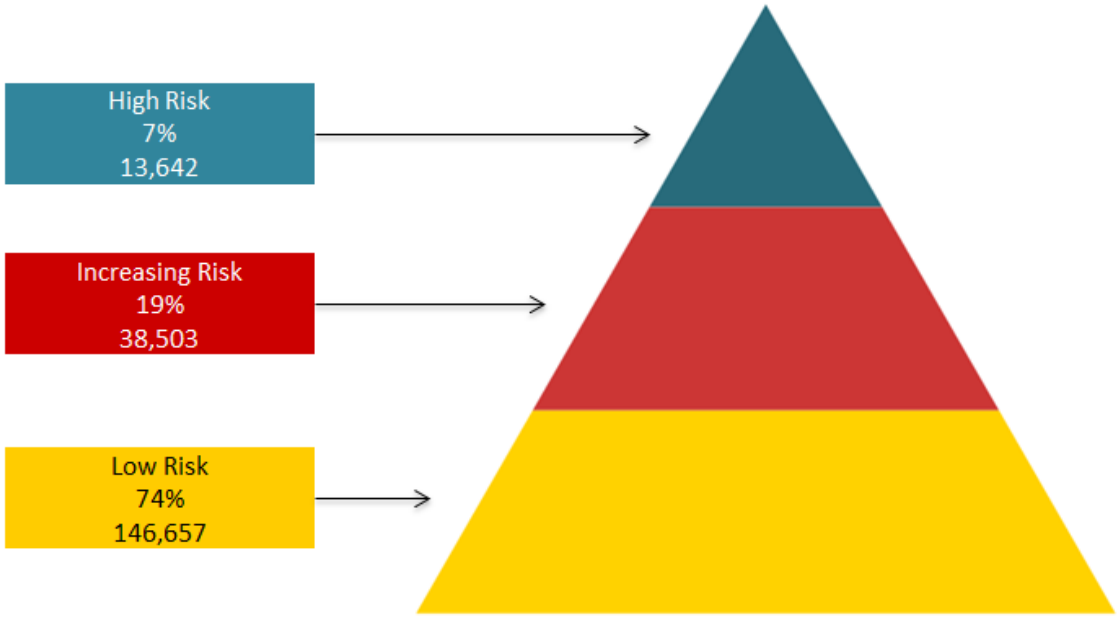
- Approximately, three quarters (74%) drink at levels that are low risk to their health (22 units of alcohol per week for males, and fewer than 15 units of alcohol per week for females).
- Approximately a fifth (19%) are drinking at levels that put them at an increased risk of alcohol-related health problems (22 and 50 units of alcohol per week for males, and between 15 and 35 units of alcohol per week for females)
- 7% are drinking at levels where there is evidence of some alcohol-related harm (more than 50 units of alcohol per week for males, and more than 35 units of alcohol per week for females)

Note that the above are based on old national guidelines (pre January 2016), see Appendix 3.

Estimates from other sources provide figures on:

- 16% of persons aged 16 and over abstain from alcohol
- 14% of persons aged 16 and over report engaging in binge drinking

Figure 2: Level of Alcohol Consumption Prevalence "the Prevalence Triangle"[17]



Source: Local Alcohol Profiles for England (estimates applied to mid-2014 population)

[17] Source: LAPE 2014 User Guide: 2009 synthetic estimate of the percentage of the total adult (16 and over) population. Modelled estimates produced by the former North West Public Health Observatory (now the Knowledge and Intelligence Team [North West]), using data from multiple sources including General Lifestyle Survey 2008 and 2009, Alcohol-specific hospital admission 2007/08 to 2009/10, Index of Multiple Deprivation 2010, Department for Communities and Local Government, Beacon and Dodsworth P2 People and Places classification (People and Places Trees)

- **Prevalence: children and young people**

According to a national survey conducted in 2014[18], 65.3% of 15 year olds in Havering have had an alcohol drink which is higher than London (41.2%) and England (62.4%). 16.1% of 15 year olds in Havering said that they had been drunk in the previous four weeks, which is higher than London (8.9%) and England (14.6%)

- **Older People**

According to the Royal College of Psychiatrists, older men are at greater risk of developing alcohol problems in later life compared to older women.

- **People with dementia**

People with dementia can become more confused after a drink, and someone with dementia can drink more because they have forgotten how much they have had. People who have dementia related to past alcohol use should not drink alcohol at all.

- **Crime and alcohol**

Excessive alcohol consumption in the night-time economy can lead to increased violence and criminal activity on our streets. According to Havering's Community Safety Annual Strategic Assessment 2015 (ASA), Havering has a higher rate of alcohol related crime than the national average but is lower than that of London. The ASA describes how people who binge drink were more likely to offend than non-binge drinkers. A study[19] of violent offences in Romford Town Centre's night time economy found that victims had consumed alcohol in 85% of cases, whilst 58% of victims could not recall the circumstances of the assault due to intoxication. Furthermore, 60% of alcohol related crime is caused by people aged 18-31.

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[18] Health and Social Care Information Centre (2015)
[19] Community Safety Report

SECTION 2: OBJECTIVES

This section describes the issues of substance abuse according to each of the strategy's three objectives, which are:

- **Objective 1: Preventing harm to the individual**
- **Objective 2: Preventing harm to families, children and vulnerable adults**
- **Objective 3: Preventing harm to the wider community**

As would be expected, many features of substance abuse relate to more than one objective. A factor that affects individual health which is described in objective 1, by default can also affect families, children and vulnerable adults (described under objective 2); and the wider community (objective 3).

OBJECTIVE 1: PREVENTING HARM TO THE INDIVIDUAL

This objective is concerned with the damage caused to individual health and wellbeing as a result of personal misuse of substances, and actions that can reduce harm.

The following describes what this means for (a) young people, (b) working age adults, and (c) older adults.

According to the national *What about YOUth* survey 2014,65.3% of 15 year olds in Havering have had an alcoholic drink, which is slightly worse that the England average (62.4%) and worse than London (41.2%). 16.1% of 15 year olds in Havering said that they had been drunk in the previous 4 weeks, compared with England at 14.6% and London 8.9%. 8.1% of 15 year olds in Havering said that they had ever tried cannabis, compared to England 10.7% and London 19.9%. 1.1% of 15 year olds said that they had taken drugs other than cannabis during the previous month, compared with England 0.9% and London 1.0%. The mean score of the 14 WEMWBS statements showed that 15 year olds in Havering had better scores (48.3) than England (47.6) and London (47.8).

(a) Young people, drugs and alcohol,

Most young people do not misuse drugs or alcohol and the national trend is that drug and alcohol use has been falling over a number of years. Despite this, for those who use drugs and alcohol, there is clear and compelling evidence that young people's substance use contributes to a wide range of other serious problems experienced by teenagers. This may include involvement in crime, gangs and anti-social behaviour, becoming a victim of crime and abuse including sexual exploitation, teenage pregnancy, mental health, future drug dependency as well as failing or falling behind at school[20].

Children should be encouraged to defer their first experience of alcohol, as an alcohol-free childhood is the healthiest and best option[21]. They should be protected from the exploitation of others who would use alcohol and drugs to groom them.

[20] HM Government (2001)
[21] . Department of Health (2009)

There are strong associations between mental health problems and substance misuse in young people and adults. Thus meeting the mental health needs of young people and building mental health resilience will reduce the likelihood of problems with substance misuse in later years. The National Service Framework for Mental Health[22] highlighted that children in the poorest households are three times more likely to have mental health problems than children in well off households. Commissioners of mental health services for children and young people should ensure that local services meet the needs of children and young people, and take into account where there is likely to be higher levels of need, including those groups that are identified as higher risk of substance misuse. The multiagency Mental Health Partnership Board[23] should consider the mental health needs of children and families in its strategic work programme (see glossary for further information on the work of the MHPB and later in this section on mental health needs of working age people).

- **Schools and colleges**

Schools and colleges play a vital role as promoters of health and wellbeing in their local community. The Havering Healthy Schools[24] programme has been a valuable resource for schools, and increasing numbers of schools are achieving bronze award. Bronze award requires the adoption of drug and alcohol policies and promotion of information about substances to the whole school community. The Healthy Schools programme should aim for all schools to achieve Bronze award status, as well as continuing to raise awareness of drugs and alcohol in the whole school community. As young people in Havering appear to be drinking at levels above London and England, there should be information about alcohol, including risks of alcohol to the unborn child. See also later content on Child Sexual Exploitation.

- **School nurses**

The school nurse make a valuable contribution to providing early help and advice on young people's health issues, particularly in areas such as mental ill health and drug and alcohol abuse, before they reach crisis point. Havering's school nursing service is commissioned by the Council from the North East London Foundation Trust (NELFT). The service is working with schools to make sure that children and young people, and their parents, know who is the school's designated school nurse, when the school nurse will be available for drop in advice, and how to contact the service during term time and holidays.

- **Parents**

Children from an early age come into contact with many sources of information about alcohol, but it is in the home that children's views are formed about drinking habits[25].

[22] Department of Health (1999)
[23] See glossary
[24] See glossary
[25] Eadie et al, 2010

According to a survey by Drinkaware[26], 54% of parents surveyed said that they had given their child an alcohol drink, and 20% of parents said they had no understanding or were unaware of medical guidance about drinking in childhood.

Many parents are reluctant to discuss the issue of alcohol with their children, even though children as young as seven have already developed a fairly sophisticated level of knowledge about alcohol. Parents can feel overwhelmed by the external pressures that encourage youth drinking, and yet studies show that children aged seven to twelve are receptive to parent advice and influence and that this is a good time to provide information and discuss alcohol, particularly as parental influence reduces as children reach their teenage years.

National research points to the need for greater consistency of information and for guidance for parents on how to embark on conversations about alcohol with their children. Parents need to know that, rather than wait until their child begins to experiment with alcohol, discussions during the child's primary school years will be a time when the child is most receptive. Agencies should work together to achieve more consistency in messaging, and to signpost parents to guidance and information that will help them to embark on discussions about all types of substances.

- **Specialist advice and support for young people**

The Council's Substance Misuse Service for young people provides a specialist service to young people aged 10 to 17 years and their families that aim to prevent and alleviate harm caused by a young person's substance misuse to themselves, their families and the communities in which they live. Specialist interventions include psychosocial interventions, criminal justice interventions, work with parents or carers, harm reduction advice and access to pharmacological services. Supporting young people with needs requires the young people's treatment service provider to work in close partnership with other key services including the Early Help Service, Youth Offending Service, Children's Services, and the Child and Adolescent Mental Health Services.

Drug use among young people from vulnerable groups (e.g. young offenders and those not in education, employment or training) is higher than it is for the rest of the population. Young people who belong to one or more 'vulnerable group' report the highest rates of all. It is anticipated that there will be a continuing demand for specialist services from this group as their frequency of drug use may lead to more harmful and problematic use. This strategy therefore recognises the importance of the Council continuing to maintain its investment in a specialist substance misuse service for young people providing a range of targeted interventions including education, information and advice. In order to achieve positive outcomes for young people with substance misuse needs, this service should work in close partnership with the Early Help Service, schools, Child and Adolescent Mental

[26] Independent charity that aims to reduce alcohol-related harm by helping people make better choices about drinking. www.drinkaware.co.uk

Health Services, the Youth Offending Service as well as the formal multi-agency bodies that coordinate local actions to prevent sexual exploitation and serious youth violence.

- **Non school settings**

There are a wealth of settings in Havering that provide activities for children and young people. Many are provided by voluntary and community groups that could also act as diversionary activities to prevent children and young people from engaging in risky behaviours involving alcohol or drugs. They are ideally placed to reinforce health promotion messages about drugs and alcohol, signpost to reliable sources of information and advice, including who to speak to if children and young people have any concerns. The Council, police, and substance misuse treatment services should ensure that information is provided to such groups so that they, in turn, can cascade the information to children, young people, and parents.

- **Sexual health clinic**

A report[27] has highlighted the opportunities for sexual health services to help tackle alcohol misuse, given the strong links between drinking and poor sexual health in the young. The report describes how attendances at sexual health clinics provide a unique opportunity to communicate key messages relating to alcohol consumption to those who are at risk. Local sexual health services should provide brief interventions about alcohol and refer to treatment services where appropriate.

(b) Working age adults

The health of working age people has become an increasing focus of attention in recent years. It is recognised that employers, communities and the taxpayer all bear the costs of working-age ill health, which is estimated by the Department of Work and Pensions to run at around £100 billion each year[28]. Misuse of substances not only contributes to short-term ill health in the working age population, but can also can impact on future health; increasing the chances of some cancers, dementia, and heart disease.

It is important that there is advice and support for adults about how to keep alcohol consumption within recommended guidelines, to avoid harmful substances, and to use over the counter and prescription only medications appropriately. It is also important that, where an adult has a problem with drugs and alcohol, that they are provided with the right level of service, depending on their level of need.

- **The Workplace**

Staff are an organisation's greatest asset, and a healthy workforce can reduce sickness absence, lower staff turnover and boost productivity. Employers can play a valuable part in helping employees to recognise their own and others substance misuse and provide information on sources of advice, help and support. This can be done through access to

[27] Royal College of Physicians and British Association for Sexual Health and HIV (2011)
[28] Department for Work and Pensions and Department of Health (2014)

confidential advice lines, signposting, as well as equipping managers to recognise and respond to substance-related under-performance. Havering Council is the first local employer to be accredited with the Workplace Wellbeing Charter. The Charter provides employers with an easy and clear guide on how to make workplaces a supportive and productive environment, including issues of substance misuse. Local employers such as the Council should make it a priority to raise awareness of alcohol and drug abuse in the workplace and signpost employees to sources of support and information.

- **Mental health**

Given the association between substance misuse and mental health problems (described above), ensuring good mental health must be a priority. The borough has many assets to help to achieve and maintain good mental health; from well-kept parks and open spaces[29], to learning and social opportunities.

There are a range of services for people who experience mental ill-health such as depression. These include Havering's IAPT[30] service provided by NELFT[31] and services provided by Havering MIND, Richmond Fellowship or Family Mosaic, to name but a few. The IAPT service works closely with the commissioned drug and alcohol treatment services to ensure a holistic approach to mental health and substance misuse (see below re primary care). Havering's multi-agency Mental Health Partnership Board should continue to work together to promote good mental health in the borough, and recognise the importance of good mental health in preventing substance misuse in all age groups.

- **National campaigns, digital and online support**

There is a wealth of advice, digital and on-line support available to maintain good mental health. Examples include digital apps to download to monitor mood, promote mindfulness and even keep track of drinking behaviour. The London Digital Mental Wellbeing Project is being commissioned collaboratively by all London CCGs to improve mental wellbeing and increase mental health resilience of adults in London, by offering an open access digital service to its 6.5 million adults. London will be the first city in the world to develop this type of project at scale, delivering a preventative city-wide service using digital innovation to enable users to self-assess and manage their own mental wellbeing via advice, peer-to-peer support, virtual communities and online support. These should be amplified and promoted locally to encourage individuals to improve their health, including where there is substance misuse.

National programmes should also be promoted locally, particularly the One You[32] Campaign (launched March 2016 and Dry January[33], together with reliable on-line sources of

[29] Faculty of Public Health and Natural England (2010)
[30] See glossary
[31] NELFT provide a range of mental health services including Access Assessment and Brief Intervention, Community Recovery Team, Recovery Community and Older Adults mental health services and Early Intervention in Psychosis
[32] See glossary

information and advice, such as “Talk to Frank” (about drugs), “Drinkaware” and “Alcohol Concern” (alcohol).

- **NHS Health Checks**

The NHS Health Check[34] programme aims to prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia, and includes advice about alcohol use. The NHS Health Check programme is commissioned by Havering Council and delivered by GPs. The Council Public Health Service should ensure that GPs are provided with information and an updated tool[35] to screen for level of alcohol-related risks to health, once new national tools are published.

- **Health Champions**

Health Champions are volunteers who, with training[36] and support, work jointly to promote health and wellbeing within their local community. They empower and motivate people to make positive choices to improve their health and wellbeing. Local voluntary organisation Tapestry is commissioned by the Council to recruit and manage volunteers as part of the *My Health Matters* Havering health and wellbeing programme. Health Champions provide information on a wide range of health matters, including alcohol and substance misuse.

- **Primary Care**

Most people turn to their GP when they have a problem with substance misuse, or the GP may identify that someone is drinking above recommended levels, including through the NHS Health Check Programme. GPs assess the nature of the problem and help the individual to choose the most appropriate action. This may include treatment, or referral to specialist treatment services, such as when someone has become dependent on alcohol[37]. GPs and practice nurses should be updated regularly about issues of substance abuse, including the availability and referral criteria for treatment services.

GPs provide general medical care to everyone registered with them, including people who have a drug or alcohol problem. In addition, GPs can provide “shared care”, which are alcohol treatment interventions in partnership with specialist drug and alcohol treatment services. Where a GP in Havering wishes to participate in shared care arrangements, the specialist treatment service and the GP should agree a protocol that outlines a clear plan of

[33] See glossary
[34] See glossary
[35] The AUDIT tool (Alcohol Use Disorders Identification Test) is a detailed questionnaire, developed by the World Health Organization, that picks up early signs of hazardous and harmful drinking, and identifies mild dependence.
[36] Training leads to a recognised qualification in Understanding Health Imrpovement, which is accredited by the Royal Society for Public Health.
[37] If someone has become dependent on alcohol, stopping drinking overnight can be life-threatening, so it is essential that they get advice about cutting down gradually.

care, monitoring arrangements and the respective role and responsibilities if the treatment service, GP and patient.

Problematic use of prescription-only and over the counter medicines can arise for a range of reasons, including individuals who unintentionally become dependent. The consequences of problematic use of prescription and over-the-counter medicine can lead to physical, psychological or social problems, and affect all age groups. GPs should implement NICE policy covering the appropriate management of prescription only medicines that are liable to abuse. The BHR CCG Medicines Management team should provide support to practices to achieve the relevant standards, through training, advice, and audit. In cases of non-compliance with the standards, where appropriate, the CCG should refer health practices to the Controlled Drugs Accountable Officer for London (Care Quality Commission).

Pharmacists explain to patients how to take medicines and can be key in recognising prescription drug abuse, and misuse of over the counter medicine. They have a key role to play in providing advice on minimising the harms caused by drugs, help to stop using drugs by providing access to drug treatment (e.g. supervised consumption of opioid substitution therapy) and signposting to other health and welfare services. There is a call for community pharmacists to take a more proactive approach in supporting patients who misuse over-the-counter medicines[38] BHRUT CCG Medicines Management Team should discuss with the Local Pharmaceutical Committee about implementation of national guidelines, once these are published.

The Pharmacist can be instrumental in supporting drug users in complying with their prescribed regimen, therefore reducing incidents of accidental deaths through overdose. Selected pharmacies in Havering provide supervised consumption of drugs, which contributes to keeping to a minimum the misdirection of controlled drugs and is one measure in preventing drug-related deaths in the

Prescription-only and over the counter medication

Of the 520 clients in drug treatment in Havering in 2011/12, 11.5% cited problematic use of prescription only medicines or over-the-counter medicines. This is slightly lower than the London average (12.6%).

The factors that are associated with an increased risk of misuse an dependence to prescription-only or over the counter drugs include:

- Personal or family history of substance abuse
- Age 16-45 years
- Older people with complex physical and psychological needs complicated by pain
- History of pre-adolscent sexual abuse
- Certain psychological diseases, such as ADHD, obsessive-compulsive disorder, bipolar disorder, schizophrenia, depressen
- Exposure to peer pressure or a social environment where there is drug abuse
- Easier access to prescription drugs, such as working in a healthcare setting
- Lack of knowledge or understanding about prescription only or over the counter drugs by the prescriber

[38] Pharmaceutical Medical Journal (2013)

community. A number of local pharmacists also provide a needle and syringe exchange service, which contributes to reducing the likelihood of blood-borne[39] infections as a result of sharing of needles.

In addition many pharmacists offer a free medicines use review. This service should be promoted locally.

- **Acute hospital**

Acute hospitals have an important role to play in identifying those who have attended A&E services or are admitted as result of substance misuse. The Council has commissioned the Drug and Alcohol Treatment Service to locate an Alcohol Liaison Nurse[40] in Queens hospital which has proved to be highly valuable in ensuring a focus on alcohol-related issues. There has been excellent partnership working with the consultant hepatologist, and with A &E services and on the wards, where the Alcohol Liaison Nurse plays a key role in working with clinicians and nurses to assess and support those patients who require inpatients detoxifications. The role also involves raising knowledge and awareness among clinical and nursing staff about alcohol related issues. In addition, the Nurse also holds clinics to assess the needs of, and agree care plans for service users presenting with alcohol use and works with the service user to achieve their care plan objectives.

Given the associations between mental health ill health and substance misuse, a closer working relationship has been established between the Alcohol Liaison Nurse and the mental health service Mental Health Liaison Nurse, and this should be continued and developed to ensure that problems are identified in acute settings and appropriate subsequent action taken.

- **Mutual Aid**

Mutual aid groups are a source of structure and continuing support for people seeking recovery from alcohol or drug dependence, and for those directly or indirectly affected by dependence, such as partners, close friends, and other family members. Some people will start attending mutual aid groups when they first recognise that they have a problem, and will continue through to recovery without further support from elsewhere. For others, attending a mutual aid group will be part of their recovery that first started with specialist or primary care treatment and advice. Mutual aid groups should be provided with specialist advice and information in order that they, in turn, are able to continue to provide support to individuals and families in Havering.

- **Specialist Adult Treatment Services**

Havering Council commissions an integrated specialist substance misuse treatment service from WDP Havering (tiers 1, 2 and 3), and commissions specialist providers for tier 4

[39] See glossary
[40] See glossary

residential detoxification and rehabilitation treatment[41]. Appendix 6 summarises the key aspects of the integrated service provided by WDP Havering. The service accepts referrals from health professionals as well as self-referrals. WDP Havering assesses the needs of the individual (and the family where appropriate) and works in partnership with agencies to support the individual to recovery. Where there are issues of dual diagnosis[42], substance misuse treatment services must work in partnership with mental health services.

- **Treatment services for women**

The JSNA drugs and alcohol highlights the different issues relating to substance abuse that affect women, compared to men, including during pregnancy.

Women who are pregnant and using alcohol or drugs may be identified either by the substance misuse treatment service, or by maternity services. When the treatment service identifies that a woman is pregnant, then depending on decisions made by the woman, they will either refer the woman to maternity services or to abortion counselling services. Where the woman decides to proceed with their pregnancy, the BHRUT maternity service aims to minimise the risk to the unborn [baby of parental substance misuse. The lead midwife is the main point of contact for the woman and who ensures that management of the woman's continuing ante-natal care includes managing the risks to the unborn child.

In order to ensure good management during the perinatal[43] period, the service provider and maternity services should work closely together, including collaborating on the woman's care plan. For pregnant women, the detox aspect of treatment should be managed by the acute hospital, with support from the drug and alcohol service for rehabilitation.

For non-pregnant women, the specialist service provider manages the woman's care (to tier 3). Where tier 4 is the best option, this should be managed by a CCQ-registered care home provider with specialist detox and rehabilitation programmes.

Women with substance misuse problems may also have problems with mental ill-health and experience domestic violence and where this is the case, the three specialist services (and maternity services as appropriate) should have good working relationships. The effectiveness of those relationships should be assessed by service user feedback (service users who are accessing all three services).

(c) Older adults

Misuse of drugs (including prescription drugs) and alcohol can have particular consequences for older people. For older people who drink excessively, their health problems can make

[41] See glossary for descriptions of tiers of services
[42] See glossary
[43] See glossary

them more susceptible to alcohol. As balance gets worse with age, even a small amount of alcohol can make an older person unsteady and more likely to fall. Alcohol can also add to the effect of some medications, such as painkillers or sleeping tablets, and reduce the effect of others, such as medication to thin the blood (warfarin), which can increase the risk of bleeding or developing a blood clot. According to the Royal College of Psychiatrists [44].older men area at greater risk of developing alcohol and illicit substance use problems than older women. However, older women have a higher risk of developing problems related to the misuse of prescribed and over-the-counter medicines. Among older people, psychosocial factors, including bereavement, retirement, boredom, loneliness, homelessness and depression, area ll associated with higher rates of alcohol use.

Problematic use of prescription-only and over the counter medicines can arise for a range of reasons, including individuals who unintentionally become dependent. The consequences of problematic use of prescription and over-the-counter medicine can lead to physical, psychological or social problems, and affect all age groups. The exact size of the problem is largely unknown, but nationally where people are reporting to drug treatment services, 12% of new clients in 2009-10 reported problems with prescription-only or over-the-counter medicine[45]. It is suspected that these figures seriously underestimate the problem, as people who are misusing these medicines may be more likely to seek help from the GP and not access specialist substance misuse centres.

The problematic use of prescription and over-the-counter medicine is becoming more widely recognised and in January 2013, the Royal College of GPs launched the *Addiction to Medicines Consensus Statement* which strongly advocates care in the initiation of any drug that can lead to dependence. According to the Royal College of GPs, problematic use of prescription drugs in older adults is a growing problem, and is a particular concern because they are often taking multiple medications, putting them at risk of drug interactions. In addition, frailty, fluctuating health and long-term conditions also increase the risk of complications of drug misuse such as falls, overdose and toxicity.

The Royal College of GPs has published fact sheets that focus on the medicines that are most commonly associated with problematic use. In Havering, we will focus on these same medicines. We recognise that there are distinct but overlapping populations that use these drugs, that problems can occur for a range of reasons, and that different approaches may be needed.

Havering CCG is committed to improving local policy and practice and continues to take steps to ensure that poor practice in prescribing is eliminated. On behalf of Havering CCG, the Havering Area Prescribing Committee[46] decides and recommends on prescribing policy

[44] Royal College of Psychiatrists (2011)
[45] Royal College of General Practitioners
[46] A sub-committee of Havering Clinical Commissioning Group Governing Body

and all medicines management matters. The means there is a co-ordinated and joined-up approach in clinical decision making, and management of medicines.

The BHR CCG Medicines Management 2014/16 work plan has been developed to monitor opioid and sedative prescribing through aligning practice with national policy directives, and is implemented by the BHR CCG Medicines Management Team. The plan includes protocols and actions to deliver the Quality, Innovation, Productivity and Prevention Prescribing Incentive Scheme, which incentivises practices to undertake reviews of patients' medicines. This scheme aims to improve prescribing to help avoid unplanned admissions and to promote cost-effectiveness.

Havering CCG ensures that budgets for drugs are used effectively

In 2014, costs for antiepileptic drugs were £486.5m, an increase of £292.7m (151%); £247.3m of this increase was for pregabalin (also used for neuropathic pain). The increased cost for pregabalin was the largest increase for any medicine in 2014/5 Havering CCG managed this increase by optimising patients doses of pregabalin from three times a day to twice a day dosing which would also have addressed misuse potential.

The protocols are followed by Havering CCG, the acute hospital, and mental health and community services, and include guidelines that cover, for example, management of Attention Deficit Hyperactivity Disorder (ADHD). This ensures that the drugs prescribed for ADHD are monitored and so reduces the risk of these drugs being misused.

The Medicines Management team provides a lead to ensure effective prescribing and support, in line with recommended guidelines, including implementation of NICE policy covering the appropriate management of prescription only medicines that are liable to abuse. Support is offered to practices to achieve the relevant standards, through training, advice, and audit. In cases of non-compliance with the standards, and where appropriate, the CCG refers health practices to the Controlled Drugs Accountable Officer[47] for London (Care Quality Commission).

The team responds to changes in legislation on the status of drugs, such as in June 2014 tramadol became a schedule 3 Controlled Drug, and Lisdexamfetamine for ADHD became a schedule 2 controlled drug. The change in legal status presented an opportunity for prescribers to review current prescribing of tramadol, in primary care.
In Autumn 2015, the Medicines Management team commenced an update to their work plan to include identification and treatment of patients who misuse and/or become dependent on prescription only and over-the-counter medicine, and is currently exploring options including:

- a prescribing incentive scheme

[47] See Glossary

- stronger and closer working relationship with the CCGs, local Acute trusts, North East London Foundation Trust, and out of hours providers
- ScriptSwitch clinical decision software
- prescribing/educational forums
- pathway development and
- education and training sessions for clinicians.

Voluntary organisations, health and social care should also raise awareness of the issues of alcohol use by older people as, once spotted it is often easier to treat drink problems in older people than it is in younger adults. Older adults should also be encouraged to access talking therapies (IAPT) to address low level mental health problems, which will help to prevent reliance on substances.

BHRUT should continue to identify older people who have been admitted as a result of drug or alcohol use, including falling whilst under the influence of alcohol, or as a result of the combination of effects cause by prescription only and over the counter medicine. There should then be an appropriate referral to the GP.

- **Drug Related Deaths**

Recorded rates of drug-related deaths are higher in England than in most other European countries[48]. This high number of drug-related deaths partly reflects the fact that the population of injecting drug users in England is growing older. People with long histories of drug dependency are more likely to be in poor health and to engage in dangerous injecting behaviour, and are at greater risk of dying from overdose. Deaths often involve a combination of drugs as well as opioids, with alcohol and stimulants frequently mentioned on death certificates. Deaths involving new psychoactive substances ("legal highs") have also increased in recent years.

There is an elevated risk of overdose for people in the immediate period after being released from prison, also where individuals have completed a drug detoxification programme.

Drug services (including, where appropriate, needle and syringe exchange sites) should identify service users at higher risk and ensure they have information and advice about the risk of overdose.

A local drug information system that uses consistent and efficient processes for sharing and assessing information and issuing warnings where needed, can help ensure that information rapidly reaches the right people. Such a system can help to avoid alarmist reports that find their way into the media which often contain inaccurate information rarely confirmed by

[48] Public Health England (2014)

toxicology tests, and which can be counterproductive to public health messages intended to reduce drug-related harms and deaths. A local drug information system should be set up in Havering, based on systems that have been shown to be effective elsewhere in England, which are low-cost, low-maintenance, multi-disciplinary systems that use existing local expertise and resources.

(d) Street drinkers and rough sleepers

Rough sleepers are one of the most vulnerable groups in society, and various studies have found strong correlations between homelessness and a multiplicity of both physical and mental health conditions. Rough sleepers are over nine times more likely to take their own lives than the general population; on average rough sleepers die at age 47 (age 43 for women)[49]. Around 50% of rough sleepers have been found to have a serious alcohol problem. Drug problems are more prevalent amongst younger rough sleepers.

In December 1999, national Government published a report detailing a range of measures that are required to address the issue. The key aspects of the report described the role of specialist workers to help rough sleepers with alcohol, drug or mental health problems, and tackling prevention so that new people do not become tomorrow's rough sleepers, particularly those leaving care, prison, and the armed forces . A Havering working group was established in 2015 to consider the increase in rough sleepers and street drinkers in Romford Town centre. Off Licenses have been encouraged not to sell single cans, and joint patrols with the Police, the substance misuse treatment service, and Thames Reach have been taking place, offering assistance interventions.

There have been recent reports in the national press about problems people with serious drink problems digesting alcohol gel that is used on hospital wards and other health and social care settings to reduce the spread of infection. The ready availability of alcohol gel in settings such as hospitals can result in its abuse by people who are alcohol-dependent. BHRUT has taken a number of measures to reduce the risk of the gel being abused, including lockable containers. When someone is admitted who is known to be a dependent drinker, all alcohol gel is removed from the ward and replaced with an increased regimen of handwashing. BHRUT has investigated the possibility of replacing alcohol gel with a nanotechnology. Currently this is not licensed for health settings but BHRUT should keep a watching brief on opportunities for replacing alcohol gel with other equally (or more) effective infection control measures.

[49] House of Commons Library (2015)

(f) Black and Minority Ethnic Communities

For some ethnic minority communities, there is an added stigma where people have problems with substance misuse. It is often perceived as a problem that should be kept hidden from the wider community. Whilst abstinence is high amongst South Asians, particularly those from Pakistani, Bangladeshi and Muslim backgrounds, nevertheless Pakistani and Muslim men who do drink do so more heavily than other non-white minority ethnic and religious groups. Similarly, problem drinking may be hidden among women and young people from South Asian ethnic groups. According to the Havering Joint Strategic Needs Assessment, there is currently an over-representation of white British service users accessing treatment. Commissioners should ensure that the services that are commissioned meet the needs of various ethnic groups equitably (including the services commissioned for young people).

DRAFT

OBJECTIVE 2: PREVENTING HARM TO FAMILIES, CHILDREN AND VULNERABLE ADULTS

Substance misuse can cause immense harm to families, children and vulnerable adults, and this is particularly the case where substance misuse co-exists with domestic violence and mental ill-health, which is commonly known as the "toxic trio". Although the numbers of families affected by all three factors are relatively small in number, there are substantial risks to children and vulnerable adults where all three co-exist together. Substance misuse by a parent or carer is widely recognised as one of the factors that puts children more at risk of harm, with the biggest risk being that, when under the influence of drugs or alcohol, parents are unable to keep their child safe. Case reviews have highlighted that professionals often focus on the issues faced by parents who misuse substances without considering the impact on their children.

- **Children in a household where there is substance abuse**

Although there are some parents who are able to care for their children despite dependence on drugs or alcohol, parental substance misuse can cause significant harm to children at all stages of development. Maternal substance misuse in pregnancy can have serious effects on the health and development of the child before and after birth.

Where a parent has enduring and / or severe substance misuse problems, children in the household are likely to suffer significant harm primarily through emotional abuse and neglect. Children may also not be well protected from physical or sexual abuse. Appendix 4] describes the risks to children as a result of substance abuse in the family, which the National Society for Prevention of Cruelty to Children emphasises as[50]:

- sudden infant death syndrome associated with co-sleeping
- accidental ingestion of drugs
- accidents (fire, drowning) due to inadequate adult supervision
- parents deliberately giving drugs to children.

As Table 2 describes, in the thirteen month period to end December 2015, 321 families were supported through the Troubled Families programme, with 17 families initially identified as having problems with the toxic trio of issues of domestic violence, mental ill health and substance misuse. There were 74 families where there were problems with substance misuse (including the 17 where there were the three issues present).

[50] National Society for the Prevention of Cruelty to Children Information Service (2013)

Table 2: Troubled families supported 1 Dec 14-31 Dec 15

Total Individuals	Total Families	Substance Misuse	Domestic Violence	Mental Health	All criteria
1487	321	84 individuals (74 Families)	427 individuals (152 Families)	197 individuals (147 Families)	19 individuals (17 Families)

Local services in Havering work hard to keep families together, and to avoid placing children in care away from their parents whilst, at the same time, keeping children safe from harm. As a result 35% of Havering parents in treatment for drug misuse were living with their children compared to 32% nationally[51]. Local data indicate that in 2014, 54% of drug users in treatment in Havering had responsibility for children, which is slightly higher than the national average of 56%.

- **Support for families**

When a family is first brought to the attention of the Early Help Service, the staff together with other partner agencies assesses the needs of the whole family. The assessment includes whether there are issues with drugs and/or alcohol, along with many other factors such as mental ill-health or behavioural problems.

The Early Help Service takes the lead and together with the family, and in collaboration with schools, health services, voluntary and community organisations, an action plan is developed for the family, which takes into account their unique set of issues and circumstances, needs and strengths. The plan sets out agreed specific goals, as this has been shown to be an effective process in achieving change. Where there is a problem with drug and alcohol misuse, the action plan will include goals that specifically address these issues.

Where substance misuse is an issue, then assessment must take into account children in the family. The assessment should contain a clear description of the user's drug and alcohol consumption, and their usage and behaviour must be properly analysed to understand the

Box 2: Key findings from self-assessment January 2016

- Information sharing between Early Help, substance misuse services, and mental health services to be strengthened
- Team around the family to be strengthened, with the inclusion of WDP at conferences
- Joint visits should be made to families where appropriate (Early Help and WDP attending together)
- A more systematic approach required to ensure that frontline staff and managers in Early Help, WDP, Mental Health and managers are knowledgeable about partner agencies
- Lack of clarity about referrals in to Young Carers services
- Potential for LSCB data set to be strengthened with substance misuse provider data
- WDP should be present when there is a safeguarding assessment and the parent is receiving treatment for substance misuse

[51] Public Health England (2014)

risks that this poses to the children including assessment of parenting capacity.

The Early Help Service forms a "Team Around the Family" to support them in achieving the action plan goals. This approach reduces duplication and bureaucracy, and by including the family throughout the process leads to better outcomes. Where substance misuse is identified as a problem, then Early Help visits to the home should be accompanied by the substance misuse advisor (from the specialist treatment service) who should advise about those aspects of risks in the home and advise parents about storing drugs and alcohol securely and out of reach of children, the risks to children of ingesting drugs or alcohol, and keeping children safe from hazards in the home.

Achieving good outcomes for the family, including children in the family, requires effective joint working between the range of organisations that can support the family to achieve change. In 2015/16 partner agencies[52] undertook a self-assessment to gain a shared understanding of the effectiveness of joint working arrangements wherever substance misuse is identified as a problem for a family. The main findings are summarised in Box 2 and priority actions are described in the Action Plan. Partner agencies should continue to strengthen all aspects of working arrangements with dynamic self-assessments that help to identify any potential weaknesses.

When called to an incident of domestic violence, the Police Office records whether or not alcohol is involved. Commencing October 2015, Havering Police have been working to improve levels of recording this information which will assist in future management of domestic violence incidents, contribute to the Council-led Early Help offer, and to the granting of alcohol licenses and licensing decisions.

- **Safeguarding**

Professionals in all agencies have a primary duty to safeguard and promote the welfare of children (including pre-birth) and vulnerable adults. Havering's Multiagency Safeguarding Hub[53] (MASH) plays a key part in ensuring that vulnerable groups are kept safe and protected.

The self-assessment described above also considered levels of knowledge of the complexities of safeguarding children when substance misuse is a factor (see Appendix 4). It was identified that there should be multi-agency safeguarding training provided in Havering that includes a particular focus on the issues of drugs and alcohol.

[52] Early Help Service, Commissioning, WDP Havering, LSCB Lead, NELFT Mental health Services, Public Health Service, Community Safety.
[53] See glossary

- **Young carers**

Young people who live in families where there is drug or alcohol misuse may take on a range of caring responsibilities, including domestic chores, dealing with bills, nursing a parent, or providing emotional support. These children may also experience very chaotic lives which lack routine, and they may often worry about the safety of their parent. These children are more likely to miss school and experience greater educational difficulty compared to other young carers.[54] The Council, as the commissioner of the Young Carers Service, should take into account the needs of young carers who have taken on caring responsibilities for someone who is abusing drugs of alcohol.

- **Vulnerable adults**

Vulnerable adults may be those who have a problem with drugs and alcohol themselves, or where, as a result of vulnerability, they are at risk of financial or other abuse because of their carer(s) or other adult's misuse of substances.

Older people's drinking can increase their susceptibility to being a victim of abuse or crime if they are less able to judge risky situations, and older people who are experiencing abuse may turn to alcohol as a means of coping with it. Social Workers, through their regular contact and established relationships, are well placed to identify alcohol problems in older people and should be using a validated alcohol screening tool when assessing the needs of older people.[55]

Whilst the use of illegal drugs has either fallen or remained stable in the past ten years, there is now a cohort of older people which has been using opiates for most of their adult life. This group is likely to be experiencing multiple health problems as they age. Commissioners should plan for the needs of this cohort, including end of life care.

- **Adult carers**

For as many people who access treatment, there will be families and carers who are dealing with the day to day reality of caring for someone who is abusing substances. According to the National Carers Strategy[56], people caring for someone with a substance misuse problem formed the group that felt least involved in discussions about support for the person they cared for. It is essential that carers are signposted to appropriate services and support groups.

[54] Dearden & Becker (2004)
[55] Livingston & Galvani (2012)
[56] HM Government

OBJECTIVE 3: PREVENTING HARM TO THE WIDER COMMUNITY

Crime and drugs are inextricably linked - anyone who sells, buys and uses drugs such as heroin, cocaine and cannabis is breaking the law. Associated with this is the violence and intimidation committed by organised criminals fighting for territory in the illicit drug trade, including gangs that lure children and young people into criminal networks to supply drugs. There is also acquisitive crime committed by people to fund an addiction, with some also supporting their use through dealing drugs or prostitution. It is widely recognised that abuse of alcohol is inextricably bound up with offending behaviour. Binge drinking can lead to anti-social behaviour, such as nuisance, increased noise levels, disorder and harassment, all of which can affect entire communities, as well as violent assault, including sexual assault.

Preventing harm to the community requires effective partnership working between a range of local agencies to interrupt the supply of illicit drugs in Havering and deal with the serious criminal activity that is associated with the use and supply of illegal drugs. It requires applying legislation and local policy to ensure that alcohol is sold and consumed responsibly, and putting into place measures to prevent harm to those who have drunk too much and who are no longer able to protect themselves from those who would do them harm. It is essential to respond to the health needs of offenders; ensuring that there is effective treatment for substance misuse to reduce the likelihood of reoffending, and to ensure that mental and other health needs are met, along with ensuring access to education, training and employment.

(a) Substance abuse and criminal behaviour

Chaotic opiate and crack cocaine use is less prevalent in Havering however, the Metropolitan Police Service (MPS) data indicates that there is an increasing problem with the combined use of cocaine and alcohol. Whilst there are inherent risks in taking either excessive alcohol or cocaine individually, the combined effect creates a third compound in the body, coca-ethylene, which poses even greater physical and psychiatric risks.

Powder cocaine use is identified in a high proportion of DIP drug tests administered for those arrested of serious acquisitive crimes, particularly burglary.
In addition, Havering had amongst the highest positive tests rates for cocaine in the London region. The National Probation Service and Community Rehabilitation Company assessments identify that 40% of this cohort have drug treatment needs. Health data also identified Havering, and neighbouring parts of Kent and Essex, as having the highest usage rates of powder cocaine nationally.
Alcohol harm, particularly in respect of violence and domestic abuse is identified as a factor in half of police recorded crime offences in Havering (in excess of 1,000 crimes per annum).

Furthermore, Probation NPS and CRC assessments indicate that 40% of offenders in Havering identify alcohol as a factor towards their offending (the 4th highest proportion in London and above the regional average). In addition within the rolling last 12 months, there were 6,000 domestic abuse crimes and of those 60% were arrested, and half of these were alcohol related.
The Havering Community Safety Annual Strategic Assessment 2015 (ASA) describes different patterns of criminality where substance abuse is concerned, which are summarised below.

- **Alcohol and criminal behaviour**

Those who commit violent crimes are more likely to have problems relating to alcohol and less likely to have problems with drugs. In Havering, 40% of offenders assessed by the National Probation Service in the twelve months to September 2015 had an identified alcohol need. The most risky age group of offenders was 18-34, accounting for 60% of all offenders who committed an alcohol related offence, of which 82% were male. The ASA, describes the presence of alcohol as a disinhibitor to offending (i.e. the offender committed the offence due to alcohol impairment, rather than a dependency on alcohol). The CSEW 2014 found 49% of victims of violence believed the offender to have been under the influence of alcohol. This ranges from 38% for domestic violence to 69% for stranger violence.

According to the ASA, Havering has a higher rate of alcohol related crime (7.4) than the national average (5.7), but lower than the average for London (8.6). Havering ranked 23rd out of 32 London boroughs for its rate of alcohol related crime.

- **Drugs and criminal behaviour**

Also, according to the ASA, those who commit acquisitive crime such as burglary and robbery are more likely to have problems with drugs (along with education, training, employment and financial needs).

The CSEW 2014 collates perception data on perpetrators. Of those respondents who reported being a victim of domestic abuse during the previous 12-months, 36% perceived the perpetrator to have been under the influence of alcohol. Alcohol feature codes are used on police crime data to identify offences which involve alcohol . The proportion of domestic abuse crimes in Havering which are alcohol related (based on the accuracy and consistency of using alcohol feature codes) was 39.5% for the previous 12-months, according to the MPS domestic abuse dashboard – this is marginally higher than the national average gauged from the CSEW. This compared to 28.9% for the MPS average and 37.5% for the East Area boroughs. Our neighbouring boroughs Barking & Dagenham (66.5%) and Redbridge (56.0%) were notably higher.

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- **Gangs and serious youth violence**

The Home Office Ending Gang and Youth Violence Programme has been working with a number of London boroughs including Havering, to help them understand how drug markets are driving violence in the boroughs.

London gangs are not just working county lines[57] to deal drugs across a large part of the country, but are also involving children in the process, to either sell, look after and/or carry drugs. The evidence available appears to indicate that these drug markets are driving violence, as well as the involvement of children and vulnerable people. The problem encompasses gang activity, drug dealing, safeguarding, children missing from home, violence, sexual exploitation, violence against girls, women and families and money laundering, as well as unknown links between Urban Street Gangs and Organised Crime Groups. The HCSP has developed a Serious Group Violence Strategy 2014-2017 and associated action plan to address the issue of gangs and associated substance misuse in Havering. The aims of the strategy are:

- intelligence and information sharing
- prevention
- intervention
- enforcement.

- **Sexual assault**

According to LBH Violence Against Women and Girls (VAWG) Problem Profile 2016, a pan-London profile showed that 25% of victims were targeted whilst under the influence of drink or drugs, whilst 14% of suspects were believed to be under the influence of drink or drugs. Females 16 – 19 accounted for the largest proportion of victims. 14% of victims had some form of disability. The locations in Havering that are of most concern are Gooshays, Romford Town, and South Hornchurch.

- **Child Sexual Exploitation**

A comprehensive problem profile into Child Sexual Exploitation (CSE) was completed in November 2015.

The 'boyfriend model' of CSE is common in Havering. This was more likely to involve an older perpetrator offering rewards including drugs and alcohol and making the victims believe they are in a relationship in order to engage in sexual activity with a minor. The young people's substance misuse service should continue to work closely with other services to identify and respond to sexual exploitation and maintain its partnership work with the two key formal bodies responsible for coordinating and monitoring local efforts to

[57] See glossary

prevent and reduce sexual exploitation, namely the local Children's Services-led virtual CSE team and Police-led Multi-Agency Sexual Exploitation (MASE) group.

In Havering, parks and derelict or disused buildings have been identified as areas used by young people for sexual activity and drug taking, and as locations where missing and vulnerable young people have been located. The Local Safeguarding Children's Board will continue to lead on a programme of work to address CSE and associated problems through a Multi-Agency Sexual exploitation panel. LBH Children's Service is undertaking a CSE strategy review which will include consideration of the influence of drugs and alcohol on this issue. The service is working closely with all relevant stakeholders, and the Drug and Alcohol Harm Reduction strategy will contribute to the knowledge base of the CSE strategy and action plan.

- **Domestic violence**

The HCSP has developed a Violence against Women and Girls Strategy (VAWG) and associated action plan which includes a programme of work to address domestic abuse within Havering. A comprehensive VAWG problem profile (Feb 2016) includes the following recommendations

Prevention and early identification objective

- Continue to deliver a communications plan to raise awareness of VAWG and provide access to information and services for residents of Havering.
- Continue to deliver training to practitioners and frontline staff within the statutory and voluntary sector. Expand this to include work with the private sector and businesses and registered social landlords.
- Continue to deliver education workshops for children and young people in Havering.
- Continue to train domestic abuse champions across the borough.

Provision of intervention services objective

- Update the MARAC information sharing protocol in line with HMIC guidance during their review of how domestic abuse is tackled, to ensure MARAC research and risk assessments are shared with the MARAC coordinator.
- Develop and implement a locally agreed threshold for automatic referral and repeat referral to the MARAC
- Launch the multi-agency MARAC operating protocol and induction pack for new agencies/representatives coming to the MARAC.
- Improve awareness and increase use of the Domestic Violence Disclosure Scheme locally.
- Maintain the current level of IDVA provision and consider contingency options should access to funding change.
- Improve the use of Victim Personal Statements / Victim Impact Statements in cases brought before court.

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Protect victims and take enforcement action against perpetrators objective

- Work with National Probation Service and Community Rehabilitation Company to understand how local domestic abuse perpetrators are being managed, and obtain information on offender needs and compliance/completion rates of perpetrator programmes and licences.
- Improve the use of alcohol treatment referrals, drug rehabilitation requirements and other relevant conditions to address alcohol/drug misuse where it is a contributory factor to offending.
- Provide access to alcohol and drug intervention for both victims and perpetrators.

Intelligence and information objective

- Continue to communicate with BHRUT in order to receive information to tackle violence.

(b) Criminal justice system

As a consequence of their criminal acts, problem drug users are highly likely to enter the criminal justice system – and it is at this point that they will be compelled to confront their drug problems.

A local priority is to identify those people with substance misuse and linked offending issues early on through the criminal justice system. The Police, Probation Services, the Council, the courts and criminal justice agencies work together on a range of initiatives under the local Drug Intervention Programme[58]. The initiatives include identifying and monitoring substance misusing offenders, disrupting repeat offenders and/ or steering them into treatment and, where appropriate, community sentencing orders and custody.

- **Testing on arrest**

Testing on arrest is a key initiative of the Drug Intervention Programme; to detect drug use, direct individuals into treatment, and interrupt the supply of drugs. The MPS tests for drugs if an individual has been arrested or charged with a trigger offence, such as shoplifting. Where a test is positive, the individual can be required to attend an assessment with a drugs worker and subsequent drug and/or alcohol treatment appointments to address their drug and or related offending.
If not a trigger offence, but a police inspector or higher rank has reasonable grounds for suspecting that the offence was linked to the use of heroin, cocaine or crack cocaine, an individual will also be tested for drugs. Examples of "Inspector's Authority" drug testing include when there has been sexual and physical violence (particularly domestic abuse), anti-social behaviour, prostitution or possession of non-Class A drug offences.

[58] Drug Interventions Programmes are described as a key part of the national Drug Strategy 2010 for tackling drugs and reducing crime (see glossary)

To ensure effective working relationships, Havering Council has commissioned the drug and alcohol treatment provider to locate a specialist substance misuse worker within Romford police station.

The target for Testing on arrest where there is a trigger offence is 95%. The local target for tests under Inspector's Authority is 15 per month. The Police have been working on achieving both targets and in January 2016, Testing on arrest target was being met, and 16 Inspector Authority tests were carried out. It is important that these are maintained, in order to ensure more people with problems are directed into treatment.

- **Court Worker Role**

The Council, together with Barking and Dagenham Council, jointly funds the drug and alcohol treatment service to locate a worker in Romford County Court. The Court Worker plays a key role in working with people who have been charged to appear at court and who have been identified as having problems with drugs or alcohol. They offer support on the day of the appearance, can advocate on behalf of clients involved with the community service and can help draw up an appropriate care plan to meet the individual's needs after court, including escorting people directly from court to local services.

- **Conditional Cautioning**

A Conditional Caution is aimed at 18 year olds and over, cases where the public interest would be met more effectively by the offender carrying out specific conditions rather than being prosecuted. Failure to comply with any condition(s) may result in the offender being charged with the original offence. The conditions must be rehabilitative (to address an offender's behaviour) or reparative (make good for the effects of the offence on the victim or the community) in nature. Restrictive conditions may be attached but only alongside a reparative or rehabilitative condition. All conditions must be proportionate, appropriate and achievable. This approach is used before their substance misuse and offending is escalated to more punitive approaches.

- **Restriction on Bail**

Individuals who have tested positive on arrest or have been charged for specified Class A drugs may be bailed with certain restrictions, provided they meet certain conditions. These include defendants agreeing to an assessment of their drug use and, where appropriate, to participate in any follow-up recommended by the assessor. If they refuse, the normal presumption for bail is reversed and the court will not grant bail unless satisfied that there is no significant risk that defendants will not offend whilst on bail.

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- **Community Sentencing**

Community sentencing was introduced as an option in 2005, as one of the provisions of the Criminal Justice Act and can include Mental Health Treatment Requirement; Drug Rehabilitation Requirement (DRR), Alcohol Treatment Requirement (ATR).

DRR can be used for low, medium and high sentencing bands and comprise structured treatment and regular drug testing. ATR should primarily be structured treatment consisting of community-based, care-planned treatment and may include psychosocial therapies and support, interventions for alcohol withdrawal, detoxification and cognitive=based treatment to address alcohol misuse.

There is a need for all parts of the criminal justice system and drug treatment services to have well established processes to ensure the effectiveness of community sentencing. Probation services have a key role to play in making recommendations to the Courts for these sentences. Local data indicates that more people should be subject to these community sentences, and that there should be a strengthening of local arrangements.

- **Offender health**

Helping offenders to recover from addiction and illness can significantly reduce reoffending and cut crime in local areas.

Where there is a custodial sentence, meeting the health needs of prisoners is the responsibility of NHS England. Prisoners should receive the same treatment in prison as the rest of the population, and specialist support if they have drug and alcohol problems. However, it has been recognised that there can be a breakdown in treatment and provision of healthcare when a prisoner is released back into the community, particularly if the ex-offender has no fixed place of address which has proved to be a barrier to GP registration. It is essential that this is addressed. In 2015 a project was initiated, led by NHS England to allow ex-offenders with no fixed address to register for primary care by giving their probation office as a proxy place of residence. This should be implemented in Havering in order that ex-offenders are able to access mental health and other services.

Post arrest and being charged for an offence, the courts have the powers to sentence substance misusing offenders to community sentences. These sentencing powers are used to steer substance misusers into compulsory treatment. The Havering Community Safety and Development Team and Public Health works closely in partnership with London Probation and the Community Rehabilitation Communities (CRC) and WDP to manage offenders, co-ordinate treatment and monitor outcomes that measure the success rate of people remaining in recovery from substance misuse and not re-offending.

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(c) Detection, licensing, town centre management

- **Detection of illicit drugs**

The Council Community Safety and Development Team and the MPS both routinely carry out unannounced swabbing of licensed premises and other locations such as colleges, leisure facilities and shopping centres, to detect the presence of drugs. The information provides intelligence in order that those businesses and organisations can address the problem. In terms of licensed premises, where licensees appear not to be taking action to stop the use of drugs, this could lead to their license being reviewed and the potential for the license to be withdrawn.

Havering's resources can be used more effectively and efficiently when there is information available that supports a targeted approach. The public should be encouraged to report any observations of supply and or use of illicit drugs, by phoning the MPS. Information is shared between key partners, and appropriate enforcement action can be taken by the Police.

The Council Trading Standards team web pages should facilitate easier reporting of underage sales, and the drug treatment providers will promote to the local population how to use the Council webpages to make such reports (including through their schools-based work).
Council frontline operatives who carry out cleansing, waste collection, grounds maintenance, street scene enforcement, parking enforcement and highways inspections, have a wealth of knowledge about what activity happens in their local environment. As the "eyes and ears" of the Council, these services are well placed to capture intelligence about areas that have high quantities of alcohol related litter, drug paraphernalia and other types of waste that indicate drug use. This should be passed on to Community Safety and the Police to inform more targeted interventions.

As part of the Council's transformation programme a review of public realm activity has been commissioned to standardise and consolidate delivery of services across the borough. The review will also address the need to invest in the latest mobile technology to enable front line staff to capture real time data and intelligence, such as information about alcohol and drug-related litter. Such real time intelligence will help those Council staff and agencies who carry out enforcement, safety and health functions, to effectively target their resources. Training should be provided to frontline operatives to recognise what is drug litter.

- **Licensing**

Licensing is a key tool for managing the local economy to prevent harm caused to communities, families and individuals through irresponsible sales of alcohol. Premises wishing to sell alcohol must be granted a licence from the local authority. Applications to

sell or vary a licence to sell alcohol are considered by “Responsible Authorities”: police, fire service, local planning, environmental health, the Director of Public Health and bodies responsible for protection children from harm. Any of the responsible authorities can make a representation to refuse a licence, where they consider that the license may not meet licensing objectives. Where representations are received relating to the licensing objectives for an application, there must be a hearing at which the committee can grant or reject the licence. Council Licensing Officers regularly work outside of office hours to check that premises are complying with their licences and to gain compliance with the legislation, and regular Responsible Authority meetings are held where current applications and premises of concern are discussed, with the aim being to target resources at the premises which most need it.

Havering currently has two special policy areas in the Statement of Licensing Policy; for Romford (within the ring road) and St Andrews ward in Hornchurch. In these two special policy areas, there is a presumption that new applications or variations will be refused unless they do not affect the licensing objectives.

- **Town Centres**

There are seven town centres in Havering, providing shops, with Romford, Hornchurch and Upminster in particular offering a range of shops, restaurants and social opportunities.

Romford has a vibrant nightlife scene, with a range of restaurants, pubs, bars and clubs which are popular with Havering residents and visitors. They provide employment and contribute to the local economy. It is important to the businesses concerned, the Council, Police and partner agencies that people can enjoy their visits to Romford town centre, whilst remaining safe.

Civil Banning Orders have been used in Havering by the Safe and Sound Partnership, comprising Police, Council services, licensees and voluntary organisations to create a safer local environment. Individuals who are arrested in Romford Town Centre are issued with a banning order, which prohibits them from entering any of the premises that are part of the Safe and Sound Scheme. This civil banning scheme is commonly referred to as the “Banned from one, banned from all” programme and formalises the sharing of information between LBH Community Safety, the Police and those Licensees who are part of the Scheme. The Scheme addresses anti-social behaviour including where this is fuelled by alcohol abuse, and is one aspect of an armoury of measures to restrict supply, use and circulation of drugs. Many premises have purchased Scan Net, a system that checks numerous amounts of photographic identification for inconsistences, which works well with people trying to use fake identification, and also supports Community Safety to capture centrally details of those who have been banned from the town centre.

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Many licensed premises in Romford and Hornchurch are equipped with a drug safe which is used to lock away seized substances. The packages of substances are "posted" into the safe, which can only be opened by the Police.

Currently Romford Town Centre is a no-street-drinking zone. Following the introduction of the Antisocial Behaviour Crime and Policing Act 2014, the Havering Community Safety Partnership will consult with local residents to move towards a Public Space Protection Order, which will strengthen enforcement for both alcohol and drugs misuse within the Town Centre. This will also address the misuse of legal highs and nitrous oxide, which have been included as the prohibitions set out under the draft proposals (2015-16).

Statutory and voluntary agencies work together on a range of projects that help to keep people safe in Romford town centre. The Taxi Marshalling Scheme, Street Pastors, Deeper Lounge, and Street Triage are all important initiatives.

Education and training is also provided to licensees, including welfare training and drugs itemising.

Challenge 21 and Challenge 25 are part of a scheme introduced with the intention of preventing young people gaining access to age restricted products including cigarettes and alcohol. Under the scheme, customers attempting to buy age-restricted products are asked to prove their age if in the retailer's opinion they look under 19, 21 or 25, even though the minimum age to buy alcohol and cigarettes in the UK is 18. Many licensed premises in Havering have the operation of a Challenge 21 or 25 as a condition of their licence and it is encouraged as part of the Statement of Licensing Policy. Trading Standards run occasional responsible retailer courses to educate business owners on their responsibilities regarding age restricted sales and to give advice on good practice.

(d) Illegal sales

- **Illicit alcohol**

During the period 2005 to 2011, HM Revenue and Customs seized nearly 15 million litres of illegally produced alcohol. Although most consumers are unlikely to be sold fake alcohol, it is important that people know how to spot and avoid fake alcohol, as these can have serious effects on health. Fake alcohol can contain cleaning fluids, nail polish remover and screen wash, as well as substances like methanol and isopropanol, which are used in antifreeze. Drinking alcohol containing these chemicals can cause nausea and vomiting, abdominal pain, drowsiness and dizziness, and can lead to kidney or liver problems, coma, and in the case of methanol, permanent blindness. Council Trading Standards officers carry out operations with other enforcement colleagues to target premises where information has been received that

non duty paid alcohol may be sold. In 2015/16 they took part in a London wide sampling project to look for counterfeit vodka.

- **Under age sales of alcohol**

Trading Standards provides advice to licensees and retailers about complying with legislation, including to the catering trade in identifying and avoiding the likelihood of sales of nitrous oxide for non-food purposes, especially to young people. Under-age test purchasing on restricted products, such as solvents and aerosols[59]. Young volunteers from the borough are trained to undertake test purchases. Trading Standards relies on the support of the public in order to understand where there are concerns about under age sales. In order to increase awareness and involvement of the public, Trading Standards should make it simpler and easier for the public to report any concerns.

- **Sales of nitrous oxide for non-food purposes**

Nitrous oxide is used as a food additive, and most commonly as an aerosol to produce whipped cream. The use of nitrous oxide is not in itself illegal, but it is illegal to sell to anyone under 18 if it is believed that they are going to inhale it. When inhaled, nitrous oxide can cause feelings of euphoria, dizziness and hallucinations and is becoming popular in bars and nightclubs as a 'party drug'. Home Office Statistics for the 2012-13 Crime Survey showed that 6.1% of 16-24 year olds had taken nitrous oxide in the last year, and 2% of adults aged 16-59[60]. Just recently Council Streetcare has reported a visible presence of cannisters and balloons being collected with street litter.

The Psychoactive Substances Act 2016 received Royal Assent on 28 January and will have implications for a number of Council Services and partner agencies going forward. Guidance is awaited on the implementation of the Act for local authorities (February 2016). The 2016/17 action plan should be updated, once guidance is made available.

- **E-cigarettes (cannabis flavouring)**

It has been observed that some e-cigarettes are being sold with cannabis flavouring. It is not yet known whether this is indeed cannabis itself. Trading Standards and Community Safety are keeping a watching brief on this issue, and should undertake testing of these products.

(e) Wider action to prevent harm

Whilst much effective action can be taken locally to reduce the harm caused by drugs and alcohol, regional, national and international actions all play a major part in prevention. This includes addressing the smuggling of drugs and illegal alcohol, setting legislation and policy,

[59] Other restricted sale products include under 18 DVDs, tobacco, knives, and alcohol.
[60] Home Office (2013)

and managing national databases for surveillance of harms caused by drugs and alcohol, for example. Following are some examples of national/regional

- **Minimum Unit Pricing**

The most effective way to reduce harm caused by alcohol is to control price and availability. Minimum pricing would mean that there is a baseline price for alcohol, below which it could not be sold. This would primarily affect high strength alcohol drinks that are currently sold very cheaply, and which are those most often consumed by the heaviest drinkers, as well as by younger drinkers. Moderate drinkers would feel little effect from minimum pricing.

The government considered bringing in a minimum alcohol unit price in 2012, but rejected the policy in July 2013. Since then the body of evidence has grown which shows that there is a clear link between the price of alcohol and the level of alcohol-related harm. The Council and partners should explore how minimum unit pricing might be pursued, including through the Devolution agenda.

- **The Responsibility Deal Alcohol Network**

In 2011, the Department of Health brought together government, businesses, charities and other organisations to help improve the health and wellbeing of the nation. Since then, UK drink producers have delivered a series of pledges to improve labelling, cut units, fund alcohol education and support community schemes to tackle alcohol harm. In July 2014, the Network updated its pledges, which includes financial support for organisations such as Drinkaware, and promoting awareness of alcohol among retailers and licensed premises.

- **Advertising**

UK alcohol advertising rules are based on evidence that points to a link between alcohol advertising and people's awareness and attitudes to drinking. The rules, which apply across all media, are mandatory and place a particular emphasis on protecting young people. Alcohol advertising must not be directed at people under 18, or contain anything that is likely to appeal to them by reflecting youth culture or by linking alcohol with irresponsible behaviour, social success or sexual attractiveness. The rules are applied by the Advertising Standards Authority, which is funding by a levy on advertising spend. The Authority is independent of Government, but the advertising codes are underpinned by consumer protection UK and EU law.

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Governance

To be agreed

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Burglary Strategic Problem Profile 2015
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APPENDIX 1: CONTRIBUTORS

The multi-agency steering group that produced this strategy would like to thank those who gave their time and expertise to the development of this strategy. These include the many representatives from local agencies, as well as service users who attended workshops in 2015 (table 1 below). Also those who contributed and commented on working drafts of the strategy including LBH Heads of Service, CCG, CCG Medicines Management, WDP Havering, NELFT, BHRUT Infection Control, and LBH Policy and Equality Advisor.

NAME	ORGANISATION	15/07/2015	4/09/15
Patricia Riley, Practice Improvement Lead	Havering Clinical Commissioning Group	✓	✓
Syed Rahman, Senior Public Health Analyst	LBH Public Health Service		✓
Elaine Greenway, Acting Consultant Public Health	LBH Public Health Service	✓	✓
Sharifa Motala, Commissioner	LBH Early Years	✓	
Trudi Penman, Licensing & Health & Safety Manager	LBH Licensing	✓	✓
Helen Morris, Team Manager	LBH Children's Centre		✓
Ogo Okoye Interim Senior Public Health Strategist	LBH Public Health Service		✓
NELFT Service Users	NELFT		✓
Claire Alp Health Improvement Specialist	LBH Public Health Service		✓
Monica Abdala	Havering Street Pastors		✓
Lynn Hunt	Havering Street Pastors		✓
Natalia Gomez Pharmacist	North East London Local Pharmaceutical Committee	✓	
Diane Egan, Community Safety Team Leader	LBH Community Safety	✓	
Rachel Palethorpe Implementation Manager	WDP	✓	✓
Denise Brown Enforcement Officer	LBH Street Care		✓
PC Kerry Newby	Metropolitan Police Service		✓
Danielle Greatrex	Romford Town Centre Team Family Mosaic		✓
Kim Smith Senior Community Engagement Officer	LBH		✓
Gary Bradshaw Service Manager	BHRUT Sexual Health Services		✓
Alice Peatling LSCB Business Manager	LBH Children's Services		✓
Iain Agar Analyst	LBH Community Safety	✓	

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Jonathan Taylor	LBH Youth Offending	✓	
Jonathon McDonnel Area Manager	CYP Addaction		✓
Marion King Midwife Lead – Substance misuse & mental	BHRUT Maternity Services		✓
Michelle Hammond Senior Fair Trading Officer	LBH Trading Standards		✓
Daren Mulley Commissioning Manager	LBH Public Health Service		✓
Trevor Meers Emergency Planning Officer	LBH Regulatory Service		✓
Ravi Nischal Alcohol Team Leader	CRI		✓
Kim Merry CEO	Across Havering Home 4 Havering		✓
David Perceval-Broadfield Team Leader	Young Addaction	✓	✓
Edward Akiode Probation Officer	Community Rehabilitation Company	✓	
Liza Bacon Police Sergeant	Metropolitan Police Service - Policy	✓	
Anita Grant-Williams Head of Barking & Dagenham, Havering and Newham and Safeguarding Children	Probation Service	✓	
Michelle Brown Commissioner	LBH Adult Services	✓	
Susan Milner Interim Director of Public Health	LBH Public Health	✓	
Yvonne Powell Substance Misuse Lead	LBH Community Safety	✓	
Belinda Rooney Police Licencing Officer	Metropolitan Police Service	✓	
Sasha Taylor Under Age Sales	LBH Environmental Health Licensing	✓	
Paul Kooner Consultant Hepatologist	BHRUT	✓	
Alex Rubens Locum Alcohol Specialist	BHRUT	✓	
Ann-Marie Gruero Services Manager	CRI	✓	
Andrea Pender Floating Support Manager	Family Mosaic	✓	
Alan Moss Youth Worker	Deeper Lounge	✓	
Olu Adeniran Disability Employment Consultant	JCP	✓	
Ana Sengupta Work Experience	Havering Clinical Commissioning Group	✓	
Matt Williamson Manager	New Directions	✓	
Bernie Stokes Midwife	BHRUT	✓	

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APPENDIX 2: DRUG CLASSIFICATIONS

Class	Drugs	Penalty for Possession	Penalty for Supply and Production
A	Powder Cocaine Crack Cocaine Ecstasy (MDMA) LSD Magic Mushrooms Heroin Methadone Methamphetamine (Crystal meth)	Up to 7 years in prison, an unlimited fine, or both.	Up to life in prison, an unlimited fine, or both.
B	Amphetamines Barbiturates Cannabis Codeine Ketamine Methylphenidate (Ritalin) Synthetic cannabinoids Synthetic cathinones (e.g. Mephedrone (a New Psychoactive Substance NSP) or methoxetamine)	Up to 5 years in prison, an unlimited fine, or both. Police can issue a warning or an on-the-spot fine of £90 if you're found with cannabis.	Up to 14 years in prison, an unlimited fine, or both.
C	Anabolic Steroids Benzodiazepines (Diazepam) Benzylpiperazine (BZP) Gamma-Hydroxybutyric Acid (GHB) Gamma-Butyrolactone (GBL)	Up to 2 years in prison, an unlimited fine, or both (except anabolic steroids – it's not an offence to possess them for personal use).	Up to 14 years in prison, an unlimited fine, or both.
Temporary Class Drugs*	NBOMe ("N-bombs") and Benzofuran compounds	None, but the police can take away a suspected temporary class drug	Up to 14 years in prison, an unlimited fine, or both.

*The government can ban new drugs for 1 year under a 'temporary banning order' while deciding how the drugs should be classified

APPENDIX 3: GUIDELINES FOR ALCOHOL CONSUMPTION

New guidelines for alcohol consumption have been produced by the UK Chief Medical Officers, warn that drinking any level of alcohol increases the risk of a range of cancers. This is supported by a new review from the Committee on Carcinogenicity (CoC) on alcohol and cancer risk .

It is now known that the risks start from any level of regular drinking and increase with the amount being drunk, and the new guidelines are aimed at keeping the risk of mortality from cancers or other diseases low. The links between alcohol and cancer were not fully understood in the original guidelines, which came out in 1995.

This review also found that the benefits of alcohol for heart health only apply for women aged 55 and over. The greatest benefit is seen when these women limit their intake to around 5 units a week, the equivalent of around 2 standard glasses of wine. The group concluded that there is no justification for drinking for health reasons.

These issues prompted changes to alcohol guidelines for men. Men should not drink more than 14 units of alcohol each week, the same level as for women. This equals 6 pints of average strength beer a week, which would mean a low risk of illnesses such as liver disease or cancer. The previous guidelines were 21 units for men and 14 units for women per week.

An additional recommendation is not to ‘save up’ the 14 units for 1 or 2 days, but to spread them over 3 or more days. People who have 1 or 2 heavy drinking sessions each week increase the risk of death from long term illnesses, accidents and injuries. A good way to reduce alcohol intake is to have several alcohol free days a week.

The guidelines for pregnant women have also been updated to clarify that no level of alcohol is safe to drink in pregnancy. The previous advice for pregnant women to limit themselves to no more than 1 to 2 units of alcohol once or twice per week has been removed to provide greater clarity as a precaution.

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APPENDIX 4: SAFEGUARDING CONSIDERATIONS WHERE DRUGS AND ALCOHOL ARE A FACTOR

Safeguarding children, young people and vulnerable adults is a statutory responsibility held by local authorities, which needs to be addressed adequately within the quality governance arrangements for alcohol and drug treatment provision. From April 2015, the Care Act (2015) put adult safeguarding on a legal footing, and requires local authorities to work in partnership with the police and the NHS to take action if they suspect an adult with care and support needs is experiencing abuse or neglect. The proper storage, prescription and administration of controlled drugs are also priorities requiring specific attention within quality governance arrangements.

Local authorities are required to have effective quality governance arrangements in place for services that are commissioned using the public health grant. Safeguarding responsibilities, in relation to children and vulnerable adults, need to be recognised within these arrangements.

The risk to children may result from:

- Substance misuse affecting their parents' practical caring skills: perceptions, attention to basic physical needs and supervision which may place the child in danger
- Substance misuse may also affect control of emotion, judgement and quality of attachment to, or separation from, the child;
- Parents experiencing mental states or behaviour that put children at risk of injury, psychological distress (e.g. absence of consistent emotional and physical availability), inappropriate sexual and / or aggressive behaviour, or neglect (e.g. no stability and routine, lack of medical treatment or irregular school attendance);
- Children are particularly vulnerable when parents are withdrawing from drugs;
- The risk is also greater where there is evidence of mental ill health, domestic violence and when both parents are misusing substances;
- There being reduced money available to the household to meet basic needs (e.g. inadequate food, heat and clothing, problems with paying rent [that may lead to household instability and mobility of the family from one temporary home to another]);
- Exposing children to unsuitable friends, customers or dealers;
- Normalising substance use and offending behaviour, including children being introduced to using substances themselves;
- Unsafe storage of injecting equipment, drugs and alcohol (e.g. methadone stored in a fridge or in an infant feeding bottle)
- Where a child has been exposed to contaminated needles and syringes;
- Children having caring responsibilities inappropriate to their years placed upon them
- Parents becoming involved in criminal activities, and children at possible risk of separation (e.g. parents receiving custodial sentences);
- Children experiencing loss and bereavement associated with parental ill health and death, parents attending inpatient hospital treatment and rehab programmes;
- Children being socially isolated (e.g. impact on friendships), and at risk of increased social exclusion (e.g. living in a drug using community);
- Children may be in danger if they are a passenger in a car whilst a drug / alcohol misusing carer is driving

APPENDIX 5:: SUBSTANCE MISUSE AND INDIVIDUAL HEALTH

Harms caused by substance misuse can have both acute (short term) and chronic (long term) effects. This appendix offers a brief overview of such health harms. For an overall presentation of acute and chronic harm see the National Treatment Agency for Substance Misuse publication *A summary of the health harms of drugs.*

Alcohol

The average human body is able to process approximately one unit of alcohol an hour. So if someone drinks excessively in a short space of time, the amount of alcohol in the blood can stop the body from working properly. It can slow down brain functions, irritate the stomach which causes vomiting and stop the gag reflex from working properly (resulting in choking), affect the nerves that control breathing and heartbeat (and can stop both), cause dehydration leading to permanent brain damage, and lower the body temperature which can lead to hypothermia.

Alcohol poisoning

Acute alcohol poisoning can be extremely dangerous, and in England in 2012/13, more than 33,870 people were admitted to hospital because of the toxic effects of alcohol, and 360 people died from alcohol poisoning in 2011[61]. Binge drinking is often the cause of alcohol poisoning. Factors that play a part include the person's age, sex, size, weight, how fast they have been drinking, how much they have eaten, general health and other drugs that might have been taken.

Mixing alcohol and energy drinks

Mixing alcohol with energy drinks can be a dangerous combination. Energy drinks can mask the effect of alcohol and lead to under-estimation of the amount of alcohol consumed. Mixing alcohol and energy drinks leads to higher consumption of sugar, calories, and caffeine than drinking alcohol by itself, and the possibility of increased physical and psychological side effects.

Fertility

Alcohol affects reproduction in both men and women. The more someone drinks, the greater the effect it can have on both male and female fertility. Drinking in late teens and early twenties can affect fertility in later life.

Alcohol and cancer

Regular alcohol consumption increases the risk of seven types of cancer; liver, bowel, breast, mouth, pharyngeal, oesophageal and laryngeal. Smoking and drinking together greatly increases the risk of developing throat and mouth cancer than either does on their

[61] https://www.drinkaware.co.uk/check-the-facts/health-effects-of-alcohol/effects-on-the-body/alcohol-poisoning (accessed Sept 15)

own as, when someone drinks alcohol, it is easier for the mouth and throat to absorb the chemicals in tobacco that cause cancer.

Alcohol, overweight and obesity

Alcohol can also contribute to overweight and obesity, partly because alcohol is high in sugar and thus high in calories[62], and partly because alcohol consumption can increase appetite and thus increase food intake.

Drug abuse

Even in moderate doses, most drugs affect bodily control and the ability to maintain attention; effects that can last for several hours. No matter how the person feels, they may not be as capable as they were before and so driving, operating machinery and even crossing the road becomes more dangerous, both for the individual and those around them. Harm to individual health as a result of drug abuse can include overdose and drug-related death. Other harms include the spread of blood-borne viruses via injecting or sexual activity, which affects long-term health.

Substance misuse and mental health

The causes and drivers of drug and alcohol dependence are complex, and people who have poor mental health have a higher risk of substance misuse. In Britain, people who experience anxiety or depression are twice as likely to be heavy or problem drinkers. For some people, the anxiety of depression came first and alcohol has been used in an attempt to relieve it; for others, drinking came first, so may be the root cause of their anxieties. Drinking above the recommended levels of alcohol also increases the risk of dementia.

Alcohol alters the chemistry of the brain and is a depressant. This means it can disrupt thoughts, feelings and actions, and sometimes long-term mental health. The relaxed feeling from a first drink is due to the chemical changes in the brain. A drink can help someone to feel more confident and less anxious, because it depresses the part of the brain associated with inhibition. But as someone drinks more, more of the brain starts to be affected, and when high levels of alcohol are involved, instead of pleasurable effects increasing, it is possible that a negative emotional response takes over, leading to anger, aggression, anxiety or depression. Regular drinking lowers the levels of serotonin in the brain, which is a chemical that helps to regulate mood.

Mixing drugs and alcohol

The effects of illegal drugs will always be unpredictable, but, generally when mixed with alcohol, the effect will be exaggerated and result in anything from nausea to heart failure. When under the influence of drugs, someone is less likely to make considered decisions

[62] contain almost as many calories as pure fat

about alcohol, thus there is greater risk of alcohol poisoning and longer-term health problems.

The combined effect of taking alcohol and cocaine together creates a third compound in the body, coca-ethylene, which poses even greater physical and psychiatric risks. These include greater risk of heart attack, liver toxicity, respiratory problems, stroke, psychiatric problems, spontaneous abortion and birth defects. There are also serious psychiatric effects[63]

Substance misuse in pregnancy

During pregnancy most drugs that are taken (including tobacco and alcohol) pass through the placenta and are absorbed by the baby. If a mother is dependent to certain drugs the baby will be born dependent on these too and can develop Neonatal Abstinence Syndrome. This is a condition where the baby shows signs and symptoms of withdrawal. It occurs often when opiate and benzodiazepine drugs are used. At birth, the baby's drug supply stops and the baby goes through a period of withdrawal, with symptoms that can be similar to how adults feel when they suddenly stop taking drugs or go 'cold turkey'.

Drinking during pregnancy can have serious consequences on the baby's growth and development. The more that a woman drinks when pregnant, the greater the risk to the unborn child; resulting in miscarriage, stillbirth, premature birth and small birth weight.

The guidelines for pregnant women were updated in 2016 to clarify that no level of alcohol is safe to drink in pregnancy. Although the risk of harm to the baby is low if women have drunk small amounts of alcohol before becoming aware of the pregnancy, there is no "safe" level of alcohol drink when pregnant, and excessive drinking can lead to children being affected by foetal alcohol syndrome, which is a condition that can result in learning disabilities, poor academic achievement, poor organisation, and attention and hyperactivity problems.

Havering maternity services advise women to abstain from alcohol during pregnancy, but according to Drinkaware, the national charity for reducing alcohol misuse and harm in the UK, many women are not aware that they should avoid alcohol altogether when they are trying to conceive, or what is the advice about drinking alcohol during breastfeeding.

Stakeholders identified that more must be done in Havering to promote messages about the harms of drinking when planning a pregnancy, during pregnancy and when breastfeeding.

New Psychoactive Substances

Recently the use of new psychoactive substances, more commonly known as "legal highs", have been featuring in the headlines. Whilst there seems to be a perception that the use of

[63] Cocaine and Alcohol: The hidden mixer. Alex Meikle. Glasgow Council on Alcohol. October 2006

such drugs is widespread, there are no reliable statistics that help to understand how many people are using them. It is suspected in some quarters that the reduction in use of illegal drugs has, in fact, been supplanted by "legal highs" and that the UK has a drug scene "in transition" rather than a genuine decline. Although described as "legal", new psychoactive substances are predominantly untested for human consumption, and can carry serious health risks. They canot be labelled as being for human consumption, and so are often marketed as plant food, bath salts or incense. Even though the substances may be legal to possess, this does not mean that the drugs are safe, and legal highs can carry serious health risks, including paranoia, coma, seizures and can also lead to death.

The threat to health of new psychoactive substances has become a particular concern in recent years, with supply and demand increasing. These substances are available over the internet and in "head shops"[64] The recent deaths of young people associated with use of legal highs has generated nationwide interest with one London Borough banning the use of legal highs such as "laughing gas".

Intravenous steroids

Anabolic steroids are prescription-only medicines that are sometimes taken illegally to increase muscle mass and improve athletic performance. If used in this way, they can cause serious side effects and dependency. Anabolic steroids are manufactured drugs that mimic the effects of the male hormone testosterone. They have limited medical uses and are not to be confused with corticosteroids, a different type of steroid drug that's commonly prescribed for a variety of conditions. Use of intravenous steroids carries a range of side effects. If anabolic steroids are misused by adolescents, they can cause premature ageing of the bones as well as restricted growth.

Prescription-only and over the counter medicine

Problematic use of prescription-only and over the counter medicine can manifest in the following ways:

- an individual can be prescribed medication for a medication condition, and subsequently, and unintentionally, develop an addiction
- someone who is taking illegal drugs, can seek out prescription medication and use over the counter medication to supplement the effect of the illegal drug – or use as a commodity to sell
- to cope with genuine or perceived physical or psychological symptoms

The Royal College of General Practitioners has published fact sheets that focus on the medications that are most commonly associated with problematic use, which are:

- Opioids used to treat pain, such as tramadol, oxycodone and dihydrocodeine.
- Sedatives (or hypnotics) and anti-anxiety medications (anxiolytics), including benzodiazepines and Z-drugs (zaleplon, zolpidem and zopiclone).

[64] A head shop is a physical or online retail outlet that sells paraphernalia used for the consumption of substances such as cannabis, tobacco, and "legal highs", with products that include pipes, vaporizers, nitrus oxide chargers, rolling papers, rolling machines, cigarette lighters, etc. Many such shops also sell art, magazines, music, clothing or oddities.

- Stimulants, such as methylphenidate used to treat attention deficit hyperactivity disorder (ADHD) and certain sleep disorders.
- Anticonvulsants and mood stabilising drugs, such as gabapentin and pregabalin.

There are distinct but overlapping populations that use these drugs, and problems can occur for a range of reasons, thus different approaches may be needed.

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APPENDIX 6: SUBSTANCE TREATMENT AND RECOVERY SERVICES (ADULTS)

Havering JSNA Drug and Alcohol Chapter provides an overview of the services that are provided in Havering, including

- NHS Health Check
- Interventions and Brief Advice (IBA)
- Mutual aid and recovery
- Specialist drug and alcohol services for children and young people

Since publication of the JSNA Drug and Alcohol chapter, an integrated adult substance misuse treatment service has been commissioned (i.e. treatment and recovery for both drugs and alcohol). This appendix provides updated information on this newly commissioned service (since October 2015).

Routes into treatment and recovery services include self-referral, referral by a GP or another health or social care professional, as well as through the criminal justice system. WDP Havering, the provider of the Council-commissioned substance misuse treatment and recovery service since October 2015, incorporate the following key elements for successful identification and referral, and good treatment and recovery outcomes:

Access, engagement, early intervention and prevention which includes delivering training to the wider workforce, such as school nurses, social workers , GPs , pharmacists, the local hospital and the voluntary sector, in order that health promotion messages are consistent, and so that individuals who would benefit from treatment services are recognised and referred/signposted . This helps to improve early intervention and prevention, as well as ensuring that the people who need treatment and support access the right service at the right time.

Specialist treatment can be provided in the community so people are able to stay in their own homes and access local treatment services, or in a residential setting. Residential treatment is intensive and costly, but necessary for some clients. As part of the treatment (in any setting), individuals may be prescribed medication. At the same time, they will have access to therapeutic support and counselling that also addresses their wider health and wellbeing needs.

Recovery, reintegration and relapse prevention, including support for people who have moved from intensive treatment to a stage of recovery. This is a key part of the programme; to ensure that people do not relapse.

New evidence-based and innovative tools to aid and maintain recovery have been introduced, including technological solutions. These include e-Groups, forums and blogs, a

single point of contact telephone line open 24 hours per day, 7 days per week, an SMS service, internet-based recovery programme (called Breaking Free), Skype and telephone interventions, smart phone apps, and a loyalty scheme to gain rewards such as cinema tickets or a fitness class.

At treatment completion the service user will continue to access interventions that will enable them to remain alcohol free and continue to recover. WDP Havering is working with partners in education, training and employment and with mutual aid groups and programmes to support and sustain recovery. Even after discharge, individuals will be able to access support at any time to prevent relapse

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APPENDIX 7: GLOSSARY

Alcohol Liaison Nurse, working for WDP Havering, is sited in Queen's Hospital, works with staff to identify the individuals that need help, including those that need high level services such as detoxification.

Alcohol Treatment Requirements
See Community Orders

Barking Havering Redbridge University Trust (BHRUT)
Provider of acute health services, including maternity care. Located at Queens Hospital (Romford), and King Georges Hospital (Goodmayes)

Blood-borne viruses (BBV)
Infections such as Hepatitis A, Hepatitis B and Hepatitis C, and HIV that are carried in the blood and can be spread either by sharing of infected needles, syringes and other injecting equipment, or by sexual contact.

Booze Buster is a free smart tool that provides tips and support to help individuals to "choose less booze".

Challenge 21 and Challenge 25
Challenge 25 is a scheme that encourages anyone who is over 18 but looks under 25 to carry acceptable ID when they want to buy alcohol. Challenge 25 builds on the Challenge 21 campaign introduced by the British Beer and Pub Association, which represents the beer and pub sector, in 2005. It's now run by the Retail of Alcohol Standards Group, which represents alcohol retailers (2016).

Civil Banning Orders
See Safe and Sound Partnership

Controlled Drugs Accountable Officer
The officer ensure compliance with the Controlled Drugs (Supervision of Management and Use) Regulations 2013. Organisations that must appoint an accountable officer include NHS Trusts, Independent hospitals, NHS England Local Area Teams, and the Armed Forces. The accountable officer's details must be registered with the Care Quality Commission.

County Lines
This is where gangs from big cities introduce a telephone number in a new area to sell drugs directly at street level. Phone lines represent a gang's "brand", rather than an individual. The numbers do no change frequently, and are usually run from the gang's "home" city. Drug users from the new area ring the number and local runners are then dispatched to may deliveries via a telephone "relay or exchange system" According to the National Crime Agency, this is increasingly exploiting children (often boys aged 14-17) to act as runners and to conduct day to day dealing.

DANOS

The Drugs and Alcohol National Occupational Standards (DANOS) specify the standards of performance/ competencies that people in the Drug and Alcohol field should be working to. They also describe the knowledge and skills needed to meet those standards

Deeper Lounge

The Deeper Lounge[65] initiative is located in South Street, in central Romford, and provides a safe haven for young people who have had too much alcohol. The Deeper Lounge provides hot and cold drinks and a safe place to recover. It is run by volunteers from local churches, and runs in partnership with the Street Pastor scheme above. Street Pastors and the Deeper Lounge also work closely with licensees, door supervisors and the police to keep young people in Havering safe.

Drug Interventions Programme (DIP)

Interventions for drug-misusing offenders throughout their criminal justice journey. DIP grips people as early as possible in their contact with the criminal justice system, from initial drug testing and assessment in the custody suite, right through to post-release care and management in the community.

Drug Itemising

A method of educating licensees about where people are taking drugs in their premises.

Drug Rehabilitation Requirement (DRR)

Introduced by the Criminal Justice Act 2003, and is a condition which can be added to a Community or Suspended Sentence Order.

Drug safe

See Safe and Sound Partnership

Dual Diagnosis

When there are problems with both substance misuse and a serious mental illness.

Dry January is a national campaign that is run each year with online support. The evidence is that, once someone has cut out alcohol for one month, their drinking habits will change after the month is up, and they will consume less alcohol.

Havering's Early Help Service works to ensure that there is a prompt and effective response to the unmet needs of children and families in order to prevent problems growing and becoming even more difficult and costly to deal with in the future.

Havering's Multiagency Safeguarding Hub (MASH) is able to swiftly collate and share information that is held by the many organisations in Havering, and so enable decisions to be taken about the best type of intervention to keep children and adults safe. Sometimes this means a direct social care intervention, at other times this might mean a referral to a service such as the Early Help service, or some other preventative or family support service.

[65] See glossary

Healthy Schools London is a programme that supports schools to help children to lead a healthy lifestyle and make healthy choices. With three levels of award (bronze, silver and gold), the bronze level requires registered schools to have a drugs and alcohol policy in place and encourage inclusion of drugs and alcohol education in the Personal Social Health Education curriculum. By August 2015, two-thirds of schools in Havering were registered with the Healthy Schools scheme, which is co-ordinated by the Council's public health service.

IAPT (Improving Access to Psychological Therapies) is an NHS programme of "talking therapies" that was introduced as a result of the national strategy *No health without mental health.* It is primarily for people who have mild to moderate mental health difficulties, such as depression, anxiety, phobias and post traumatic stress disorder.

Junior Citizen Programme

A project that targets 2000 year 6 students as they are about to move onto secondary schools. The programme covers healthy eating, alcohol, drugs, legal highs, knife crime.

Licensing Objectives

Licensing objectives are:

- the prevention of crime and disorder
- public safety
- the prevention of public nuisance
- the protection of children from harm

The licensing objectives currently do not include consideration of health, as this is not permitted under current legislation.

Licensing Policy

The Local Authority acting as a the Licensing Authority must publish its Statement of Licencing Policy every 5 years which sets out how the Licensing Authority will approach applications for licences. Havering Council introduced a new Statement of Licensing Policy in January 2016 following consultation with stakeholders and the public. The Policy sets out requirements that applicants must consider. The Policy includes special policies on cumulative impact in the areas of Romford town centre, St. Andrews ward (Hornchurch) and Harold that presumes no new licences will be issued, except to restaurants (i.e. where alcohol is sold ancillary to a table meal).

Mental Health Partnership Board

Havering's mental health partnership board is a multiagency steering group whose purpose is to provide strategic leadership and develop and maintain high quality mental health services in Havering through a partnership approach. The Board has an oversight of all adult mental health services excluding dementia; reviews changes to local services; monitors service plans and receives information concerning all aspects of adult mental health services. Its strategic workstreams include:

- Mental Health Promotion
- Personalised care and support
- Employment, Education, Training and Social Inclusion
- Carers mental health

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- Accommodation and Housing
- Mental Health / Criminal Justice
- Benchmarking quality and effectiveness
- Self-harm and suicide prevention

No street drinking zone

Currently Romford Town Centre is a no-street-drinking zone. Following the introduction of the Antisocial Behaviour Crime and Policing Act 2014.

National Drug Treatment Monitoring System (NDTMS)

NDTMS captures data about structured drug and alcohol treatment - structured community-based services, or residential and inpatient services for those individuals whose substance use has become problematic

New Psychoactive Substances

A psychoactive substance is a chemical substance than when consumed (eaten, inhaled or administered in some way) causes changes in brain function and results in alterations in perception, mood or consciousness. Also known in the market as 'legal highs', 'designer drugs', 'herbal highs', 'bath salts', 'research chemicals', or 'laboratory reagents', they are now referred to under the term New Pscyhoactive Substance (NPS). The key features are that NPS are psychoactive (i.e. ones that stimulate or depress the central nervous system or cause a state of dependence); have a comparable level of potential harm to internationally controlled drugs; and are newly available, rather than newly invented.

NHS Health Checks

The NHS Health Check programme in Havering is commissioned by the Council's and delivered by GPs. The aim is prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the aged of 40 and 74 who has not been diagnosed with one of these conditions or with certain risk factors which have already been identified, will be invited once every five years to have a check to assess their risk of these diseases. Patients are then given support and advice to help them reduce or manage that risk, which includes advice about alcohol use

One You National Campaign

Due to be launched summer 2016 by Public Health England, this is a major national programme to energise and engage with adults in making changes to improve their own health. It will target adults in mid-life encouraging them to make seven lifestyle changes (stopping smoking, reducing alcohol consumption, taking more exercise, improving diet, reducing stress, improving sleep and checking for common signs and symptoms of disease.) By making these seven changes individuals vastly improve their chances of a longer more active fulfilled life.

Opiates

A group of drugs including heroin, opium, methadone and buprenorphine

Perinatal period

Commences at 22 completed weeks of pregnancy and ends seven completed days after birth.

Safe & Sound Partnership

Civil Banning Orders have been used in Havering by the Safe and Sound Partnership, comprising Police, Council services, licensees and voluntary organisations to create a safer local environment.

Individuals who are arrested in Romford Town Centre are issued with a banning order, which prohibits them from entering any of the premises that are part of the Safe and Sound Scheme. This civil banning scheme is commonly referred to as the "Banned from one, banned from all" programme and formalises the sharing of information between LBH Community Safety, the Police and those Licensees who are part of the Scheme. The Scheme addresses anti-social behaviour including where this is fuelled by alcohol abuse, and is one aspect of an armoury of measures to restrict supply, use and circulation of drugs

Many licensed premises in Romford and Hornchurch are equipped with a drug safe which is used to lock away seized substances. The packages of substances are "posted" into the safe, which can only be opened by the Police.

Scan Net

A system that scans photographic identification for inconsistencies, which works well with young people trying to use fake identification.

Statement of Licensing Policy

See Licensing Policy

Street Pastors

Street Pastors is a voluntary, inter-denominational church response to urban problems. This innovative scheme aims to help curb crime and anti-social behaviour. Led by a local co-ordinator, street pastors are trained volunteers that patrol Havering streets from 10pm to 4am on Friday and Saturday evenings. Street pastors work in Romford and Hornchurch town centres.

Street Triage

Delivered by St John's Ambulance, street triage operates on Friday and Saturday nights in Romford town centre between 10pm and 4am. The Street Triage team assesses people who may have need of medical treatment, and give advice and treatment as needed or refer onwards. This may include transfer to Accident and Emergency, signposting to services, or giving first aid treatment. The scheme is funded by MOPAC to March 2017.

Structured drug and alcohol treatment

Structured drug and alcohol treatment consists of a comprehensive package of concurrent or sequential specialist drug and alcohol focused interventions. It addresses multiple or more severe needs that would not be expected to respond, or have already not responded, to less intensive or non-specialist interventions alone. Structured treatment requires a comprehensive assessment of need, and is delivered according to a recovery care plan, which is regularly reviewed with the client.

The plan sets out clear goals which include change to substance use, and how other client needs will be addressed in one or more of the following domains: physical and psychological health; criminal involvement and offending; and social functioning.

All interventions must be delivered by appropriately trained and competent staff, within supervision and clinical governance structures. Structured drug and alcohol treatment provides integrated access to specialist medical assessment and intervention, and works jointly with mental & physical health services, and safeguarding & family support services according to need.

In addition to pharmacological and psychosocial interventions provided as part of the keyworking or case management function of structured treatment, service users should be provided with the following as appropriate: harm reduction advice and information; BBV screening and immunisation; advocacy; appropriate access and referral to healthcare and health monitoring; and crisis and risk management.

Tiers of Treatment

Substance misuse treatments, usually describes as a four-tier framework:
Tier 1: Non-substance misuse specific services requiring interface with drug and alcohol treatment services
Tier 2: Open access drug and alcohol treatment services
Tier 3 Structured community-based drug treatment services
Tier 4: Residential and inpatient services for drug and alcohol misusers

Taxi Marshalling Scheme

Romford's taxi marshal scheme is located in Eastern Road in central Romford. It operates on a Friday and Saturday night from 10.30pm until 3.30am. The scheme is funded by Transport for London and reduces alcohol-related violence in Romford Town Centre, and improves the safety of young people. It is planned for this scheme to continue in 2015-16.

Trigger offence

A trigger offence usually involves stealing, fraud or drugs

Welfare Training

Training to licensees provided by Council Licensing; encouraging licensees to use their existing staff (i.e. glass collectors) to do patrols around pubs and clubs and look for those who have had too much to drink – so that they are not served with any more alcohol and are looked after.

Young Persons Specialist Substance Misuse Service

A service for young people aged 11 to17 years and their families in the London Borough of Havering, through education, care planned psychosocial, harm reduction and early interventions. These interventions are aimed at prevention and alleviating current harm caused by a young person's substance misuse to themselves, their families and the communities in which they live. The service works with schools, the Youth Offending Team, and social care.

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KEY PERFORMANCE INDICATORS

To be agreed from indicators already available from:

- Public health
- Community Safety
- YOT
- MASH
- Adult Social Services
- Commissioners of Drug and Alcohol services
- Mental health services
- Healthy schools
- Trading Standards
- Public realm

Proposed:

- Months of life lost due to alcohol (male) (9 months – better than England, better than London)
- Months of life lost due to alcohol (female) (4.1 months - better than England, better than London)
- Admission episodes for alcohol-related CVD conditions (male) (worse than England, worse than Bexley)
- Alcohol related road traffic accidents
- Waiting times for drug treatment
- Waiting times for alcohol treatment
- Successful completion of treatment of opiate use – current performance 7.0% (currently 78 out of 149 local authorities)
- Successful completion of treatment for non-opiate use – current performance 46.1% (31 out of 149 LAs)
- Successful completion of treatment for alcohol – current performance 41.5% % (48 out of 149 LAs)
- Testing on Arrest – achieve 95%
- Alcohol Treatment Requirements – increase on 2015/16 baseline (annual)
- Drugs Rehabilitation Requirements – increase on 2015/16 baseline (annual)
- % of current foster carers having attended information sessions on substance misuse and CSE during the three years to end Mar 2017 (annual)
- % of Early Help home assessment visits attended by WDP Havering where substance misuse is, or is identified as likely to be, an issue (annual)
- % of recovery plans for parents by WDP that are shared with Early Help (annual)

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Objective 1: Preventing harm to the individual					
Project/ Action *What we will do to achieve it*	**Outcome** *How we will know we've achieved it*	**Resources** *What we need to be able to achieve it*	**Timescale**	**Lead Organisation (Officer/staff)**	**Impact on other services and organisations**
Specialist young people's substance misuse service recommissioned in 2016, in consultation with key partners; youth offending team, community safety, education services, public health service	Service commissioned: KPIs, service specification informed by key partners	Engagement by key partners; youth offending team, community safety, education services, public health service, equality impact advisor	Sept 2016	LBH Commissioner	
Substance misuse awareness sessions to be delivered to Looked After Children and their carers (inc foster carers and semi-independent placement providers) – including association with CSE	Foster carers more knowledgeable about substance misuse by young people	Young People's Substance Misuse Service commissioned	Ongoing	LBH Commissioner	
Identify young people (aged under 18) who are at a higher risk of harm caused through risky behaviours (inc drug and alcohol misuse) – including appropriate response such as referral to appropriate young people's substance misuse service.	Young people who are at higher risk to be referred by NELFT School Nursing Service Early Help Service Children's Social Care Schools	Young People's Substance Misuse Service commissioned LBH Commissioner to monitor contract on referral sources	Ongoing	NELFT School Nursing Service Early Help Service Children's Social Care Schools	
Healthy Schools programme to provide information drugs and alcohol to the whole school community including national campaigns and information about the effect of substances on the unborn child.	Information	Healthy Schools Co-ordinator recruited Engagement by schools	Ongoing	LBH (Healthy Schools Co-ordinator)	Dependent on decisions re funding /Traded Services status of Healthy Schools programme

Objective 1: Preventing harm to the individual					
Project/ Action *What we will do to achieve it*	**Outcome** *How we will know we've achieved it*	**Resources** *What we need to be able to achieve it*	**Timescale**	**Lead Organisation (Officer/staff)**	**Impact on other services and organisations**
Drug and alcohol service provider to support schools develop their drugs policy and deliver substance misuse awareness training o headteachers and wider school workforce .		Young People's Substance Misuse Service commissioned Healthy Schools Co-ordinator recruited Engagement by schools	Ongoing	LBH Commissioner LBH Healthy Schools Co-ordinator	
Drug and alcohol service provider to advise schools and parents how to report concerns about availability of drugs, and under age sales of alcohol and sales of "legal highs" (such as nitrous oxide)		Young People's Substance Misuse Service commissioned Healthy Schools Co-ordinator recruited Engagement by schools		LBH Commissioner LBH Healthy Schools Co-ordinator	
Information and factsheets about not drinking in pregnancy and during breastfeeding to be displayed in Children's Centres	Information and factsheets to be available in Children's Centres Frontline workers actively promoting messages.	LBH Officer Capacity (Children Centre frontline workers) LBH Frontline staff trained in IBA	Ongoing To be agreed: where resources /capacity allow	LBH Early Help, BHRUT maternity Services, NELFT health visiting and school nursing services	

Objective 1: Preventing harm to the individual					
Project/ Action *What we will do to achieve it*	**Outcome** *How we will know we've achieved it*	**Resources** *What we need to be able to achieve it*	**Timescale**	**Lead Organisation (Officer/staff)**	**Impact on other services and organisations**
Develop consistent messages and signpost parents to information that will support parents in their discussions with their children about drugs and alcohol	Key messaging for parents agreed by LBH Public Health Service and partners, and hosted by LBH website	LBH Officer Capacity (Public Health Service, Communications, Commissioner) Engagement by partner agencies	March 17	LBH Public Health	
Havering contraception service to advise women to abstain from alcohol when planning a pregnancy	Contraception service to display information about alcohol in pregnancy Service to deliver IBA to women considering pregnancy	Sexual health service commissioned.	Apr 16 and ongoing To be agreed: where resources allow	LBH Commissioner	BHRUT Joint Commissioners
Skills audit to be undertaken among health visitors and school nurse workforce on levels of skills for engaging with families on the topic of substance misuse, including safeguarding concerns relating to drugs and alcohol. Findings to be used to inform workforce development, including numbers to be trained on IBA.	Skills audit undertaken. Workforce development plan informed by results. Workforce trained in IBA.	Way forward to be agreed between service and commissioners	To be agreed: where resources allow	LBH Commissioner	LSCB Co-ordinator WDP Havering
Continue to advise pregnant women and new parents about risks of co-sleeping with an infant	Routine antenatal advice given Routine postnatal advice to parents by midwives, health visitors, Children's Centres.		Ongoing	BHR Maternity Services NELFT (Health visitors)	LBH Children's Centres
Deliver training to Pubs/clubs door staff on how to recognise fake ID	Businesses better trained to recognise fake ID	Capacity of Police Engagement by businesses	Ongoing	Metropolitan Police	LBH Licensing Officers

Objective 1: Preventing harm to the individual					
Project/ Action *What we will do to achieve it*	**Outcome** *How we will know we've achieved it*	**Resources** *What we need to be able to achieve it*	**Timescale**	**Lead Organisation (Officer/staff)**	**Impact on other services and organisations**
Deliver training to retailers and licensed trade on complying with legislation, inc sales of age-restricted products, and nitrous oxide for non-food purposes. Training to be uploaded to Council website.	Businesses better trained on legislation	Capacity of Licensing Engagement by businesses	Ongoing	LBH Licensing	
Information about drugs and alcohol, including where to report concerns, to be cascaded to voluntary organisations that provide activities to children and young people	Agreed information products for voluntary organisations	LBH Officer Capacity (Public Health Service, Trading Standards, Commissioner, Communications, Community Development)	To be agreed: where resources allow	LBH Public Health	
Sexual health services to (a) offer brief advice about alcohol to young people and adults where alcohol plays a part in risky sexual behaviour (b) deliver IBA and psychosexual counselling to MSM re Chemsex	Sexual health service performance against KPI	Sexual health service commissioned, and KPI agreed for IBA		LBH Commissioner	LBH Public Health Service to advise
Drug and alcohol treatment service to demonstrate to commissioner how advice and services are meeting the needs of LGBT, veterans, ethnic minorities, ex-offenders, those leaving care (including via mutual aid organisations).	Evidence of evidence-based programmes of work in place/planned by substance misuse treatment specialists that meet the needs of harder to reach groups	Engagement by mutual aid organisations, and by organisations	March 2017	LBH Commissioner	
WDP and NELFT Mental Health Services to develop an integrated approach to presentations at the acute hospital that involve mental health and substance misuse	Written protocols in place	Agreement of commissioners	Jul 16	CCG Mental Health Commissioner LBH Commissioner	BHRUT

Objective 1: Preventing harm to the individual					
Project/ Action *What we will do to achieve it*	**Outcome** *How we will know we've achieved it*	**Resources** *What we need to be able to achieve it*	**Timescale**	**Lead Organisation (Officer/staff)**	**Impact on other services and organisations**
Ensure the care pathway for women during the perinatal period meets the needs of women with substance misuse problems, including onward referral	Care pathway shared with maternity commissioner, mental health commissioner, substance misuse commissioner, Early Help service	Agreement of commissioners		CCG Maternity Commissioner WDP Havering/ LBH Commissioner	LBH Early Help Service Perinatal Steering Group
Understand how to provide better support to mutual aid groups and improve access and take up of mutual aid services. WDP Havering to scope needs of mutual aid groups and propose plan of action to commissioner	Proposals received by Commissioner	Proposals based on evidence base and consultation with mutual aid groups	Dec 16	LBH Commissioner	Mutual Aid organisations LBH Community Development
CCG and adult social care to plan for the needs of older adults who are long-term users of opiates, including end of life care	Plans in place	CCG and Adult Social Care capacity	Dec 16	CCG Commissioner Adults Social Care Commissioner	NELFT Community Services
The drug and alcohol treatment service will be further developed to meet the needs of those with problematic use of prescription and over-the-counter medication, including: (a) advising GPs to treat (b) directly treating (where appropriate)	Reports received from WDPH Havering	Capacity of WDP Havering Engagement with GPs Ensure adherence to referral/care pathways Identified budgetary allocation for any GP prescribing		LBH Commissioner	CCG GPs Pharmacists

Objective 1: Preventing harm to the individual					
Project/ Action *What we will do to achieve it*	**Outcome** *How we will know we've achieved it*	**Resources** *What we need to be able to achieve it*	**Timescale**	**Lead Organisation (Officer/staff)**	**Impact on other services and organisations**
Produce guidance for prescribers on "Review of medicines with the potential for misuse"	Guidance produced for prescribers approved at Area Prescribing sub-Committee and on CCG website	Prescriber education and training via quarterly prescribing forums	June 16	BHR CCG Medicines Management	Local Medical Committee GPs WDP Havering
Devise and deliver a programme of education for prescribers on the topics of prescription only and over the counter medicines misuse and dependence.	Training programme delivered	Prescribers trained	Dec 16	BHR CCG Medicines Management	Local Medical Committee GPs
Reduce the prescribing of benzodiazapines and Z drugs, as part of the 2016/18 medicines management work plan	Reduction in prescription items from baseline	Practice support, quarterly prescribing performance scorecards	Dec 17	BHR CCG Medicines Management	Local Medical Committee GPs
Council Public Health Service to ensure that GPs are provided with information and an updated AUDIT tool to screen for level of alcohol-related risks to health, once new national tools are published	Tools actively in use by GPs e.g. as part of Health Check programme	Materials to be provided by PHE/national body; local distribution requested via CCG	When national materials available	LBH Commissioner Havering CCG	GPs
Set up a local drug information system in Havering for issuing public health alerts on new and/or novel, potent, adulterated or contaminated drugs.	System set up, relevant partners engaged	Task and finish group to establish system Evaluation of effectiveness end of year 1	Apr 16 –Jun 16	LBH Public Health	LBH Commissioner MPS, WDP Havering, Community Safety CCG, GPs, Pharmacists, BHRUT,
Monitor demand and stimulate innovative solutions to meet the needs of increasingly ethnically-diverse population, some of whom will inevitably develop substance misuse problems.	Report, describing solutions	Contract monitoring	Apr 16 and ongoing	LBH Commissioner WDP Havering	Faith groups Community groups

Objective 2: Preventing harm to the family					
Project/ Action *What we will do to achieve it*	**Outcome** *How we will know we've achieved it*	**Resources** *What we need to be able to achieve it*	**Timescale**	**Lead Organisation (Officer/staff)**	**Impact on other services and organisations**
Substance Misuse Treatment Service and Mental Health Service will take part in "Team around the Family" meetings where substance misuse/mental health are identified as a factor,	Records of meetings showing attendance by Substance Misuse Treatment Service and Mental Health Service in "Team around the Family" meetings	Processes established: invitation, recording of attendance, review of arrangements	Commence Apr 16	LBH Early Help Service	WDP Havering NELFT Mental Health
Substance Misuse Treatment Service and Mental Health Service to agree a joint protocol where there is dual diagnosis (substance misuse and mental health)	Protocol in place and implemented - Substance Misuse Treatment Service Commissioner and Mental Health Service Commissioner to be informed	Protocol in place	June 16 and ongoing	LBH Commissioner CCG Commissioner	NELFT WDP Havering
Provide access to alcohol and drug intervention treatment programmes for victims and perpetrators of domestic abuse	Protocol in place and implemented	Protocol/referral processes established between domestic violence lead and substance misuse treatment service	Apr 16 and ongoing	VAWG strategic partnership VAWG Officer LBH Commissioner	
VAWG strategic partnership to Increase awareness of domestic abuse among agencies and residents through communications.	Communication delivered		Apr !6 and on-going	VAWG strategic partnership VAWG Officer	
Integrate VAWG into all relevant service areas and ensure effective inter-agency co-ordination By Training of Domestic Abuse/VAWG Champions based in local authority departments, statutory partnership agencies and local private/voluntary sector services.			Apr 16 and ongoing	VAWG strategic partnership VAWG Officer	LBH services Partner agencies Private and voluntary sector services

Objective 2: Preventing harm to the family					
Project/ Action *What we will do to achieve it*	**Outcome** *How we will know we've achieved it*	**Resources** *What we need to be able to achieve it*	**Timescale**	**Lead Organisation (Officer/staff)**	**Impact on other services and organisations**
Continue to improve the efficiency and effectiveness of the MARAC.			Apr 16 and ongoing	VAWG strategic partnership VAWG Officer	
A Task and Finish Group to be set up to identify issues, barriers and solutions for information sharing, and develop an action plan of implementation	Action plan developed and implemented		Jul 16	LBH Early Help Service	
Early Help, WDP Havering and NELFT mental health services to collaborate on strengthening staff induction programmes so that staff have a good understanding of roles of partner agencies, and know who are the key individuals in each of the agencies	Induction processes reviewed and strengthened. Frontline staff and managers better informed.		Jul 16	LBH Early Help Service, NELFT Mental Health WDP Havering	
Early Help Service, WDP Havering and NELFT mental health services to cascade regular newsletters to partner agencies about their work (via LSCB). All three services to ensure that the information is communicated to frontline staff through team meetings.	Frontline staff and managers better informed.	LSCB Co-ordinator to facilitate	Jul 16	LBH Early Help Service, NELFT Mental Health WDP Havering	
MASH to take into account how WDP Havering is linked into the MASH processes. Once agreed, a contract variation to be agreed that describes the processes.	Contract variation issued	Service capacity	Jul 16	LBH Early Help LBH Commissioner	
WDP to advise LSCB how they can contribute to the data set that is being collected. WDP to be invited to attend LSCB Operational Board.	WDP advice to LSCB. WDP invited to operational board.	Service capacity	Apr 16	LSCB Co-ordinator WDP Havering Service Manager	
Early Help to ensure that WDP Havering is invited on joint home visits where substance misuse is, or likely to be, an issue	WDP invited on joint home visits as appropriate	Service capacity Training to staff to implement	Apr 16 and ongoing	LBH Early Help	WDP Havering

Objective 2: Preventing harm to the family					
Project/ Action *What we will do to achieve it*	**Outcome** *How we will know we've achieved it*	**Resources** *What we need to be able to achieve it*	**Timescale**	**Lead Organisation (Officer/staff)**	**Impact on other services and organisations**
WDP Havering joint working arrangements with the Early Help Service to include protocol of actions where a parent does not attend an appointment with WDP	Process in place and implemented	Service capacity to set up protocol Training to staff to implement	Apr 16 and ongoing	LBH Commissioner	LBH Early Help
Where WDP develops a recovery plan with a parent, this to be shared with Early Help.	Process in place and implemented	Service capacity to set up protocol Training to staff to implement	Jul 16 and ongoing	LBH Commissioner	LBH Early Help
Children's Social Care to invite WDP Havering to assessments, conferences and meetings when parents are receiving substance misuse treatment	Timely invitations issued	LBH Social Care to issue invitation & record attendance by WDP Havering	Apr 16 and ongoing	LBH Social Care LBH Commissioner	WDP Havering
Early Help and WDP to work to resolve issues where lack of childcare is a barrier for parent's treatment, including residential detox treatment	Solution achieved	Potential financial implications to resource childcare	May 16	LBH Early Help LBH Commissioner WDP Havering	
WDP Havering to deliver training to Early Help and Adult Social Care teams on working effectively with families affected by substance misuse	Programme of training agreed (including at induction). Training programme delivered.	Training programme	Mar 17	LBH Commissioner LBH Early Help Adult Social Care	WDP Havering
LSCB to deliver multi-agency training on safeguarding that specifically takes into account issues of substance misuse	Programme of training agreed and implemented	Training programme	Mar 17	LSCB Co-ordinator	All
Increase access to mental health services: IAPT (for adults) or CBT (for children via CAMHS), and monitor referrals and access	Increased uptake of IAPT and increased provision of CAMHS	Raise awareness of all potential referrers	Mar 17	CCG Commissioner	All

Objective 2: Preventing harm to the family					
Project/ Action *What we will do to achieve it*	**Outcome** *How we will know we've achieved it*	**Resources** *What we need to be able to achieve it*	**Timescale**	**Lead Organisation (Officer/staff)**	**Impact on other services and organisations**
All services to identify carers (inc young carers) and ensure they are signposted to the right services		Young Carers Service commissioned that meets the needs of young carers affected by substance misuse Communications about carers services/support		LBH Commissioner	All

Objective 3: Preventing harm to the community					
Project/ Action *What we will do to achieve it*	**Outcome** *How we will know we've achieved it*	**Resources** *What we need to be able to achieve it*	**Timescale**	**Lead Organisation (Officer/staff)**	**Impact on other services and organisations**
Primary care registration scheme to be agreed in Havering for prisoners released with no permanent address	Registration scheme established and agreed by Local Medical Committee and CCG	London-wide agreement with Probation Services	Oct 16	CCG	GPs LMC Local Probation Service WDP Havering
Achieve and maintain number of Inspector's Authority testing at 15 per month	Achievement of target		Apr 16 and ongoing	Metropolitan Police	WDP Havering
Achieve and maintain % of Test on Arrest where there is a trigger offence at 98% per month	Achievement of target		Apr 16 and ongoing	Metropolitan Police	WDP Havering
Identify lower risk acquisitive offenders with substance misuse treatment needs within criminal justice system and increase numbers of recommendations for DRR/ATR community sentencing to the courts. Increase numbers of DRR/ATR as a result of pre-sentence reporting by NPS. Achieve improvement in numbers successfully treated through DRR/ATR community sentencing.	Increase on 2015/16 baseline Monitor numbers successfully treated	Effective partnership arrangements within local feeder courts: Barkingside, Snaresbrook and Chelmsford to reduce timelines between recommendations being made for DRR/ATR community Orders NPS to identify more substance misusers at assessment stage	Apr 16 and ongoing	National Probation Service Community Rehabilitation Company WDP Havering Police Community Safety National Probation Service	WDP Havering
Continued use of town link radio, ensure all required persons are joined up / kept up to date. Provision of Deeper Lounge safe haven. Provision of Street Triage within Fiction night club.	Continued implementation of initiatives	Resourcing of initiatives	Apr 16 and ongoing	Community Safety and Development Manager	Havering Community Safety Partnership

Objective 3: Preventing harm to the community					
Project/ Action *What we will do to achieve it*	**Outcome** *How we will know we've achieved it*	**Resources** *What we need to be able to achieve it*	**Timescale**	**Lead Organisation (Officer/staff)**	**Impact on other services and organisations**
Develop and deliver a programme of work to address gang related offending and associated drug dealing , CSE and exploitation	Programme of work developed and delivered		Apr 16 and on-going	Community Safety and Development Manager	Havering Community Safety Partnership
Deliver training for Licensing Responsible Authorities on making effective representations in response to licensing applications.	Training delivered	Officer capacity Attendance by Responsible Authorities	Apr 16	LBH Licensing	All Responsible Authorities
Delivery training for Licensing Committee members	Training delivered	Officer capacity	Apr 16	LBH Licensing	All Responsible Authorities
Explore investment in mobile technology to enable frontline staff to capture data and intelligence, including as relates to drugs and alcohol	Exploration completed	Officer capacity	Tba	LBH Streetcare	
Training to be delivered to LBH frontline operatives to improve recognition of drug litter	Training delivered	Capacity of services	Mar 17	LBH Streetcare LBH Commissioner	WDP Havering
Prepare and consult on a Public Protection Order in Romford Town Centre	Consultation completed	Officer capacity	Apr 16	Community Safety and Development Manager	
Test cannabis-flavoured e-cigarettes to establish whether contents include cannabis	Test purchases made and contents analysed	LBH Licensing capacity	Dec 16	LBH Licensing	LBH Licensing – potential enforcement/legal action
Deliver Junior Citizen Programme to 1,500 year six children, including content on drugs/alcohol, and a specific gangs element	Programme delivered	Services capacity	Jul 16	LBH Community Safety and Development Manager	
WDP to deliver training about drugs and alcohol to Early Help services	Training delivered	Service capacity	Mar 17	LBH Commissioner Early Help	WDP Havering

Objective 3: Preventing harm to the community					
Project/ Action *What we will do to achieve it*	**Outcome** *How we will know we've achieved it*	**Resources** *What we need to be able to achieve it*	**Timescale**	**Lead Organisation (Officer/staff)**	**Impact on other services and organisations**
Healthy Schools Network to showcase/share the successes of schools' own commissioned information sessions for increasing parental knowledge about engaging with their children on topics such as drugs and alcohol	Showcased event takes place	Recruitment of Healthy Schools Co-ordinator	Dec 16	LBH Healthy Schools Co-ordinator	Healthy Schools Network (schools)
Continue to work with other enforcement agencies to target premises where intelligence indicated that non duty paid alcohol may be sold.	Joint working between enforcement agencies	Information / intelligence	Ongoing – as resources allow	Customs & Excise LBH Trading Standards	Metropolitan Police Service

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Havering Obesity Prevention Strategy
Board Lead:	Sue Milner, Interim Director of Public Health
Report Author and contact details:	Mark Ansell, Consultant in Public Health Mark.ansell@havering.gov.uk 01708 431818

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

Very large numbers of Havering residents, both adults and children, are obese and/ or could improve their health by being more active and eating more healthily.

The preventable harm caused by obesity, sedentary behaviour and poor diet is enormous and will only increase unless effective action is taken now.

The obesity epidemic is the result of a complex array of interacting factors. Some can only be addressed through national if not international action. However some are in the gift of local partners to address and it is only by taking every opportunity that we will collectively achieve the scale of change required.

The Havering Obesity Prevention Strategy sets out what participants in the Havering Health and Wellbeing Board will do. The local approach to prevent people becoming

obese, and enjoy the additional benefits of being more physically active and eating healthily is presented as three interlinked work streams to: -

- Shape the environment to promote healthy eating and physical activity;
- Support a culture that sees physical activity and healthy eating as the norm;
- Prompt individuals to change, primarily through self-help.

We will focus on early years as weight is difficult to lose once gained and attitudes and behaviours established during childhood shape lifestyle in later life.

Our approach will consciously seek to remedy the inequalities in obesity, physical activity and healthy eating that affect specific communities and population groups.

Specialist health improvement and/ or treatment services may have a role in supporting high risk individuals achieve improvements in nutrition, physical activity and weight but their impact on the prevalence of obesity across the population as a whole is modest and thus they represent only a small part of our overall approach to obesity prevention.

The Executive Summary of the Havering Obesity Needs Assessment, which brings together the best available evidence and authoritative guidance underpinning the Strategy, is included as an Appendix.

A set of KPIs is suggested to monitor progress over time.

A detailed action plan with milestones and timescales is provided.

Given the wide range of activities proposed, straddling most if not all Council services and NHS partners, its suggested that the task and finish group established to inform development of this strategy is strengthened to become a permanent working group reporting to the H&WB and responsible for delivery of action plan.

RECOMMENDATIONS

The Board is asked to: -

- Discuss the Strategy
- Suggest any amendments and additions needed
- Subject to there being general agreement with the approach proposed, and that any changes suggested by members are made, agree that the Chair of the Health and Wellbeing Board can approve a final draft of the Strategy without further reference to the Board

- Further agree that an obesity working group is established to periodically refresh and oversee delivery of a rolling annual action plan.

- Subsequently receive an annual report describing progress made implementing the action plan and changes in levels of obesity, physical activity and healthy eating locally.

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REPORT DETAIL

Obesity Strategy including a detailed action plan and KPIs is attached.

IMPLICATIONS AND RISKS

Financial implications and risks:

Any significant decisions arising from this strategy have or will be subject to normal governance processes within the relevant organisation. There are no additional significant implications arising from adoption of this strategy.

Legal implications and risks:

Ditto

Human Resources implications and risks:

Ditto

Equalities implications and risks:

Ditto

BACKGROUND PAPERS

The Executive Summary of the Havering Obesity Needs Assessment is included as an appendix to the Strategy.

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LONDON BOROUGH OF HAVERING

Prevention of obesity needs assessment

2016

Executive Summary

Joint Strategic Needs Assessment

By London Borough of Havering
Public Health Service

Executive Summary

Facts and figures

Definition of obesity

- Overweight and obesity is excessive fat accumulation that may impair health.
- Obesity is usually categorised in terms of Body Mass Index (BMI).
- BMI is calculated by dividing weight (in kilograms) by height (in metres) squared.
- People with a BMI of 30 or greater are obese; 25 – 29 are overweight.

Prevalence of obesity

- Levels of obesity in Havering are similar to the national average - more than a quarter of adults are obese and two-thirds are overweight or obese (110,000 residents).
- The prevalence of adult obesity in England has more than doubled in the past twenty-five years.
- Rates of morbid obesity have doubled in the last twenty years – to 2.7% of adults in 2014 (5,700 Havering residents).
- 1 in 10 Havering children (290) in Reception Year (age 4-5) are obese; almost a quarter of the children (680) are overweight or obese. Levels of obesity amongst Reception Year children resident in Havering are similar to those in London but significantly higher than England average.
- 1 in 5 Havering children (530) in year 6 (age 10 - 11) are obese; more than a third are overweight or obese. Levels of obesity in Havering for Year 6 children are similar to the London and England averages.
- Levels of obesity double from 1 in 10 to 1 in 5 during the primary school years.
- 70-80 children in each school year are likely to be severely obese – equivalent to an adult BMI of 35 or higher.
- About 1 in 5 women of child bearing age are obese.

Burden of disease and financial cost

- Obese adults are more likely to die prematurely (e.g. from cancer and circulatory diseases), develop limiting long term illness (e.g. diabetes and osteoarthritis) and experience mental illness (e.g. anxiety and depression).
- Maternal obesity is a risk in the short term to the health of both mother and baby but also increases the risk that the child and possibly their children may be obese.
- Obese and overweight adolescents have a third more sick days than peers with a healthy body weight as a result of the physical and mental health problems associated with childhood obesity.
- Obese children are between 2 and 10 times more likely to be obese in adulthood.
- Nearly 9% of the total UK burden of disease (measured in DALYS) is due to high BMI.
- The total cost of obesity to the UK economy is estimated at £27bn per year. Costs to the NHS alone are more than £6bn and projected to rise by a further £2bn if the prevalence of obesity continues to rise and more effective but expensive treatments are introduced.

What are the key inequalities?

- More men than women are overweight; more women than men are obese and morbidly obese.
- The prevalence of obesity varies between ethnic groups as does the risk of harm associated with a given BMI level. As a result, 'Black' and 'Asian' communities are at greater risk of obesity related harm.
- People with physical disabilities, long term health problems and learning disabilities are more likely to be obese.
- Adults, particularly women, living in disadvantaged communities are more likely to be obese than peers living in more advantaged communities.
- At both reception and Year 6, children in all but the 'White' and 'Chinese' ethnic groups have significantly higher prevalence of obesity than the average for 'all' children. The prevalence is particularly high amongst 'Black' children.
- Children with a limiting illness are more likely to be obese or overweight, particularly if they also have a learning disability – children with both conditions were almost twice more likely to be overweight or obese than children with neither.
- Obesity prevalence in children is strongly correlated with disadvantage. Prevalence in the most deprived decile is about twice that in the least deprived for both reception and Year 6 children.

Causes of obesity

Obesity occurs when energy intake from food and drink consumption is greater than energy expenditure through the body's metabolism and physical activity over a prolonged period, resulting in the accumulation of excess body fat.

It is tempting to believe that obesity can be addressed by shifting decisions at the level of the individual. However, humans evolved in a world of relative food scarcity and hard physical work and now live in a world where energy-dense food is abundant and we have access to many labour-saving technologies. As a result, the majority of the population are now predisposed to gaining weight.

Therefore, action is needed to address the environmental and societal factors that contribute to 'passive' obesity to assist the individual – who may also benefit from support to initiate and maintain conscious behaviour change. To maximise the chances of success we must address all the factors driving the obesity epidemic. Taken together, their complementary and reinforcing action may achieve the significant shift in population obesity levels required.

Physical activity and healthy eating

Individuals and communities that eat well and are physically active are more likely to maintain a healthy body weight and will accrue many other benefits independent of the positive impact on obesity levels.

- Relatively modest levels of activity are recommended for adults – 150 minutes of moderate intensity physical activity per week.

- But only two-thirds of men and half of women in England get this amount; and levels of activity in Havering are lower still.
- Children and young people aged 5–18 year olds should get at least 60 minutes per day, which should be a mix of moderate intensity (e.g. walking to school) and vigorous intensity aerobic activity (e.g. playing football).
- Under–fives should be active for three hours, spread throughout the day
- But only 1 in 5 children aged 5 - 15 years and 1 in 10 children aged 2- 4 get the recommended level of activity.

In the United Kingdom, the Scientific Advisory Committee on Nutrition (SACN) publishes recommendations regarding the intake of energy, nutrients and some specific food groups. The potential benefit if everyone met these recommendations would be enormous e.g. more than 10% of deaths avoided and £6billion reduction in NHS expenditure.

- Average adult energy consumption is about 10% more than needed to achieve energy balance – equivalent to 4 chocolate digestives or a can of soft drink too much each day.
- Sugars (1/2) and fats (1/3) account for the majority of energy intake.
- SACN has recommended that free or added sugars should make up no more than 5% of energy intake – equivalent to 7 sugar cubes for adults per day; less for children.
- Only 4% of children and 13% of adults meet the SACN recommendation about free sugars and average consumption by young people is three times the recommended amount.
- Levels of 'healthy' and 'unhealthy' eating vary with age, gender, ethnicity and disadvantage. Very few people with a learning disability eat well.

Healthy nutrition in early life is of crucial importance

- Both maternal under- and over-nutrition around the time of conception and during pregnancy increases the risk of childhood obesity.
- Pregnant women are advised to consume only an additional 200 kcal/day in the last trimester – and definitely not to 'eat for two'.
- Babies that are breastfed are less likely to become obese. But a quarter of babies born in Havering are not breastfed at all, and 6 out of 10 are bottle fed by 6-8 weeks.
- Delaying weaning until babies are at least six months old reduces the likelihood of obesity.

What works?

To prevent people becoming obese, and increase levels of physical activity and healthy eating, local partnerships should: -

- reduce the environmental and societal factors that contribute to passive obesity and replace them with 'cues' or 'nudges' for healthier choices.
- work to make more people perceive obesity, healthy eating and physical activity to be issues that affect them personally; prompting them to take up the available opportunities to be more active and eat more healthily.
- focus on early years as weight is difficult to lose once gained and the attitudes and behaviours established in childhood serve to shape our lifestyle in later life.

- seek to remedy the inequalities regarding obesity, physical activity and diet that affect specific communities and population groups.

Current activities and future opportunities

Shaping the physical activity environment

Creating 'healthy streets'

For many people, walking, whether for pleasure or travel purposes, represents the most likely sustainable form of physical activity. Residents are more likely to walk when commonly used amenities are relatively close by and the street scene is 'inviting'.

The Council fosters ever healthier streets in a variety of ways e.g. through

- structural improvements to the street scene,
- high standards of street cleaning and maintenance,
- using spatial planning to ensure new housing is well served by public transport and has a range of high quality amenities in walking distance,
- encouraging new enterprises to locate to local centres etc.

Improving the public transport offer in the borough

A quarter of Londoners already get their recommended daily physical activity as part of a longer commute by public transport. But Havering has the lowest percentage of commuting by public transport of any London borough. Havering also has the 2nd lowest Public Transport Accessibility Levels (PTALS) of any borough in the capital. Improving access to public transport would boost levels of physical activity as well as contribute to a range of other priorities.

The Council and TfL have a number of priorities for public transport including:

- Romford Station – improvements with Crossrail
- New station at Beam Park to serve London Riverside area
- Rainham regeneration
- Improved north-south bus links and better links between hospitals

Maintaining and improving access to high quality green space

Parks and green spaces provide safe and attractive spaces in which to walk, cycle and play. Access to good quality green space is associated with a range of positive health outcomes including lower levels of overweight and obesity.

Havering as a whole has a large number of parks and open spaces, which make it one of the greenest boroughs in the capital. The borough contains a number of nature reserves, including an area of Special Scientific Interest. The majority of residents have good access to playgrounds and outdoor gym facilities.

Improving the 'cyclability' of Havering

Cycling improves cardiovascular health, is kind to joints and is associated with increased longevity. However, relatively few people in Havering cycle compared with other London boroughs. Since 2012, Havering has been a 'Biking Borough' and is actively addressing barriers to cycling.

Considerable activity is underway to increase rates, supported by £600K funding from TfL including the development of dedicated cycleways and 'greenways', regular bike security marking events, organises 'led' rides around the area, as well as a variety of riding and maintenance courses. The cycle to work scheme assists employees to buying a bike.

Road design

Actual and/or perceived safety influences decisions about whether individuals choose to walk or cycle or whether parents allow their children to do so. Good road design, including the use of 20mph limits in priority areas, reduces the likelihood of accidents and their severity should they occur.

Shaping the food environment to promote healthy eating

Central to tackling obesity and other diet-related poor health outcomes is creating an environment where it is normal, easy and enjoyable to eat healthily.

While reducing intake of saturated fat, sugar and salt and increasing intake of fruit, vegetables, dietary fibre and oily fish remain central to promoting a balanced diet, much of the current policy focus is targeted at reducing sugar intake.

Environmental variables that have an influence on eating patterns can be grouped into four overlapping areas:

- Community nutrition environment (type, location and accessibility of food outlets);
- Organisational nutrition environment (home, school, work and other settings);
- Consumer nutrition environment (availability, cost and promotion or placement of healthy options);
- Information environment (media and advertising).

Shaping the community environment (type, location and accessibility of food outlets)

Food businesses are an essential part of a vibrant, healthy and prosperous high street. However, a balance needs to be struck between commerce and health. Too many fast food outlets selling cheap, energy-dense, nutrient-poor foods, served in larger portion sizes, is detrimental to the health of local communities.

Analysis by PHE demonstrates that fast food outlets are concentrated in disadvantaged communities thereby contributing to local health inequalities. The same analysis demonstrates that Havering, although not particularly disadvantaged, has a relatively high concentration of fast food restaurants, in common with many other London boroughs.

The National Planning Policy Framework (NPPF) makes clear that local planning authorities (LPAs) have a responsibility to promote healthy communities. To this end, local plans should 'take account of and support local strategies to improve health, social and cultural wellbeing for all'.

Both NICE and PHE recommend that planning authorities restrict planning permission for takeaways and other food retail outlets in specific areas for example, within walking distance of schools. Given that Havering already has a relatively high number of fast food outlets, schools should also consider more direct action e.g. restricting pupils to school premises at lunchtime.

Organisational nutrition environment (home, school, work and other settings)

Large sections of the population rely on others to buy, prepare and serve food on their behalf for a significant number of their meals e.g. children and young people in pre-schools, schools and colleges, patients in health care settings and people in residential care. For some people, this may be all the food that they eat. These individuals rely on the providers of their food to plan menus in such a way that it is possible for them to meet dietary recommendations.

Using food and nutrient-based standards as a framework on which to base menus will help to ensure that people can achieve dietary recommendations. A much larger proportion of the population would benefit if the food in workplaces was also guided by these principles.

Consumer nutrition environment (availability, cost and promotion or placement of healthy options)

The previous government initiated the public health responsibility deal to encourage the food and drink industry to work with it to improve health as opposed to legislating to enforce change.

The responsibility deal included a calorie reduction pledge to provide a mechanism for the food and drink industry to make and record its contribution to reducing the population's energy intake and 43 manufacturers have done so.

PHE, in their analysis of how intake of sugar might best be reduced, advocates for many of the interventions voluntarily put in place via the responsibility deal (e.g. reformulation of products to reduce sugar content). However, PHE recommends that such approaches should be adopted industry wide thereby undermining the voluntary approach behind the public health responsibility. Moreover, PHE has also stated that financial measures e.g. a sugar tax would be effective.

Campaigners have sought to demonstrate to central Government that such measures would be publically acceptable e.g. by placing a self-imposed levy of 10p to the price of soft drinks with added sugar to heighten consumer awareness of hidden sugars.

Information environment (media and advertising)

The available research evidence shows that all forms of marketing consistently influence food preference, choice and purchasing in children and adults.

PHE recommends that Government should set a clear definition for high sugar foods and thereafter take action to significantly reduce opportunities to market and advertise high sugar food and drink products to children and adults across all media including digital platforms and through sponsorship.

PHE recommends that campaigns such as Change4life should be continued to raise awareness of concerns around sugar levels in the diet, encourage action to reduce intakes and provide practical steps to help people lower their own and their families' sugar intake.

Creating a healthy community

Leadership and 'walking the walk'

The Health and Wellbeing Board is ideally placed to provide strategic leadership; the adoption of a strategy to tackle obesity is an essential first step.

More importantly, public sector agencies must then demonstrate to their staff, clients, patients, Council Tax payers, etc. that they take health seriously. If not, they will undermine their own efforts to motivate individuals to change and adopt healthier lifestyles.

Key opportunities to 'walk the walk' include:

- putting in place a high quality healthy workplace offer.
- active participation in national health improvement campaigns.
- ensuring health professionals, the wider public sector workforce and the premises they work from actively promote healthy choices.
- ensuring all corporate decisions are assessed for health impacts.
- recognising and fostering the contribution of the community and voluntary sector.
- engaging the business community in health improvement.

Healthy working places

Every employer has a vested interest in ensuring the good health of its workforce so sickness absence is minimised and service delivery improved. Obese employees have more and longer sickness absences than workers of a healthy weight. Effective healthy workplace schemes in the statutory sector would benefit a significant minority of households in Havering given that a high proportion of Council and NHS employees are local residents.

The London Healthy Workplace Charter is a self-assessment framework that recognises employers for investing in workplace health. It provides a series of standards for workplaces to meet in order to guide them to creating a health-enhancing workplace. London Borough of Havering reached the 'Achievement' standard in 2014.

Ensuring public sector premises support healthy choices

Nudge theory suggests that the available options can be presented in such a way as to favour a desired outcome whilst preserving the individual's ability to choose. Nudges may vary from simple promotion of healthy options e.g. sign posting the stairs as opposed to the lift or putting fruit by the checkout as opposed to confectionary to more direct incentives (e.g. making healthy food options noticeably cheaper than less healthy ones). A periodic audit of the environment in which statutory sector services are provided to identify opportunities to nudge in favour of healthier options would add value and ensure that health improvement messages are not unintentionally undermined.

Enlisting the wider workforce to promote healthy choices

The Making Every Contact Count (MECC) concept draws on the established role of health professionals, particularly in primary care, who provide opportunistic brief advice to patients about lifestyle related issues. There is good evidence that such advice has a small but measurable impact on the behaviour of patients e.g. provision of brief advice about smoking by a doctor produces 1 additional quitter for somewhere between every 33 to 80 patients offered advice. The national aspiration is to extend this approach to all NHS staff, clinical and administrative; in primary care, community and acute hospitals settings.

The Council has developed a 'health champion' scheme called 'my health matters' which fits with the MECC concept. Tapestry, a local VCS provider has been commissioned to recruit and thereafter manage a network of community health champions drawn from employees and residents.

Health impact assessment of corporate decisions

A complex array of factors has an impact on obesity levels. As a result, it may be difficult to identify which decisions, and by whom, will or won't impact on obesity levels, still less on health in the round. Health impact assessment (HIA) is a process whereby significant decisions by public sector agencies could be reviewed to identify potential health impacts so that potential benefits can be maximised and potential harms mitigated. A light touch HIA process, analogous to the existing Equality Impact Assessment process, would over time work to ensure that the collective decisions of the public bodies improve health.

The community and voluntary sector contribution

Community groups can drive health improvement in many ways. Most obviously in the context of obesity prevention, a huge range of sports and active leisure options are provided by third sector organisations. The Council and other public bodies should continue to support the community and voluntary sector to support residents to live more healthily.

Engaging the business sector

The local business sector has huge resources, energy and innovation. Yet this analysis has identified very little positive input to healthy living in the borough – beyond the obvious employment opportunities provided and income resulting which are crucial determinants of health.

More research may identify a greater contribution. Either way, more consideration should be given to how the private sector could be involved e.g. involvement in campaigns, healthy workplace schemes etc.

Supporting individuals to change

Health improvement campaigns

Effective campaigns have a role to play in changing attitudes with the ultimate aim of changing social norms such that the healthy choice becomes the usual choice for the majority. National bodies, primarily Public Health England have developed a number of increasingly sophisticated and successful campaigns such as Change4Life *'10 Minute Shake Up'* campaign with Disney; *'Couch to 5K'* and *'sugar smart'*.

Local agencies have neither the resources or expertise to develop similar campaigns but we can seek to amplify the message and use it to promote relevant local resources e.g. the Council's Sport Development Team badged programmes of activity for women and girls under the *'this girl can'* banner to tie in the Sport England campaign. Campaigns should be coordinated across the partnership and linked to the 'MECC' activity of health care workers and health champions everywhere.

NHS Health checks

NHS health checks are one of the Council's mandated public health responsibilities. As part of a holistic assessment of cardiovascular risk, they are an opportunity to periodically advise ostensibly healthy adults aged 40 – 74 years about the benefits of maintaining a healthy bodyweight and signposting to sources of support and advice that might help them do so.

Weight management services and clinical interventions

Lifestyle weight management programmes and health care interventions form part of the overall care pathway for obese people.

- The Council is responsible for tiers 1 and 2, including population level interventions to encourage healthy eating and physical activity, as well as lifestyle related weight management services
- The Clinical Commissioning Group is responsible for tier 3, clinician-led specialist multidisciplinary teams
- NHS England is responsible for commissioning tier 4 services, including bariatric surgery

What is provided is a local decision, reflecting the local priorities and resource constraints
The bulk of this assessment has described activity that could broadly categorised as tier 1.
Tier 2 lifestyle weight management programmes are multi-component programmes that aim to reduce a person's energy intake and help them to be more physically active by changing their behaviour.

NICE recommends that adults who are obese, that is with a BMI over 30 kg/m2, or lower for those from black and minority ethnic groups or with other risk factors e.g. comorbidities such as type 2 diabetes may benefit.

The expected outcomes from an effective programme include completion by at least 60% of participants, resulting in an average weight loss of 3% or more, with at least 30% of participants losing 5% or more of their initial weight. Weight losses of between 5 and 10% in overweight and obese individuals with type 2 diabetes have been associated with significant improvements in CVD risk factors at 1 year; but those with larger weight losses benefit more. Services achieving modest weight loss are cost effective if that weight loss is maintained for life. There is a lack of evidence that this is the case – hence tier 2 services commissioned by the public sector are only probably effective / cost effective and unlikely to be harmful. The same can be said for a number of commercial weight management programmes.

A tier 3 obesity service is for obese individuals (usually with a body mass index of 35 and over with co-morbidities or 40 and over with or without co-morbidities) who have not responded to previous tier interventions; comprising a multi-disciplinary team of specialists, typically including: a physician specialist nurse; specialist dietician; psychologist or psychiatrist; and physiotherapist/physical activity specialist. Patients may respond well to intense support from tier 3 services and loss significant weight; they are also essential in preparing patients for bariatric surgery.

Tier 4 services provide bariatric surgery – a highly specialised intervention, offered to carefully selected patients with severe and complex obesity that have not responded to all other non-invasive therapies. In such patients, it is effective and cost effective, i.e. significant weight loss results; health outcomes improve and hence the overall cost of care is reduced such that within 2 – 3 years the initial cost of surgery is offset. Very small numbers of patients undergo bariatric surgery – as is the case nationally.

The obesity pathway in Havering needs to be clarified. Tier 2 services are currently not commissioned and information about reliable self-help aids and effective commercial providers have not been collated. Tier 3 services have not been commissioned. The tier 4 provider is supporting prospective bariatric surgery candidates but a local service would be more convenient. Likewise, the support available to children and young people with weight problems and their families also needs clarification and agreement.

Giving children and young people the best start

There are numerous reasons why children and young people should be our priority over and above the obvious moral obligation to protect the vulnerable; not least because losing weight in later life is difficult; and experiences in early life, indeed before birth, predispose individuals to obesity in adulthood.

As with obesity in general, there is no single silver bullet to the problem of childhood obesity. There are numerous opportunities to intervene, many of which would benefit parents and the wider community.

- Support to obese women pre-conception and during pregnancy would reduce foetal programming – which predisposes their offspring to obesity in later life.
- The promotion of breast feeding and healthy weaning is crucially important in reducing the likelihood of excessive weight gain during the early years and establishing preferences for healthier foods.
- Midwives, health visitors and children's centre staff have a potentially crucial role if adequately resourced and trained to identify at risk women / infants; and offer effective support to change unhealthy behaviours.
- Action to assisting parents with the knowledge and skills necessary to cook healthily may help. As would support and guidance to nurseries and childminders who assume direct control of the child's diet and activity for significant periods.
- Schools have enormous potential; providing children with a healthy environment and assisting them to make healthier choices. The curriculum offers opportunities for children to learn practical cooking skills; be active for significant periods and develop the knowledge and attitudes that underpin healthy living in adulthood. Extensive assets, developed over a long period, relevant to sport and PE are evident in the borough; the same can't be said with regard to diet and cooking skills.
- The healthy schools award programme has been well received and has motivated a large number of schools to systematically review their contribution to the health of their pupils and how it can be improved; action regarding healthy eating and physical activity is a particular focus.
- School meals are of a consistently high standard; further work is needed to encourage still greater uptake and assist children to make healthy choices from the available menu.
- School transport plans can increase levels of physical activity – for children and parents – and reduce congestion around schools.
- The National Child Measurement Programme, carried out in schools, is an opportunity to raise awareness and prompt action by parents.
- The views of peers can be particularly important to children and young people and we should consider how we involve young people in improving their own health. Youth health champions are one possibility.

Tackling inequalities in obesity

There are very significant inequalities in the prevalence of obesity between communities and population groups. Focusing on the early years is crucial to narrowing inequalities in obesity. As stated by Marmot, "*Giving every child the best start in life is crucial to reducing health inequalities across the life course. (We need) to increase the proportion of overall expenditure allocated to early years, and it should be focused proportionately across the social gradient to ensure effective support to parents, starting in pregnancy and continuing through the transition of the child into primary school* ."

Health visitors, working with early years staff, are uniquely placed to support with the transition to parenthood; breastfeeding and healthy weaning which are crucial to the prevention of childhood obesity during the early years. Strengthening Havering's under resourced health visiting team should be a priority.

Residents with a learning disability appear particularly vulnerable to obesity, poor diet and sedentary lifestyles. Further work with professionals, carers and people with learning disability is needed to identify opportunities for improvement.

What should we be doing next?

This needs assessment has been undertaken to inform development of an obesity prevention strategy requested by the Havering Health and Wellbeing Board. Therefore, a strategy and action plan, and systems to effectively coordinate and report on progress are essential first steps.

The content must be decided on by the Health and Wellbeing Board, having considered the evidence presented here, but also the wider priorities of the Board and its constituent bodies, and the resources available to support delivery, both financial and human. This assessment suggests 3 broad streams of work:

- Shaping the environment to promote healthy eating and physical activity
- Supporting a culture that sees physical activity and healthy eating as the norm
- Prompting individuals to change, primarily through self-help.

A focus on children and young people – particularly the early years is essential, both to reduce levels of obesity amongst children – but also tackle the significant inequalities associated with social disadvantage.

Key opportunities to tackle obesity are within the gift of central Government rather than local partners e.g. regulation of the food industry. Local partners should take any opportunities that arise to encourage central Government to take effective action.

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Appendix 2 – Contributing Stakeholders and Strategy Development Group

The full list of stakeholders involved in the consultation on this strategy is provided below.

The Strategy Development Group will continue to draw on this cross-borough engagement and ensure representation across all services.

Daphne Edwards	Service Unit Manager		Adult Services, LBH
Michael Mackay	Commissioning Development Officer	Strategy and Commissioning	Children's Services, LBH
Jacqui Hanton	Children's Centre Manager	Early Help, Youth Engagement and Troubled Families	Children's Services, LBH
Jonathan Taylor	Service Manager	Early Help, Youth Engagement and Troubled Families	Children's Services, LBH
Helen Anfield	Children's Centre Manager	Early Help, Youth Engagement and Troubled Families	Children's Services, LBH
Robert South	Service Manager Care Resources		Children's Services, LBH
Gary Jones		Adoption Support	Children's Services, LBH
Deborah Redknapp	Strategy and Commissioning Manager		Children's Services/ Public Health, LBH
Kayleigh Pardoe	Policy, Marketing and Admin Manager		Corporate Policy and Community, LBH
Savinder Bhamra	Corporate Policy and Diversity Advisor		Corporate Policy and Community, LBH
Martin Stanton	Parks and Open Spaces Manager	Parks and Open Spaces	Culture and Leisure, LBH
Stephen Rawlins	Parks Protection Manager	Parks Security/ Parks & Open Spaces	Culture and Leisure, LBH
Simon Parkinson	Head of Culture and Leisure		Culture and Leisure, LBH
Guy Selfe	Health and Wellbeing Manager	Health and Sports Development	Culture and Leisure, LBH
Nicky Dunne	Frontline Services Manager	Corporate and Customer Transformation	Culture and Leisure, LBH
Jane Herbert	MyPlace Manager		Culture and Leisure, LBH
Karen Heilbrunn	Physical Activity Coordinator		Culture and Leisure, LBH
Bob Flindall	Senior Projects and Programmes Manager	Regeneration	Economic Development, LBH
Chris Barter	Project and Programme Manager	Regeneration	Economic Development, LBH
Chris Smart	Regeneration Officer	Regeneration	Economic Development, LBH
Jolly Choudhury	Business Development Officer	Regeneration	Economic Development, LBH
Rebecca Davey	Business Development Manager	Regeneration	Economic Development, LBH
Louise Wilkinson	Environmental Protection and Housing Divisional Manager		Homes and Housing, LBH
Kirsty McArdle	Project Manager,	Bedfords Park Walled Garden	Clear Village
Sharon Phillips	School Games Organiser		Havering Sports Collective
Breda Kavanagh	Operational Lead		North East London Foundation Trust

Clare Burns	Deputy Chief Operating Officer		Havering Clinical Commissioning Group
Trudi Penman	Licensing and Health and Safety Manager		Homes and Housing, LBH
Dennis Brewin	Interim Head of Catering	Catering and Traded Services	Learning and Achievement, LBH
Charlotte Newman	Administration Assistant	Catering and Traded Services	Learning and Achievement, LBH
David McKenzie	Business Manager	Catering and Traded Services	Learning and Achievement, LBH
Kathryn Gray	Early Education Inclusion Officer	Early Years Alternative Provision	Learning and Achievement, LBH
David Allen	Strategic Finance	Education Finance Manager	Learning and Achievement, LBH
Paul Tinsley	Education Inclusion and Support Manager	Education Inclusion and Support	Learning and Achievement, LBH
Vedia Mustafa	Curriculum Development Manager	Havering Adult College	Learning and Achievement, LBH
Susie Williams	Inspector, Quality Assurance	Early Years	Learning and Achievement, LBH
Jane Eastaff	Community Safety Officer (Programmes)	Community Safety	Policy and Performance Management, LBH
Chris Stannett	Integrated Offender Management Case Worker	Community Safety	Policy and Performance Management, LBH
Elaine Greenway	Acting Consultant in PH		Public Health, LBH
Claire Alp	Health Improvement Specialist		Public Health, LBH
Natalia Clifford	Senior Public Health Strategist		Public Health, LBH
Lindsey Sills	Senior Health Improvement Specialist		Public Health, LBH
Mark Ansell	Consultant in Public Health		Public Health, LBH
Louise Dibsdall	Senior Public Health Strategist		Public Health, LBH
Lauren Miller	Team Leader (Development Plan)	Development and Transport Planning	Regulatory Services, LBH
John Lynn	Cycling Officer	Development and Transport Planning	Regulatory Services, LBH
Elaine Keeler	Road Safety Officer	Development and Transport Planning	Regulatory Services, LBH
Daniel Douglas	Team Leader (Transportation)	Development and Transport Planning	Regulatory Services, LBH
Martin Day	Smarter Travel Officer	Travel Plan Project	Regulatory Services, LBH
Jay Amin	Smarter Travel Assistant	Travel Plan Project	Regulatory Services, LBH
Mark Philpotts	Principal Project Leader	Engineering Services	Streetcare, LBH
Roxy Naz	Senior HR Advisor		Internal Shared Services, LBH

Equality Impact Assessment (EIA)

Document control

Title of activity:	*Prevention of Obesity Strategy 2016-2019*
Type of activity:	*Strategy*
Lead officer:	*Claire Alp* *Health Improvement Specialist (Schools)* *Public Health* *Children, Adults and Housing*
Approved by:	*Mark Ansell* *Consultant in Public Health* *Public Health* *Children, Adults and Housing*
Date completed:	*8th March 2016*
Scheduled date for review:	*In line with strategy review date (expected to be March 2019)*

The Corporate Policy & Diversity team requires **5 working days** to provide advice on EIAs.

Did you seek advice from the Corporate Policy & Diversity team?	Yes
Does the EIA contain any confidential or exempt information that would prevent you publishing it on the Council's website?	No

1. Equality Impact Assessment Checklist

The Equality Impact Assessment (EIA) is a tool to ensure that your activity meets the needs of individuals and groups that use your service. It also helps the Council to meet its legal obligation under the Equality Act 2010 and the Public Sector Equality Duty.

Please complete the following checklist to determine whether or not you will need to complete an EIA. Please ensure you keep this section for your audit trail. If you have any questions, please contact the Corporate Policy and Diversity Team at diversity@havering.gov.uk

About your activity

1	**Title of activity**	*Prevention of Obesity Strategy 2016-2019*
2	**Type of activity**	*Strategy*
3	**Scope of activity**	*The strategy outlines the approach of the Havering Health and Wellbeing Board to the prevention of obesity. It sets out how people living and working in Havering will be encouraged and supported to increase levels of physical activity and healthy eating.*
4a	**Is the activity new or changing?**	*Yes*
4b	**Is the activity likely to have an impact on individuals or groups?**	*Yes*
5	**If you answered yes:**	*Please complete the EIA on the next page.*
6	**If you answered no:**	*Please provide a clear and robust explanation on why your activity does not require an EIA. This is essential in case the activity is challenged under the Equality Act 2010.* *Please keep this checklist for your audit trail.*

Completed by:	*Claire Alp* *Health Improvement Specialist (Schools)* *Public Health* *Children, Adults and Housing*
Date:	*8th March 2016*

2. Equality Impact Assessment

The Equality Impact Assessment (EIA) is a tool to ensure that your activity meets the needs of individuals and groups that use your service. It also helps the Council to meet its legal obligation under the Equality Act 2010 and the Public Sector Equality Duty.

For more details on the Council's 'Fair to All' approach to equality and diversity, please visit our Equality and Diversity Intranet pages. For any additional advice, please contact diversity@havering.gov.uk

Please note the Corporate Policy & Diversity Team require **5 working days** to provide advice on Equality Impact Assessments.

Please note that EIAs are public documents and must be made available on the Council's EIA webpage.

Understanding the different needs of individuals and groups who use or deliver your service

In this section you will need to assess the impact (positive, neutral or negative) of your activity on individuals and groups with **protected characteristics** (this includes staff delivering your activity).

Currently there are **nine** protected characteristics (previously known as 'equality groups' or 'equality strands'): age, disability, sex/gender, ethnicity/race, religion/faith, sexual orientation, gender reassignment, marriage/civil partnership, and pregnancy/ maternity/paternity.

In addition to this, you should also consider **socio-economic status** as a protected characteristic, and the impact of your activity on individuals and groups that might be disadvantaged in this regard (e.g. carers, low income households, looked after children and other vulnerable children, families and adults).

When assessing the impact, please consider and note how your activity contributes to the Council's **Public Sector Equality Duty** and its three aims to:

- eliminate discrimination, harassment and victimisation;
- advance equality of opportunity, and
- foster good relations between people with different protected characteristics.

Guidance on how to undertake an EIA for a protected characteristic can be found on the next page.

Guidance on undertaking an EIA

Example: Background/context
In this section you will need to add the background/context of your activity. Make sure you include the scope and intended outcomes of the activity being assessed; and highlight any proposed changes. **Expand box as required*

Example: Protected characteristic		
Please tick (✓) the relevant box:		**Overall impact:** *In this section you will need to consider and note what impact your activity will have on individuals and groups (including staff) with protected characteristics based on the data and information you have. You should note whether this is a positive, neutral or negative impact.* ***It is essential that you note all negative impacts. This will demonstrate that you have paid 'due regard' to the Public Sector Equality Duty if your activity is challenged under the Equality Act.*** **Expand box as required*
Positive		
Neutral		
Negative		

Evidence: *In this section you will need to document the evidence that you have used to assess the impact of your activity.*

When assessing the impact, please consider and note how your activity contributes to the three aims of the Public Sector Equality Duty (PSED) as stated in the section above.

It is essential that you note the full impact of your activity, so you can demonstrate that you have fully considered the equality implications and have paid 'due regard' to the PSED should the Council be challenged.

- *If you have identified a **positive impact**, please note this.*
- *If you think there is a **neutral impact** or the impact is not known, please provide a full reason why this is the case.*
- *If you have identified a **negative impact**, please note what steps you will take to mitigate this impact. If you are unable to take any mitigating steps, please provide a full reason why. All negative impacts that have mitigating actions must be recorded in the **Action Plan.***

**Expand box as required*

Sources used: *In this section you should list all sources of the evidence you used to assess the impact of your activity. This can include:*

- *Service specific data*
- *Population, demographic and socio-economic data*

Suggested sources include:

- *Service user monitoring data that your service collects*
- *Havering Data Intelligence Hub*
- *London Datastore*
- *Office for National Statistics (ONS)*

If you do not have any relevant data, please provide the reason why.

**Expand box as required*

The EIA

Background/context:

The Prevention of Obesity Strategy 2016-19 outlines the approach of the Havering Health and Wellbeing Board to preventing obesity. The health and economic drivers for addressing the obesity epidemic are clear, and the benefits to length and quality of life significant. The strategy sets out a vision for how Havering, as a place and community, will support its residents to eat healthily, be active and achieve a healthy body weight.

All actions in the plan fall under the overarching corporate goal that "people will be safe, in their homes and in the community", and the associated strategic outcome to "promote healthier lifestyles to help residents live well for longer".

Three key themes are identified, with associated objectives developed under each theme:

- Shaping the environment to promote healthy eating and physical activity;
    - Ensure strategic spatial plans are consistent with efforts to increase levels of healthy eating and physical activity
    - Continue programme of work to create 'healthy streets'
    - Continue to improve the public transport offer
    - Maintain and improve access to high quality green space
    - Improve the 'cyclability' of Havering
    - Further improve schools as healthy environments
    - Ensure environment provided for clients/ staff in public sector premises supports healthy choices
- Supporting a culture that sees physical activity and healthy eating as the norm;
    - Ensure key decisions are consistent with healthy living ethos
    - Continue to ensure that workplaces support healthy choices
    - Continue to ensure the ethos of local education and community setting supports and encourages healthy choices
    - Coordinated programme of campaigns and marketing across partnership
- Prompting individuals to change, primarily through self help
    - Increase and import self-help capacity particularly regarding healthy eating
    - Ensure that residents and professionals working with them are aware of relevant (self-help) resources
    - Ensure care and support provided to vulnerable residents addresses wider health needs including healthy eating and physical activity
    - Ensure obese women are effectively supported during pregnancy
    - Increase rates of breastfeeding
    - Ensure care pathway is in place for obese children and adults

The outcomes associated with these actions will make it easier for residents to maintain or achieve a healthy bodyweight and enjoy the additional benefits that result from eating healthily and being physically active. Outcomes are listed in full in the action plan included within the strategy.

**Expand box as required*

Age: Consider the full range of age groups		
Please tick (✓) the relevant box:		**Overall impact:** The Prevention of Obesity Strategy has taken account of the needs of different age groups. Actions planned will have a positive impact on people of all ages, with a particular focus on improving outcomes for children by supporting them to be a healthy weight. An obesity care pathway will be developed to support obese children and adults. **Expand box as required*
Positive	✓	
Neutral		
Negative		

Evidence:

Prevalence of obesity increases with age. National Child Measurement Programme data demonstrates that in 2014/15, 23.7% of children in Reception Year (aged 4-5) in Havering were overweight or obese, whilst amongst Year 6 children (aged 10-11) prevalence is 35.9%. Data collected for the adult population shows a further increase in prevalence, projecting that in 2012-14 65.6% of Havering adults were overweight or obese.

As reported in Havering's Obesity Needs Assessment:

- maternal obesity is a risk in the short term to the health of both mother and baby, and also increases the risk that the child and possibly the child's children may be obese;
- breastfeeding reduces the risk of childhood obesity
- a child is more likely to be overweight if he or she has one or more overweight parents;
- obese children are between two and ten times more likely to be obese in adulthood;
- weight is more difficult to lose once gained; and
- attitudes and behaviours established during childhood shape lifestyle in later life.

The Foresight report recommends a lifecourse approach to tackling obesity. The evidence supports a focus on early years and children as a starting point for this approach.

The Prevention of Obesity Strategy therefore covers all age groups of the population, but places emphasis on giving children the best start in life by focusing on the early years. Interventions in schools also impact the wider school community (staff, parents). Adults will also be supported by workplace health initiatives. People not in work (elderly, unemployed) will benefit from community activities. Most importantly, all age-groups will benefit from the focus on shaping the local environment and public realm. As a result, intended outcomes are expected to positively impact all age groups whilst aiming specifically to address the increase in obesity levels from birth through childhood.

**Expand box as required*

Sources used:

National Child Measurement Programme
Public Health Outcomes Framework
Havering Obesity Needs Assessment

**Expand box as required*

Disability: Consider the full range of disabilities; including physical, mental, sensory and progressive conditions		
Please tick (✓) the relevant box:		**Overall impact:** The strategy will be published electronically so that it is fully accessible to people who are partially sighted or blind. The Prevention of Obesity Strategy has taken account of people living with disabilities and long term conditions. Actions planned are inclusive of the whole population, including people with disabilities and long term conditions. Reducing obesity prevalence, the overarching aim of the strategy, reduces the risk of developing long term conditions associated with obesity. **Expand box as required*
Positive	✓	
Neutral		
Negative		

Evidence:
According to the latest ONS Annual Population Survey, 18% of working age people living in Havering have disclosed that they have a disability or long term illness.

As noted in the Havering Obesity Needs Assessment, a person is more likely to be overweight or obese if he or she has a physical disability, long-term health problem or learning disability. A child is more likely to be overweight if he or she has a limiting illness, particularly a learning disability. Actions planned are inclusive of the whole population, including people with disabilities and long term conditions. The settings in which actions will take place (e.g. schools, community facilities) provide equity of access for people with disabilities and reasonable adaptations will be made as appropriate.

Additionally, as also noted in the Obesity Needs Assessment, being overweight or obese increases the risk of developing limiting long-term illness (e.g. type 2 diabetes and osteoarthritis) and mental illness (e.g. anxiety and depression). In England in 2014, 30% of obese adults had a limiting longstanding illness, compared to 19% of healthy weight peers. In 2010, high body mass index accounted for 8.6% of all disability adjusted life years. Planned actions are intended to decrease prevalence of overweight and obesity, and thus decrease risk of developing limiting long-term illnesses.

**Expand box as required*

Sources used:

This Is Havering: A Demographic and Socio-economic Profile
Havering Obesity Needs Assessment
Health Survey for England 2014

**Expand box as required*

Sex/gender: Consider both men and women		
Please tick (✓) the relevant box:		**Overall impact:** Overweight and obesity affect both men and women. Prevalence of overweight is higher amongst men, whilst obesity tends to be higher amongst women. Planned actions in the Prevention of Obesity Strategy are inclusive of men and women. Particular focus is placed on supporting women who are pregnant in light of evidence that maternal obesity is a threat to both mother and child. **Expand box as required*
Positive	✓	
Neutral		
Negative		

Evidence:
The Health Survey for England demonstrates that more men (65%) than women (58%) are overweight or obese. However, when obesity is separated out, prevalence tends to be higher for women (27%) than men (24%), particularly among younger adults. Morbid obesity is twice as common in women (3.6%) as it is in men (1.8%).

Obesity amongst women of childbearing age is a particular concern in light of growing evidence that maternal obesity is a threat to the health of both mother and child.

Compared to men, women living in disadvantaged communities are more likely to be overweight or obese.

In line with the national 'This Girl Can' campaign, specific promotion of physical activities to women and girls is being carried out at local level.

**Expand box as required*

Sources used:

Havering Obesity Needs Assessment

**Expand box as required*

Ethnicity/race: Consider the impact on different ethnic groups and nationalities

Please tick (✓) the relevant box:	
Positive	✓
Neutral	
Negative	

Overall impact:
The Prevention of Obesity Strategy has taken account of the needs of different ethnic groups. Planned actions are inclusive of all groups. Settings where some planned activities will take place, e.g. schools, will be responsible for meeting needs of people for whom English is an additional language in line with their existing policies.

**Expand box as required*

Evidence:
83% of Havering residents are recorded as White British, higher than both London and England averages. It is projected that this will decrease to 79% by 2030.

The Havering Obesity Needs Assessment states that a person is more likely to be overweight or obese if he or she is from a Black or Asian ethnic background. A child is least likely to be overweight if he or she is from a White or Chinese ethnic group.

Planned actions in the Prevention of Obesity Strategy are inclusive of all ethnic groups.

**Expand box as required*

Sources used:

Havering Obesity Needs Assessment

**Expand box as required*

Religion/faith: Consider people from different religions or beliefs including those with no religion or belief		
Please tick (✓) the relevant box:		**Overall impact:** Planned actions are inclusive of people from all religions or beliefs, including those with no religion or belief. There are no known inequalities in healthy weight between different religions. **Expand box as required*
Positive		
Neutral	✓	
Negative		
Evidence: The Havering Obesity Needs Assessment identifies groups at greater risk of becoming overweight or obese. People of different religions are not identified as an at risk group. Actions planned in the obesity strategy will benefit people from all religions or beliefs, including those with no religion or belief. **Expand box as required*		
Sources used: Havering Obesity Needs Assessment **Expand box as required*		

Sexual orientation: Consider people who are heterosexual, lesbian, gay or bisexual		
Please tick (✓) the relevant box:		**Overall impact:** Planned actions are inclusive of people from all sexual orientations. There are no known inequalities in healthy weight between people of different sexual orientations. **Expand box as required*
Positive		
Neutral	✓	
Negative		
Evidence: The Havering Obesity Needs Assessment identifies groups at greater risk of becoming overweight or obese. Sexual orientation is not identified as having any impact on inequalities related to healthy weight. Actions planned in the obesity strategy will benefit people from all sexual orientations. **Expand box as required*		
Sources used: Havering Obesity Needs Assessment **Expand box as required*		

Gender reassignment: Consider people who are seeking, undergoing or have received gender reassignment surgery, as well as people whose gender identity is different from their gender at birth	
Please tick (✓) the relevant box:	**Overall impact:** Planned actions are inclusive of people seeking, undergoing, or who have undergone gender reassignment surgery or whose gender identity is different from their gender at birth. There are no known inequalities in healthy weight for people who have undergone gender reassignment. **Expand box as required*
Positive	
Neutral	✓
Negative	
Evidence: The Havering Obesity Needs Assessment identifies groups at greater risk of becoming overweight or obese. People who are seeking gender reassignment surgery or whose gender identity is different from their gender at birth are not identified as an at risk group. Actions planned in the obesity strategy will benefit people from all genders. **Expand box as required*	
Sources used: Havering Obesity Needs Assessment **Expand box as required*	

Marriage/civil partnership: Consider people in a marriage or civil partnership	
Please tick (✓) the relevant box:	**Overall impact:** Planned actions are inclusive of people who are married or in a civil partnership. There are no known inequalities in healthy weight for people who are in a marriage or civil partnership. **Expand box as required*
Positive	
Neutral	✓
Negative	
Evidence: The Havering Obesity Needs Assessment identifies groups at greater risk of becoming overweight or obese. Sexual orientation is not identified as having any impact on inequalities related to healthy weight. Actions planned in the obesity strategy will benefit people whether or not they are in a marriage or civil partnership. **Expand box as required*	
Sources used: Havering Obesity Needs Assessment **Expand box as required*	

Pregnancy, maternity and paternity: Consider those who are pregnant and those who are undertaking maternity or paternity leave		
Please tick (✓) the relevant box:		**Overall impact:** Maternal obesity presents a risk in the short term to the health of both mother and child. It also increases the risk that the child and possible the child's children may be obese. Actions planned in the obesity strategy therefore focus on ensuring obese women are effectively supported during pregnancy. **Expand box as required*
Positive	✓	
Neutral		
Negative		
Evidence: The Havering Obesity Needs Assessment identifies groups at greater risk of becoming overweight or obese. Children of women who are obese in pregnancy are more likely to become overweight or obese, and women who are obese in pregnancy are also at increased risk of ill health or complications during pregnancy. The risk of ill-health increases with increasing BMI but many of the complications of obesity can be reduced by weight loss. Actions planned in the obesity strategy will support women, along with the rest of the population, to be a healthy weight and also focus on ensuring obese women are effectively supported during pregnancy. **Expand box as required*		
Sources used: Havering Obesity Needs Assessment **Expand box as required*		

Socio-economic status: Consider those who are from low income or financially excluded backgrounds		
Please tick (✓) the relevant box:		**Overall impact:** A person is more likely to be overweight or obese is he or she lives in a disadvantaged community. Obesity prevalence in children is strongly correlated with disadvantage with children more likely to be overweight if they are from a lower income family. Overall the strategy will have a positive impact on people from all socioeconomic backgrounds. Improvements to the public realm and built environment will benefit people universally. Targeted work will ensure children eligible for free school meals are identified, are encouraged to take up this entitlement and that the meal they receive is healthy. However, there is some stigma attached to the uptake of free school meals and steps to reduce any discrimination attached to this are provided in the action plan below. **Expand box as required*
Positive		
Neutral		
Negative	✓	

Evidence:
The Havering Obesity Needs Assessment identifies an association between obesity and area deprivation (IMD 2010) with 22% of adults in quintile 1 (least disadvantaged) recorded as obese rising to 29% in quintile 5 (most disadvantaged). Obesity prevalence in children is strongly correlated with disadvantage, with prevalence in the most deprived decile being about twice that in the least deprived for both Reception and Year 6 children.

Prevalence of deprivation varies across Havering: 12.9% of children in Havering are eligible for and claiming free school meals which is less than the average for London (21.2%) and England (16.0%), however at school level the proportion varies from 1.9% to 46.8%.

Actions planned in the obesity strategy will support children and families from all socioeconomic backgrounds. Improvements to the public realm and built environment will benefit people universally. Targeted work will ensure children eligible for free school meals are identified, take up this entitlement and that the meal they receive is healthy.

There is some stigma attached to the uptake of free school meals and in order to reduce any discrimination attached to this, Havering Catering Services is working to eliminate the 'dinner tickets' given to free school meal children by introducing a cashless system. The aim is for this to be in place in all schools by the end of the 2016/17 school year.

Vulnerable families and children are supported by actions focused on improving outcomes for looked after children and families accessing the Early Help service offer.

**Expand box as required*

Sources used:

Havering Obesity Needs Assessment

**Expand box as required*

Action Plan

In this section you should list the specific actions that set out how you will address any negative equality impacts you have identified in this assessment.

Protected characteristic	Identified negative impact	Action taken to mitigate impact*	Outcomes and monitoring**	Timescale	Lead officer
Socio-economic status	Improving identification of children eligible for free school meals could expose these children to the stigma sometimes attached to being in receipt of a free meal.	Havering Catering Services is introducing a cashless system in all primary schools which will eliminate 'dinner tickets' given to free school meal children. With the cashless system, accounts are pre-credited, and the source of this credit is not known to other children.	Havering Catering Services will be monitoring the implementation of the cashless system on a termly basis.	The aim is for the cashless system to be in place in all schools by the end of the 2016/17 school year.	Dennis McKenzie (Havering Catering Services)

***** You should include details of any future consultations you will undertake to mitigate negative impacts

** Monitoring: You should state how the negative impact will be monitored; how regularly it will be monitored; and who will be monitoring it (if this is different from the lead officer).

Review

This EIA will be reviewed on an annual basis for the duration of the strategy (2016-2019). The next review will be March 2017.

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