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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD
AGENDA

1.00 pm	Wednesday, 10 May 2017	Committee Room 3B - Town Hall

Members: 16, Quorum: 9

BOARD MEMBERS:

Elected Members:	Cllr Wendy Brice-Thompson (Chairman) Cllr Gillian Ford Cllr Roger Ramsey Cllr Robert Benham
Officers of the Council:	Andrew Blake-Herbert, Chief Executive Tim Aldridge, Director of Children's Services Barbara Nicholls, Director of Adult Services Mark Ansell, Interim Director of Public Health
Havering Clinical Commissioning Group:	Dr Atul Aggarwal, Chair, Havering Clinical Commissioning Group (CCG) Dr Gurdev Saini, Board Member Havering CCG Conor Burke, Accountable Officer,Barking & Dagenham, Havering and Redbridge CCGs Alan Steward, Chief Operating Officer, Havering CCG
Other Organisations:	Anne-Marie Dean, Healthwatch Havering Matthew Hopkins, BHRUT Ceri Jacob, NHS England Jacqui Van Rossum, NELFT

For information about the meeting please contact:
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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.

   Cllr Brice-Thompson.

   Start time: 13.00

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 any 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 OR AGENDA) (Pages 1 - 12)

To approve as a correct record the minutes of the Committee held on 15 March 2017 (attached) and to authorise the Chairman to sign them.

Cllr Brice-Thompson

13.05

5. ACTION LOG (Pages 13 - 14)

Attached.

Cllr Brice-Thompson.

13.10

6. UPDATE ON REFERRAL TO TREATMENT DELAYS (Pages 15 - 20)

Report attached.

Sarah Tedford/Louise Mitchell

13.15

7. DEMENTIA STRATEGY FOR SIGN OFF (Pages 21 - 54)

Report and draft strategy attached.

Andrew Rixom, on behalf of CCG.

13.35

8. INTEGRATED CARE PARTNERSHIP (Pages 55 - 64)

Report attached.

Barbara Nicholls/Alan Steward.

13.50

9. UPDATE ON STP (Pages 65 - 118)

Report attached.

Ian Tompkins.

14.10

10. HEALTH AND WELLBEING STRATEGY: EXTENSION TO JUNE 2019 (Pages 119 - 120)

Report attached.

Mark Ansell.

14.25

11. REFRESHED HEALTH AND WELLBEING BOARD STRATEGY DASHBOARD/INDICATOR UPDATE (Pages 121 - 144)

Report attached.

Mark Ansell.

14.40

12. FORWARD PLAN (Pages 145 - 148)

Attached.

Mark Ansell

14.55

13. DATE OF NEXT MEETING

Tuesday 19 July 2017, 1 pm, Havering Town Hall.

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MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD Committee Room 3B - Town Hall 15 March 2017 (1.00 - 3.06 pm)

Board Members Present:

Elected Members: Councillors Wendy Brice-Thompson (Chairman), Gillian Ford, Roger Ramsey and Robert Benham

Officers of the Council: Dr Susan Milner (Interim Director of Public Health), Andrew Blake-Herbert (Chief Executive) and Tim Aldridge (Director of Children's Services)

Havering Clinical Commissioning Group (CCG): Dr Atul Aggarwal (Chair, Havering Clinical Commissioning Group (CCG)) and Alan Steward (Chief Operating Officer, Havering CCG)

Healthwatch: Anne-Marie Dean (Healthwatch Havering)

Carol White, Integrated Care Director, North East London NHS Foundation Trust (NELFT)*

+ substituting for Barbara Nicholls, Director of Adult Services, London Borough of Havering
*substituting for Jacqui van Rossum, NELFT (part of meeting)

Also Present:
Mark Ansell, Public Health
Elaine Greenway, Public Health
Gloria Okewale, Public Health
Miriam Fagbemi, Public Health
Claire Alp, Public Health
Pippa Brent Isherwood, Head of Business and Performance
Ian Elliott, Children's Services
Anthony Clements, Democratic Services
Louise Mitchell, Redbridge CCG
Ian Tompkins Sustainability and Transformation Plan (STP) team

One member of the public was also present.

Apologies were received for the absence of Matthew Hopkins, Barking, Havering and Redbridge University Hospitals' NHS Trust (BHRUT) Jacqui van Rossum, NELFT, Conor Burke, BHR CCGs, Dr Gurdev Saini (Havering CCG) and Ceri Jacob (NHS England)

All decisions were taken with no votes against.

24 WELCOME AND INTRODUCTIONS

The Chairman welcomed all present to the meeting and reminded everyone present of the action to be taken in the event of an emergency.

25 DISCLOSURE OF INTERESTS

The following interest was disclosed:

11. UPDATE ON SUSTAINABILITY AND TRANSFORMATION PLAN (STP).
Councillor Gillian Ford, Personal, Family relationship with presenter of the item.

26 MINUTES AND MATTERS ARISING (NOT ON ACTION LOG OR AGENDA)

The minutes of the meeting of the Board held on 18 January 2017 were agreed as a correct record and signed by the Chairman. There were no matters arising not covered elsewhere on the agenda.

27 ACTION LOG

It was confirmed that a list of pharmacists taking referrals from NHS 111 had been circulated to the Board.

A lot of work had been undertaken to clarify which groups looked to the Board for their governance. This would be completed within the next two weeks and circulated to the Board by e-mail.

A great deal of work had been done to identify appropriate KPIs for the HWB strategy dashboard. It had been originally suggested that KPIs would be selected from those strategies and action plans that contribute to delivery of the high level HWB strategy. However, in most cases, it was not possible to obtain trend data or to compare performance with other areas. It was therefore proposed to use indicators from sources such as national health and social care outcomes frameworks to produce a high level set of outcomes. Greater detail regarding the delivery of strategies and action plans and their respective KPIs would be provided through the HWB receiving reports from relevant groups.

A regular slot on the agenda had been created to receive an update on work on the Sustainability and Transformation Plan. A locality boundaries paper would be brought to the May meeting of the Board.

The updated Board action log is attached to these minutes.

28 UPDATE ON REFERRAL TO TREATMENT DELAYS

BHRUT officers reported that there had been significant progress at the Trust in reducing the backlog of patients awaiting treatment. The Trust was due to reach the 92% target for patients waiting less than 18 weeks in September 2017. It had also been confirmed that legal directions issued to Havering CCG on this issue had now been removed.

The Trust continued to review the backlog weekly and a Referral to Treatment Programme Board continued to meet on a fortnightly basis. The CCG was also on track to deliver its target for the number of referrals diverted from hospital to other healthcare facilities.

The data quality problem that BHRUT had experienced had now been resolved and third party assurance had been received on this.

The Board:

- **NOTED** progress of RTT activity and the reduction in long waiting patients
- **NOTED** progress with the clinical harm reviews of long waiting patients
- **NOTED** the work and support BHRUT had given with the development of a system-wide RTT recovery plan in response to the legal directions placed on NHS Havering Clinical Commissioning Group by NHS England which came into force on 20 June 2016.

29 HEALTH PROTECTION FORUM REPORT

The 2016 report summarised arrangements for protecting the health of the population. The report also provided a spotlight on seasonal influenza which described the uptake of flu immunisation, arrangements for ensuring good uptake, and surveillance arrangements.

A number of agencies and groups provide reports to the Health Protection Forum, including the air quality working group. The main campaigns on air quality were funded by the Greater London Authority for whom this was a key issue. Havering had the best air quality in London although it was accepted that this could still be improved further.

The Board **NOTED** the report.

30 HAVERING CCG 17/18 OPERATING PLAN

CCG officers explained that the plan would be delivered over a two year timescale and covered the financial challenges facing the CCG as well as quality and performance issues. The financial challenge across the three local boroughs totalled £55 million (5-6% of the total budget) of which

Havering's share was around £22 million due to being the highest user of Queen's Hospital. This meant savings of £35 million had to be delivered for 2017/18 and a system delivery plan was being developed in conjunction with NHS Improvement and the rest of the health economy.

Whilst some inefficiencies could be driven out e.g. there were currently ten different providers of urgent and emergency care, it would remain necessary to also decide which services could continue to be funded. People also needed to be encouraged to use more self-care via for example seeking advice from their pharmacist. Having clinicians available at NHS 111 was also being piloted as a way of allowing people to self-care more.

The main decision making body for this work would be the Integrated Care Partnership Board and a Performance and Delivery Board had been established below this comprising representative of GPs, Local Authorities and providers such as NELFT. Operating plan priorities included primary care improvements, access to emergency care and work on Referral to Treatment times and cancer services. There would also be additional funding for mental health and learning disability services. End of life care would also be covered within the system delivery plan.

It was agreed that responsibilities towards Looked After Children would be included within the plan. There would also be a focus on non-elective admissions. It was suggested that a recent paper from BHRUT on the numbers of children self-harming could be brought to a future meeting of the Board.

Members felt that it was necessary to define what was meant by 'prevention' and to also look at how resources were moved across the system. It was noted that GPs spent large amounts of resources prescribing e.g. paracetamol which could be purchased cheaply from supermarkets. It was also not a good use of time for GP's to chase up patients' appointments with consultants etc.

It was confirmed that delays to treatment at BHRUT would cost Havering CCG £22 million this year and £8 million next year. Whilst 24,000 patients had been diverted from BHRUT, other providers would still need to be paid for this work.

The Board **NOTED** the report.

31 PRESENTATION OF RECENT AREA INSPECTION OF SEND JOINT SELF-EVALUATION

It was noted that this work was covered by the Children and Families Act 2014 and incorporated a move from Statements to Education, Health and Care Plans (EHCPs). The aim was to have children's needs met within school settings where possible. The inspection concentrated on joint

commissioning of these services and how children, parents and carers were involved in this.

A single inspection in autumn 2016 had given positive feedback on services for disabled children. Education provision had improved and a Joint Strategic Needs Assessment deep dive for SEND had been completed. The Local Offer would be relaunched in summer 2017. The SEND 2 survey had been completed and additional resources had been put in place to convert Statements to Education, Health and Care Plans (EHCPs).

Outcomes of the self-evaluation process included plans to have quicker decision making for children with EHCPs and moving to having a single child record in one place. The short breaks service was currently out to tender and a High Needs review would commence in mid-2017. Options for joint working with Barking & Dagenham and Redbridge were also being explored.

Of seventeen OFSTED or CQC inspections to date, there had been four formal statements of action given. Recurring themes included parents and carers not being sufficiently involved and a need for better timeliness in the agreeing of EHCPs. Other issues identified included long waits for treatment such as speech and language therapy, audiology, paediatrics and occupational therapy. The use of personal budgets was also limited.

Risks identified included demand management with more children in Havering having more complex needs than previously. Limited use of personal budgets was also an identified risk as were waiting times for some therapies and services around the transition into adulthood. A programme of improvements had been agreed and an action plan put in place, overseen by an Executive Board including representatives of parents and schools. Regular updates on progress would be provided to the Board.

The Board **NOTED** the update and the areas for action over the coming months.

32 **OBESITY STRATEGY UPDATE**

It was noted that an Obesity Prevention Working Group had been established which had received good press coverage for pan-London initiatives. The group had also met with the Youth Council. Engagement with School Councils would also be covered in the development of the Healthy Schools Programme.

Key issues included the Local Government Declaration on Sugar Reduction and Healthier Food which could lead to Public Health having input into decisions about Council advertising and sponsorship. An update on this area could be given at the next meeting of the Board.

The Havering Show could be used as an opportunity to supply information on obesity and it was suggested that Children's Centres could also be used

to educate parents about obesity via healthy cooking etc. The Early Help team also had health visitors, breast feeding nurses etc who could support women with infant feeding. Under the Localities model, ante-natal care could also be delivered at Children's Centres.

The Board:

- Reviewed progress made with the action plan during 2016-17;
- Discussed the refreshed action plan for 2017-18 and suggested any amendments and additions;
- **APPROVED** the Obesity Prevention Working Group to pursue cross-Council commitment to the Local Government Declaration on Sugar Reduction and Healthier Food;
- **AGREED** that the Chair of the Health and Wellbeing Board could approve the 2017-18 action plan without further reference to the Board;
- **AGREED** that the next update should be provided at the May 2018 meeting of the Health and Wellbeing Board. The slightly later date would allow for year-end data to be collected and reported.

33 UPDATE ON SUSTAINABILITY AND TRANSFORMATION PLAN (STP)

The top priority of the Sustainability and Transformation Plan (STP) had been identified as prevention and defining what was done locally. Board members felt that it should established who benefitted from prevention work as well as who paid for this. The amount of investment required and at what level was not known at this stage. Hence a system-wide approach was required. Officers agreed, confirming that the STP area covered a population of around 2 million people and this was expected to grow by approximately 300,000.

Workforce issues were also a priority with a considerable number of local GPs approaching retirement age. Efforts were being made to promote the local area to new doctors and work supplying affordable housing or key worker accommodation was also in progress. The Council Chief Executive added that key worker accommodation was a major aspiration for Havering.

A total of eight work streams were being developed in the draft STP. A Memorandum of Understanding (now called a Partnership Agreement) had been agreed but this would not constitute a formal sign-off of the full STP. Three Council Chief Executives would be members of the STP Shadow Governance Board.

Directors of Adult Services, Children's Services and Public Health had been brought together in the previous week to discuss the STP and notes could

be shared of this meeting. Proposals would also come forward from this group. Terms of reference for the STP community group had also been drafted. This group included Healthwatch, voluntary organisations and charities. The wider STP reference group included representation from the British Medical Association, Local Medical Committee, Trade Unions, Police and the London Fire Brigade.

The STP would now be called the East London Health and Care Partnership and officers had recently met with communications and engagement leads from across the area. A central on line briefing room for the proposals would also be created.

It was planned that engagement would take place over the spring and summer and STP officers were keen to have a presence at the Havering Show. It was accepted that there was currently some lack of working across the boroughs.

Board members felt that the STP was unclear on what capital funding would be available to fund any expansion of A & E at Queen's Hospital. Officers responded that clarity was needed over what services the Urgent Care Centre at King George would be providing. There would not be any overnight closure of King George A & E this year nor were any bed closures planned. Assurances on the level of provision in nearby hospitals would be required before any closure of the A & E at King George. The STP partnership could be involved in brokering a solution to this issue.

The recent delay to the announcement of plans for the devolution of London health services was a challenge as this could impact on investment into the health sector.

Engagement was under way between the Council and the CCG to build health facilities and capacity into planning developments. This also linked to the housing development targets being set the Mayor of London's office. The Leader of the Council added that 50,000 extra people were expected to move to Havering in the next 15 years.

The Board **NOTED** the update.

34 BETTER CARE FUND REPORT

Officers explained that, whilst a technical update on the Better Care Fund was expected shortly, there was not likely to be any increase in funding for Havering.

The Better Care Fund plan covered a two year period (2017-19) and looked to move to a tri-borough approach. The Health and Wellbeing Board would have oversight of this. If Havering could achieve graduation from Better Care Fund planning, this would allow more flexibility. Guidance on the assurance process was awaited but this was likely to be less onerous than in previous years.

The sharing of risk would be revisited once the guidance had been received and CCG officers added that how risk was shared was important, given the reduced funding to support social care. Agreement on this should allow more of a focus on patients. The Council Chief Executive agreed that an improved pathway should be designed for patients.

The Board:

1. **AGREED** to delegate authority to the HWBB Chair to approve the final submission of the BCF Plan 2017/19 to NHS England for submission as required by the guidelines, subject to obtaining approval from the Council and the Havering Clinical Commissioning Group (CCG).

2. **NOTED** the intention to consider a three borough approach in year two of the plan, which will be subject to further consultation and agreement with the HWBB.

3. **AGREED** to receive, at the first opportunity, the final submission that was made, and subsequently to receive monitoring reports at six monthly intervals.

4. **AGREED** to delegate authority to the HWBB Chair to approve BCF statutory reporting returns each quarter.

35 **FORWARD PLAN**

It was agreed that the CCG System Delivery Plan should be brought to the May meeting of the Board.

The paper to be circulated detailing what groups looked to the Health and Wellbeing Board for governance would give an indication of what strategies were due to come to the Board although other groups could also be asked to present to the Board if required.

The CCG Chief Operating Officer would lead on a future item concerning the consultation on service restriction and prior approval. A report on the CAMHS transformation plan would also be brought to a future meeting of the Board.

It was agreed that any other suggestions for the forward plan should be forwarded to the Interim Director of Public Health.

36 DATE OF NEXT MEETING

The next meeting of the Board was scheduled at 1 pm on Wednesday 10 May at Havering Town Hall.

Chairman

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Health and Wellbeing Board Action Log (following March 17 Board meeting)

No.	Date Raised	Board Member Action Owner	Non-Board Member Action Owner	Action	Date for completion	RAG rating	Comments
17.02	18 January 17	Susan Milner		SM to produce governance diagram for circulation to HWB members.	29th March		
17.03	18 January 17	Susan Milner		HWB strategy dashboard to be circulated o HWB members.	10th May		
17.06	15 March 17	Matthew Hopkins,		BHRUT to provide a paper on the numbers of children self-harming. This will be presented at future meeting.	10th May		
17.07	15 March 17	Susan Milner		Paper to be circulated detailing what groups looked to the Health and Wellbeing Board for governance.	10th May		
17.08	15 March 17	Alan Steward		CCG Chief Operating Officer to lead on a future item concerning the consultation on service restriction and prior approval	10th May		
17.09	15 March 17	Jacqui Van Rossum,		A report on the CAMHS transformation plan to be brought to a future meeting of the Board	10th May		

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17.07	15 March 17	Alan Steward		CCG Chief Operating Officer to lead on a future item concerning the consultation on service restriction and prior approval	TBC		
17.08	15 March 17	Jacqui Van Rossum		A report on the CAMHS transformation plan to be brought to a future meeting of the Board	TBC		
17.09	15 March 17	Barbara Nicholls		Final Better Care Fund report to be brought to future meeting and subsequently to receive monitoring reports at six monthly intervals.	TBC		

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LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	**Update on Referral to Treatment (RTT) Delays**
Board Lead	**Alan Steward, Chief Operating Officer, Havering CCG**
Report Author and contact details:	**Sarah Tedford (PA LeeAnn Hamilton 01708 435039) and Louise Mitchell**

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

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- ☐ Theme 1: Primary prevention to promote and protect the health of the community and reduce health inequalities
- ☐ Theme 2: Working together to identify those at risk and intervene early to improve outcomes and reduce demand on more expensive services later on
- ☐ Theme 3: Provide the right health and social care/advice in the right place at the right time
- ☒ Theme 4: Quality of services and user experience

SUMMARY

Significant issues were identified with how Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) had historically reported Referral to Treatment (RTT). We suspended reporting of the RTT standard in 2014 so that we could fully investigate the issues and create a robust and comprehensive recovery plan. Since the RTT issues were identified in 2014 we have been working to recover our RTT position and implement our Recovery and Improvement Plan.

As of the end of March 2017, we were 7.4% ahead of our recovery trajectory to deliver the RTT national standard by the end of Sept 2017. We have treated 2,781 more patients than anticipated. In April 2014 we had just over 1,000 patients who had waited more than a year for their treatment. At the end of March 2017 we

reported 3 patients had waited more than a year for their treatment, with a number of these patients choosing to wait longer following our offers to treat them sooner.

RECOMMENDATIONS

- To note progress of RTT activity and the reduction in long waiting patients
- To note progress with the clinical harm reviews of long waiting patients
- To note the work and support we have given with the development of a system-wide RTT recovery plan in response to the legal directions placed on NHS Havering Clinical Commissioning Group by NHS England which came into force on 20 June 2016.

REPORT DETAIL

In December 2013, the Trust migrated from Total Care Patient Administration System (PAS), to Medway PAS. This change in information system for the management of patient waiting lists, whilst large and complex, should not have affected performance. However, the migration exposed a discrepancy between current performance and historical performance and suggested that we were not compliant with Referral To Treatment (RTT) standards, as was previously thought. A reporting break was agreed in February 2014 to give us time to investigate.

In light of the issues identified, we undertook an investigation into the matter in August 2014, which concluded that there are five main reasons for the decline in performance following the deployment of Medway:

1. RTT performance was not calculated correctly
2. Our governance processes for reporting and oversight were weak
3. Demand and capacity were not aligned
4. Data quality was poor
5. Training and organisational awareness of RTT and its rules were limited.

Since the RTT issues were identified in 2014, we have been working to recover our RTT position as captured in this Recovery and Improvement Plan.

Current RTT Position

There is dedicated Project Management Office support for RTT across the whole health system and there are a number of work streams in motion to support the delivery of the recovery plan for RTT:

1. Operational management
2. Outsourcing
3. Demand and capacity analysis
4. RTT administration and governance
5. Validation and data quality
6. Theatre productivity
7. Clinical harm reviews
8. GP Referral demand management programme

Clinical Harm Reviews

A key element of the RTT Recovery Plan is the Clinical Harm Programme. The programme is designed to ensure risk to patients waiting longer than the NHS constitutional standards for their treatment are appropriately and efficiently managed. Patients are reviewed, and the findings reported weekly via Access Board and the Clinical Harm Review Panel.

Phase 1

- Focused on patients on admitted pathway
- More than 900 reviews carried out
- No moderate or severe harm identified.

Phase 2

- Focused on patients on non-admitted pathway
- More than 3,500 reviews carried out
- No moderate or severe harm identified

Phase 3

- Commenced 1 October 2016
- Focused on patients who would have been waiting more than 52 weeks before 3 December 2016
- All 83 patients have been reviewed and no moderate or severe harm identified

Phase 4

- Commence 5 December 2016
- Focused on a random sample of 10% of undated patients with a 35 week breach date between 4 December and 13 March 2017
- 206 patients have been reviewed for risk of deterioration with no harm found.

Phase 5

- Commenced 15th March 2017
- Focused on non-admitted patients who have been waiting between 30 and 40 weeks

- 225 patients in this cohort, a random sample of 10% of patients (23 in total) are being reviewed – this work is still ongoing.

GP referral demand management programme

The challenge of delivering the national standard for RTT has been prioritised by all three BHR Clinical Commissioning Groups (CCG). They have the responsibility to avert 24,575 GP outpatient referrals this year by sending patients to a range of alternative independent sector and community providers. At end of March 2017, a total of 28,540 referrals have been diverted - 22,187 were redirected to alternative service and 6,353 diverted to new pathways.

Patients who have waited a long time for treatment (52 weeks plus)

We have a small number of patients who are now waiting over 52 weeks for treatment. These are patients who have;

- chosen to postpone their treatment for personal reasons having been offered reasonable choice
- not responded to three letters, contact via their GP asking them to arrange an appointment
- not attended two consecutive appointments are on a complex care pathway

We will continue to reduce waiting times to prevent this issue from arising again and in line with our commitment to deliver the RTT national standard by September 2017.

RTT recovery plan in response to legal directions

In response to the legal directions issued by NHS England in June 2016 to Havering CCG, (Lead CCG for BHRUT contract) we developed a robust and credible recovery plan, which will allow us to return to delivering the RTT standards. Based upon the modelling, the expectation is to deliver the national 92% RTT incomplete standard by the end of September 2017.

NHS England is now fully assured that all requirements, as set out in the original Directions, have been satisfied. This is the result of focused work to deliver our plan, plus subsequent system performance. The Legal Directions against Havering CCG concerning RTT have now been lifted (Feb 2017).

There is a significant challenge to return to meeting the RTT standards in a sustainable manner that has involved undertaking a significant amount of extra

operations (5,000) and outpatient appointments (95,000) over a 12-month period, and we have worked hard with our system-wide partners on this challenge.

We continue to make good progress with our agreed RTT recovery plan. For the end of March 2017 we were 7.4% ahead of our trajectory with an incomplete performance of 88.2% against a month end target of 80.8%. In April 2014 we had just over 1,000 patients who had waited more than a year for their treatment. At the end of March 2017 we reported 3 patients had waited more than a year for their treatment, with many choosing to wait longer following our offers to treat them sooner.

Return to Reporting RTT standards

Following extensive validation and improvements in data quality we have taken steps to assure a return to reporting for RTT performance. We returned to reporting with the October 2016 RTT position, which was reported at our December 2016 Board and nationally mid-December 2016. This was following a suspension of reporting since February 2014.

We constructed a detailed plan to support this work and sought external assurance as recommended by NHS England with this work. This was a big step for us as an organisation and has helped to increase our confidence with reducing waiting times and delivering the national RTT constitutional standards.

On-going assurance

A Governance and Assurance Framework has been developed with a clear reporting line and for governance. RTT assurance and governance will be managed through the RTT Programme Board. External assurance is also provided through weekly meetings with NHSE and NHSI. The Trust also has a weekly Access Board that feeds into the RTT Programme Board. This is chaired by the Deputy Chief Operating Officer. There is also an External Clinical Harm Panel chaired by NHS England.

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HEALTH & WELLBEING BOARD

Subject Heading:	**Joint Dementia Strategy for Havering 2017-2020**
Board Lead:	**Dr Gurdev Saini, Havering CCG**
Report Author and contact details:	**Dr Gurdev Saini, Havering CCG**

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

- ☐ Theme 1: Primary prevention to promote and protect the health of the community and reduce health inequalities
- ☒ Theme 2: Working together to identify those at risk and intervene early to improve outcomes and reduce demand on more expensive services later on
- ☒ Theme 3: Provide the right health and social care/advice in the right place at the right time
- ☒ Theme 4: Quality of services and user experience

SUMMARY

The vision of the Dementia Partnership Board strategy is

> For all people with dementia and their carers to continue to “live life to the full” from diagnosis to end-of-life.

There is a requirement for all local areas to have a joint commissioning strategy for dementia. This is particularly crucial to Havering, given the ageing population and the anticipated rise in the numbers of people with dementia. The key commissioning organisations, Havering CCG and LBH, are committed to work together to procure quality responsive services for people living with dementia and their carers, a priority area of the Health and Wellbeing Board. This strategy includes a work plan and proposed indicators to support this vision.

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RECOMMENDATIONS

That the Health and Wellbeing Board support this strategy.

REPORT DETAIL

Please see attached strategy

IMPLICATIONS AND RISKS

Financial implications and risks: None
Legal implications and risks: None
Human resource implications and risks: None
Equalities implications and risks: None

BACKGROUND PAPERS

None

Havering
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NHS
Havering Clinical Commissioning Group

Joint Dementia Strategy for Havering

2017 -2020

'a dementia friendly borough'

Version Control

Author	Dr Jacqui Lindo, CPHM		
Acknowledgments	Havering Dementia Partnership Board LBH: Syed Rahman, Jenny Gray HCCG: Jordanna Hamberger		
Implementation Date	2017		
Expiry Date	2020		
Responsibility for Strategy	Havering Dementia Partnership Board		
Version	Author(A) Reviewer(R)	Issue date	Reason
Draft 1 v.01	Dr Saini(R) Jordanna Hamberger(R) Dr Saini(R)	08/09/2016	Comments from Jenny Gray re current service provision; dementia coordinator role
Draft 2 V0.2	Havering Dementia Partnership Board (R)	19/09/2016	Comments regarding prevalence, early onset dementia, care pathway, evidence based care
Draft 3 v0.3	Havering HWB	TBC/11/2016	For agreement
Draft 4 v0.4	Dementia Liaison Officer	21/12/2016	For presentation to OSC – Jan 2017
Draft 5 v0.5	Jenny Gray LBH Clare Conn HCCG	18/04/2017	Refine work plan and indicators

1. Table of Contents

2. Foreword

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Dementia is a growing, global challenge. As the population ages, it has become one of the most important health and care issues facing the world. The number of people living with dementia worldwide today is estimated at 44 million people, set to almost double by 2030[6].

The Dementia UK Update [1]report calculated the overall costs of dementia in the UK as £26.3 billion per annum, with an average cost of £32,250 per person. This included care provided by formal agencies, as well as the value of unpaid care provided by carers, and included loss of earnings. The estimated cost of unpaid care amounted to £11.6 billion.

It is important to note that dementia and dementia care costs the health and social economy more than those for cancer, heart disease and stroke combined.

The fall-out on people's lives can be simply catastrophic. Those coping with dementia face the fear of an uncertain future; while those caring can see their loved ones slipping away.

Although the challenge is great, we believe that in Havering if we work effectively with people with dementia, their families and caregivers, we can meet this challenge.

The overall aim of this strategy is to raise the profile and importance of dementia care and support; and to build on the progress that Havering has already made in improving the lives of those with dementia

This refresh of the 2014-2017 strategy will be overseen by the Havering Dementia Partnership Board which is committed to ensuring that the people of Havering have access to high quality dementia care and support.

Dr Gurdev Saini ***Councillor Wendy Bryce-Thompson***

[1] Alzheimer's Society: Dementia UK Update Second Edition 2014

3. Introduction

The Prime Minister's Challenge on Dementia 2020 builds on that of 2012 with the new Challenge aiming to make England, by 2020, the best country in the world for dementia care, support, research and awareness. England should be the best place for people with dementia, their caregivers and families to live.

The national dementia strategy[2] provides the objectives around which local strategies should be developed (Table 1).

Table 1: Living well with dementia -*the 17 key objectives of the national dementia strategy*

Objective 1: Improving public and professional awareness and understanding of dementia	Objective 10: Considering the potential for housing support, housing-related services and tele-care to support people with dementia and their carers
Objective 2: Good-quality early diagnosis and intervention for all	Objective 11: Living well with dementia in care homes
Objective 3: Good-quality information for those with diagnosed dementia and their carers	Objective 12: Improved end of life care for people with dementia
Objective 4: Enabling easy access to care, support and advice following diagnosis	Objective 13: An informed and effective workforce for people with dementia
Objective 5: Development of structured peer support and learning networks	Objective 14: A joint commissioning strategy for dementia
Objective 6: Improved community personal support services.	Objective 15: Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers
Objective 7: Implementing the Carers' Strategy	Objective 16: A clear picture of research evidence and needs
Objective 8: Improved quality of care for people with dementia in general hospitals	Objective 17: Effective national and regional support for implementation of the Strategy.
Objective 9: Improved intermediate care for people with dementia	

[2] DH: Living well with dementia: A **National Dementia Strategy**. 2009

3.1 What is dementia?

The term 'dementia' describes a set of symptoms that include loss of concentration and memory problems, mood and behaviour changes and problems with communicating and reasoning. These symptoms occur when the brain is damaged by certain diseases, such as Alzheimer's disease, a series of small strokes or other neurological conditions such as Parkinson's disease. Around 60 per cent of people with dementia have Alzheimer's disease, which is the most common type of dementia, around 20 per cent have vascular dementia, which results from problems with the blood supply to the brain and many people have a mixture of the two.

Dementia is a progressive condition, which means that the symptoms become more severe over time. People with dementia and their families have to cope with changing abilities such as the capacity to make decisions about major life events as well as day-to-day situations.

The reality for many people with dementia is that they will have complex needs compounded by a range of co-morbidities.

After 65, the likelihood of developing dementia roughly doubles every five years.[3]

Currently, dementia is not curable. However, medicines and other interventions can lessen symptoms for a period of time and people may live with their dementia for many years after diagnosis. There is also evidence that more can be done to delay the onset of dementia by reducing risk factors and living a healthier lifestyle.

3.2 Why have a local strategy?

There is a requirement for all local areas to have a joint commissioning strategy for dementia[4]. It is vital that the public, stakeholders, commissioners and providers develop a shared vision of aspirations for the future with regard to dementia care and services. This is particularly crucial to Havering, given the ageing population and the associated anticipated rise in the numbers of people with dementia. Both key commissioning organisations, that is, Havering CCG and LBH, are committed to work together, with dementia identified as a key shared priority area by the Health and Wellbeing Board.

[3] LSE, King's College London, Alzheimer's Society. Dementia UK: The Full Report,2007

[4] DH: Living well with dementia: A **National Dementia Strategy**. 2009

4. Vision for Dementia

Our vision is for all people with dementia (PWD) and their carers to continue to 'live life to the full' from diagnosis to end of life. This vision aligns with the Havering Health and Wellbeing Strategy.

4.1 Our principles

We believe we should:

- Listen to and engage with people with dementia and their carers
- Enable and facilitate people to make informed choices and exercise choice and control over their lives
- Involve people in decisions about their lives
- Support people in accessing the right service at the right time
- Involve, engage and support carers
- Strive to tackle the stigma associated with dementia
- Commission integrated services which are straightforward to navigate
- PWD and carers should have appropriate and relevant support and be aware of how and where to access the support

If we are successful in delivering this strategy patients, families and their carers will agree with the 'I' statements described in the national outcomes framework[5] (Table 2).

Table 2: Vision Statements

✓ **I was diagnosed early**	✓ **I understand , so I make good decisions and provide for future decision making**
✓ **I get the treatment and support which are best for my dementia and my life**	✓ **Those around me and looking after me are well supported**
✓ **I am treated with dignity and respect**	✓ **I know what I can do to help myself and who else can help me**
✓ **I can enjoy life**	✓ **I feel part of a community and I'm inspired to give something back**
✓ **I am confident my end of life wishes will be respected**	

[5] Quality Outcomes for People with Dementia: building on the work of the National Dementia Strategy (2010).

5. What do we know about levels of need in the community, both now and in the future?

5.1 Population projections

Dementia mainly affects older people, and after the age of 65, the likelihood of developing dementia roughly doubles every five years[10].

In England, it is estimated that around 850,000 people have dementia[6]. It is now one of the top five underlying causes of death and one in three people who die after the age of 65 have dementia[7]. Nearly two thirds of people with dementia are women, and it is a leading cause of death among women – higher than heart attack or stroke[9].

Havering has one of the highest proportions of older people in London. The population of over 65s is expected to increase by 26% over the next 15 years; and that of the 85+ by 46% over the same period[8] (Table 3 and Fig 1).

Table 3: Projected percentage population change by age group since 2016, for 2021, 2026 and 2031

	Percentage change from 2016 to:		
Age group	**2021**	**2026**	**2031**
0-4	6%	8%	4%
05-10	11%	16%	15%
11-17	13%	26%	29%
18-24	-5%	0%	10%
25-64	5%	7%	5%
65-84	5%	16%	26%
85+	14%	26%	46%

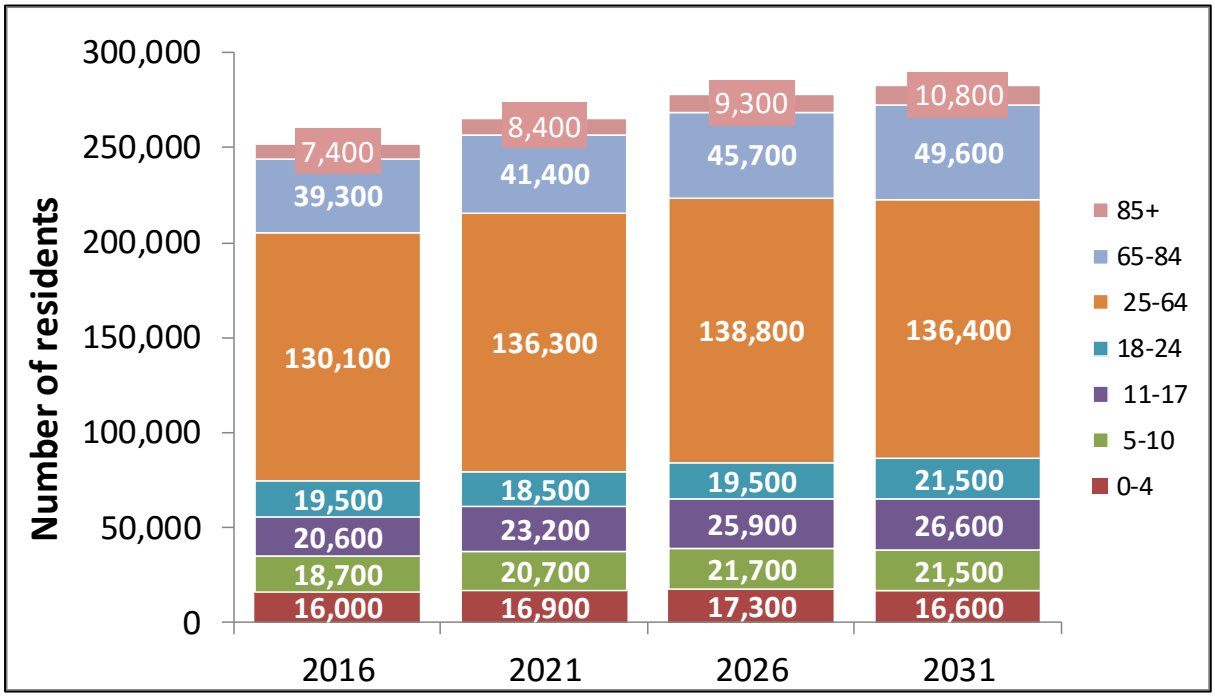
Data source: 2015 Round Strategic Housing Land Availability Assessment (SHLAA)-Based Projections; Greater London Authority (GLA); Produced by Public Health Intelligence

6 Dementia UK Update, second edition, November 2014

7 Brayne C et al, Dementia before death in ageing societies – the promise of prevention and the reality, PLoS Med 2006;3; 10

8 This is Havering - A Demographic and Socio-economic Profile (Some key facts and figures). Havering Public Health Service. 2016

Figure 1: Projected population growth by age group (to nearest hundred), 2016, 2021, 2026 and 2031



Data source: 2015 Round Strategic Housing Land Availability Assessment (SHLAA)-Based Projections; Greater London Authority (GLA); Produced by Public Health Intelligence

5.2 Life expectancy

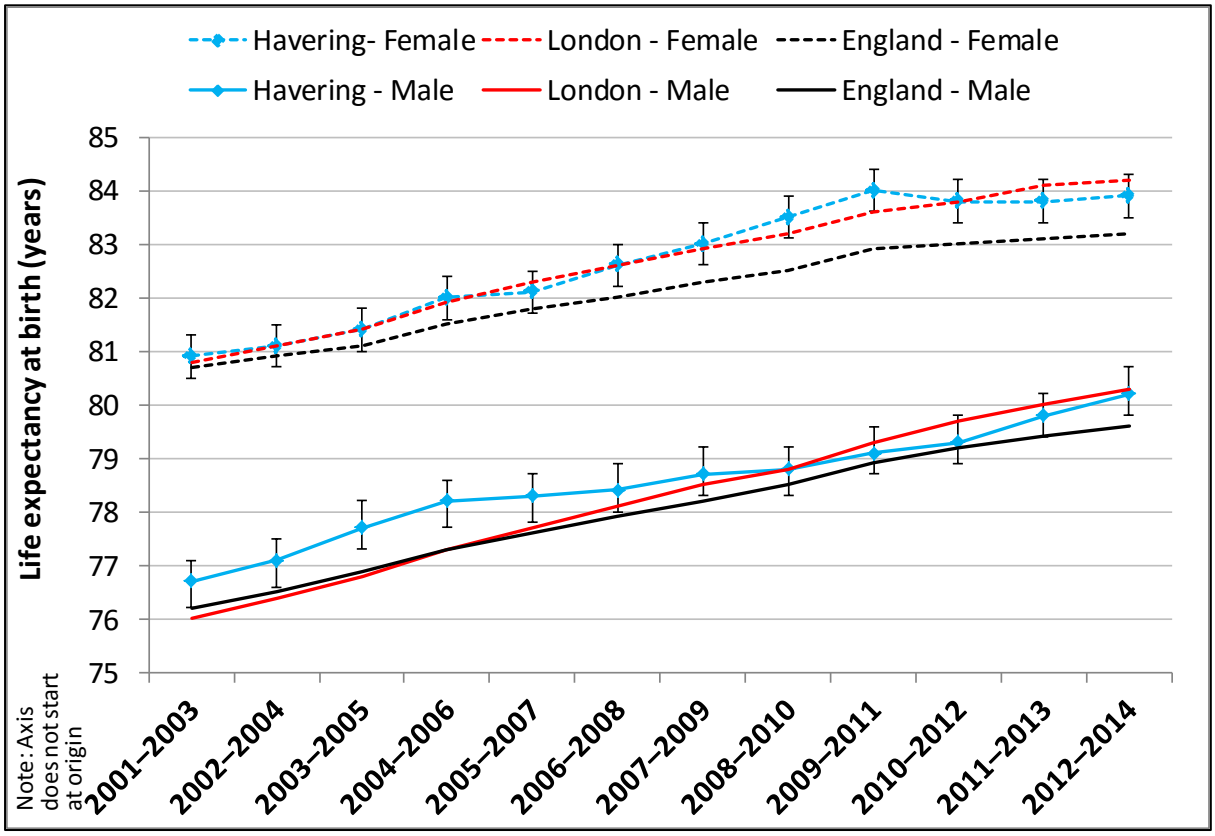
The life expectancy[9]' [10] for people living in Havering is 80.2 years (for males) and 83.9 years (for females) from birth. Life expectancy in Havering has been mostly higher than the England average and has been on the increase over the last decade (Fig.2). The life expectancy for females is significantly higher than males.

With increasing life expectancy and no effective prevention programmes, there will be more people living with dementia, and also an ageing cohort of caregivers.

[9] ibid

[10] *Life expectancy is a frequently used indicator of the overall health of a population: a longer life expectancy is generally a reflection of better health. Reducing the differences in life expectancy is a key part of reducing health inequalities. Life expectancy at birth for an area is an estimate of how long, on average, babies born today may live if she or he experienced that area's age-specific mortality rates for that time period throughout her or his life.*

Figure 2: Life expectancy at birth (years), by gender, Havering compared to London and England, 3-year rolling periods, 2001-03 to 2012-14



Data source: Life expectancy at birth, 2001-2003 to 2012-2014; Office for National Statistics (ONS); Produced by Public Health Intelligence

5.3 Ethnicity

In Havering the proportion of the population classed as white is expected to decrease from 85% in 2015 to 79% by 2030. The Black African population will increase from 3.8% in 2015 to 5.2% in 2030[11]. Provision will need to be appropriate to need including ethnicity, cultural beliefs and religion.

The Equality Act 2012[12] also requires that there is appropriate provision that takes account of the other protected characteristics

[11] This is Havering - A Demographic and Socio-economic Profile (Some key facts and figures). Havering Public Health Service 2016

[12] Equality Act 2012 states that the 9 protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, and sex.

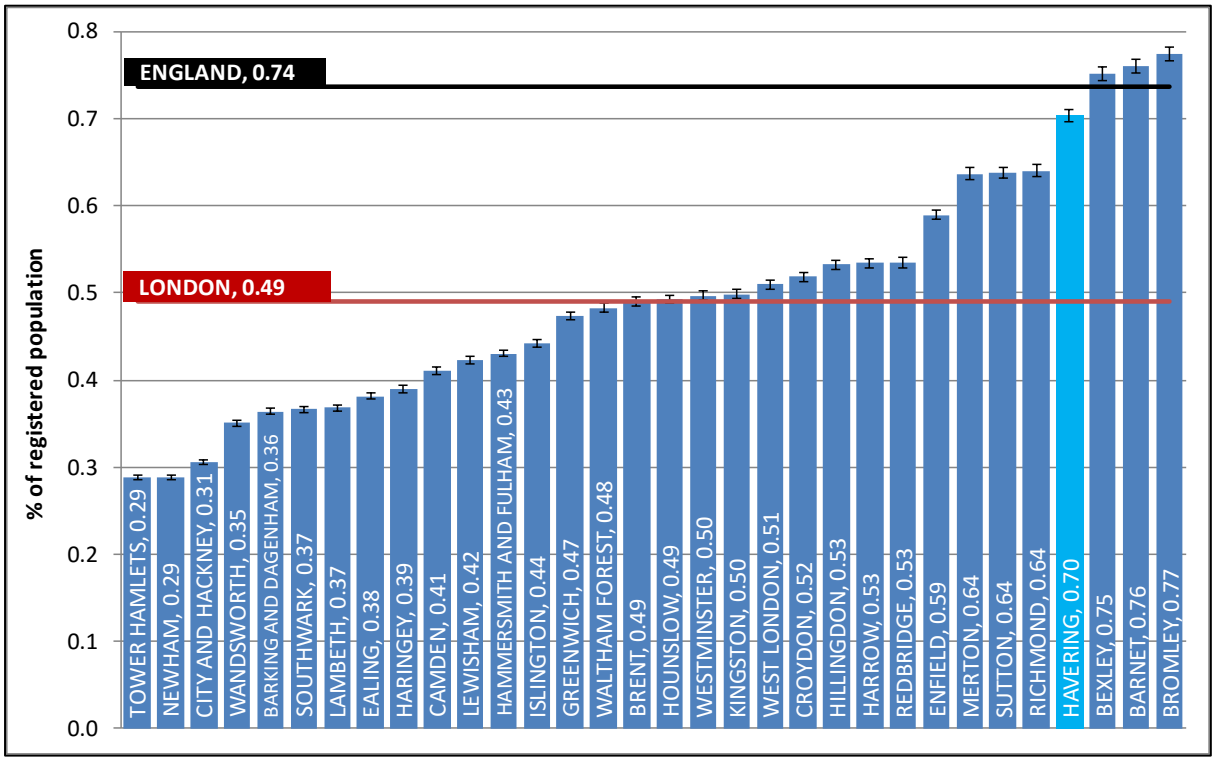
5.4 Dementia Prevalence and projections

Figure 3 shows that dementia is more common in Havering (0.7%) than in London (0.49%) but similar to England (0.74 %)[13]. This is based on GP registers. It is estimated that around half of people living with dementia are as yet undiagnosed[14].

Many people with dementia will also be living with other long-term conditions, as the risk factors for the main types of dementia are similar to those that result in conditions such as cardiovascular diseases (CVD) and diabetes.

People with a learning disability are more at risk of developing dementia compared with the general population, with a significantly increased risk for people with Down's syndrome and at an earlier age.

Figure 3: Prevalence of dementia in registered patient, all ages, London boroughs and England 2014/15



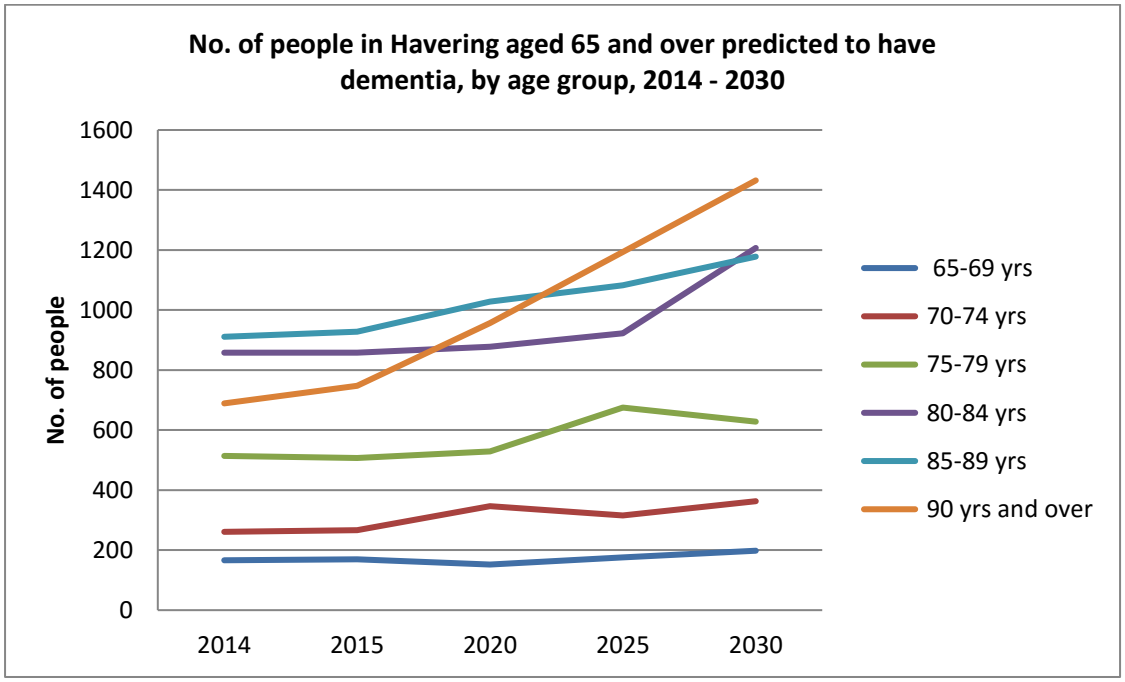
Data source: Quality Outcomes Framework 2014/15 (published October 2015), Health and Social Care Information centre; Produced by Public Health Intelligence

[13] Havering Health and Social Care Needs- and overview. Havering Public Health Service 2016.

[14] *Primary Care Web Tool* https://www.primarycare.nhs.uk/default.aspx

The dementia diagnosis rate in Havering is 62% [15] against a target of 67%. This is a calculation based on the number of patients that have been identified divided by the number of people that we are expected to know about based on the age structure of the local population. Fig 4 and Table 4 show that the predicted number of cases of dementia will continue to rise from 3,398 in 2014 to 5,005 by 2030, with the steepest increase expected in those 90 years and over. These projections are for those aged 65 and over. The prevalence of early onset dementia (dementia diagnosed before the age of 65) is more difficult to calculate but it is estimated that there are 42,325 people in the UK who have been diagnosed with young onset dementia[16] . They represent around 5% of people with dementia. The actual figure could be higher because of the difficulties of diagnosing the condition and might be closer to 6-9%. Awareness amongst GPs is still relatively low and when people are still at work, symptoms are often attributed to stress or depression[17] .

Fig.4: People aged 65 and over predicted to have dementia, by age group, projected to 2030



[15] QOF register August 2016

[16] Dementia UK, 2nd edition 2014, *Alzheimer's Society*

[17] Young Dementia UK https://www.youngdementiauk.org/young-onset-dementia-facts-figuresaccessed 28/9/2016

Data source: POPPI – Projecting Older People Population Information System accessed 06/07/2016

Table 4: Number of people by age group expected to have dementia 2014 - 2030

Age group	2014	2015	2020	2025	2030
65-69 yrs	166	169	152	176	198
70-74 yrs	261	267	346	316	363
75-79 yrs	514	507	529	675	628
80-84 yrs	858	858	878	922	1,207
85-89 yrs	911	928	1,028	1,083	1,178
90 yrs and over	689	748	957	1,194	1,432
Total 65 and over	3,398	3,476	3,890	4,366	5,005

Data source: POPPI – Projecting Older People Population Information System accessed 06/07/2016

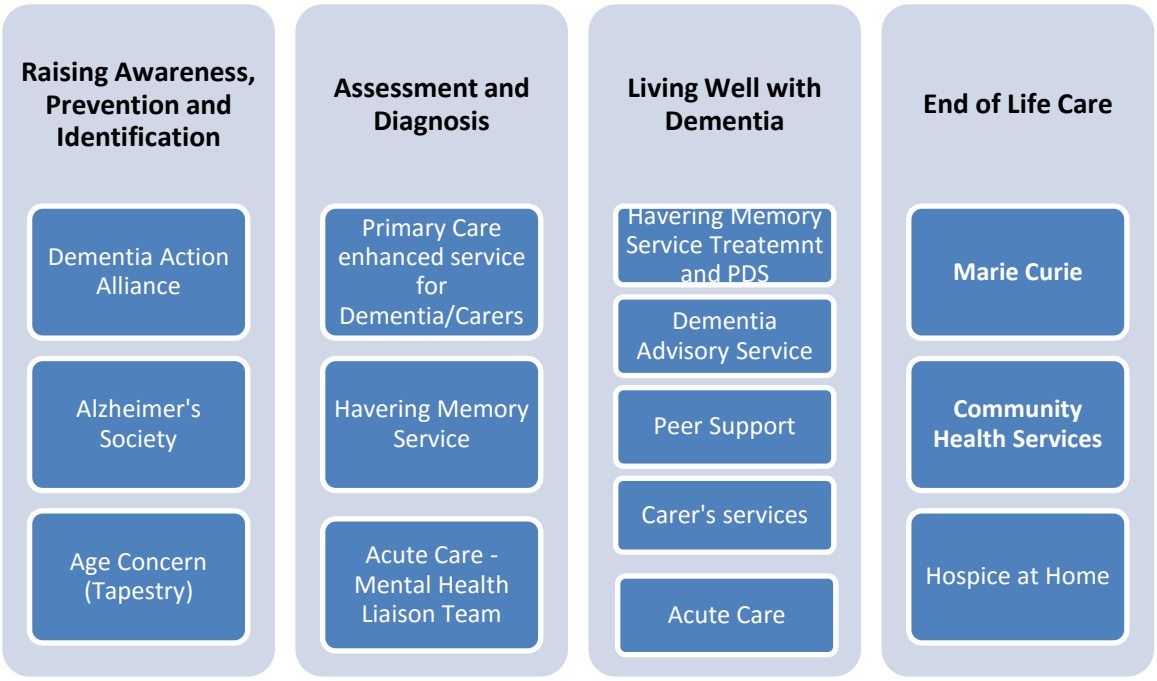
6. Current Service Provision (Fig 5)

The Dementia Partnership Board has determined that the local dementia pathway should be straightforward and streamlined, and grouped under four key headings:

- Raising Awareness, Prevention and Identification
- Assessment and Diagnosis
- Living Well with Dementia
- End of Life Care

Currently in Havering, for the majority, a diagnosis of dementia is made by a mental health professional, following referral by the GP to the Havering Memory Service which is provided by North East London Foundation Trust (NELFT) .In addition there are a range of older people's mental health services, including the Community Mental Health Teams (CMHTs), inpatient assessment and treatment services, and the Enhanced Mental Health Liaison Service (EMHLS). The latter is based in the local acute hospital. In some cases however people are diagnosed by the neurologists at Queens Hospital and may not be sign posted to the Post Diagnosis Support (PDS) services provided by the Memory service.

Fig. 5: Current Dementia service provision in Havering



Social care support via a Direct Payment is commissioned by the London Borough of Havering, and is accessed if eligible following a community care assessment. This includes services such as assistive technology, social inclusion, equipment and adaptations domiciliary care, respite and residential care.

The voluntary and community sector also provide a range of jointly commissioned support via organisations such as Tapestry, Alzheimer's Society and Crossroads Care Havering.

The private and independent sector provide a number of residential and nursing home establishments within the Borough, a number of which have specialist dementia units, with experienced staff and adapted facilities.

7. Issues for consideration:

7.1 Early onset dementia

Dementia can start before the age of 65, presenting different issues for the person affected, their caregiver and family. People with young onset dementia are more likely to have active family responsibilities – such as children in education or dependent parents – and are more likely to need and want an active working life and income. Family members are more frequently in the position of becoming both the sole income earner, as well as trying to ensure that the person with young onset dementia is appropriately supported. Their needs

are therefore very different from those of older people with a diagnosis of dementia. In addition awareness amongst GPs is still relatively low and when people are still at work, symptoms are often attributed to stress or depression. Locally there is a limited service for this client group. Further considerations need to be taken in order to address the gap in local provision.

7.2 Learning Disability

People with a learning disability are at greater risk of developing dementia at a younger age. Studies have shown that one in ten people with a learning disability develop young onset Alzheimer's disease between the ages of 50 to 65. The number of people with Down's syndrome who develop Alzheimer's disease is even greater with one in 50 developing the condition aged 30-39, one in ten aged 40-49 and one in three people with Down's syndrome will have Alzheimer's in their 50s[18].Local dementia services need to work together with Learning Disabilities services to develop and agree the interface and pathways between them, in order that individuals with a learning disability receive a timely diagnosis and appropriate services to meet all of their needs.

7.3 End of Life Care

The national Dementia strategy sets out the intention to improve end of life care for people with dementia. Every person with dementia should receive excellent care at the end of their life and be treated with dignity and respect. Forward planning and the use of Advance Directives should be embedded within practice, with the intention of giving people more choice and control over their care, an improved experience and their needs and wishes respected. The use of advanced directives remains a challenge locally despite it being actively offered in the local memory service. In addition many of these patients are not aware of the support available to them in the community (Marie Curie and Hospice at Home)[19]

7.4 Black, Asian and Minority Ethnic groups

Prevalence of dementia among Black, Asian and minority ethnic (BAME) groups is the same as for the UK population as a whole [20] although prevalence rates for young onset

[18] *Dementia UK, 2nd edition 2014,* Alzheimer's Society

[19] Communication form Memory Clinic Consultant

[20] *Dementia UK, 2nd edition 2014,* Alzheimer's Society

dementia are thought to be higher than for the population as a whole and are less likely to receive a diagnosis or support [21].

7.5 Carers

Carers play a vital role in supporting the people with dementia particularly as they become increasingly reliant on their caregivers throughout the course of the disease. It is therefore crucially important to ensure that the care packages also meet the needs of the caregiver[22].

In summary achieving the aims and objectives of this strategy is likely to require re-examination of the financial investment in dementia care; how we jointly develop the quality and capacity of care providers in Havering [23], and a review of the quality and cost effectiveness of current pathways of care.

[21] Young Dementia UK https://www.youngdementiauk.org/young-onset-dementia-facts-figuresaccessed 28/9/2016

[22] World Alzheimer Report, 2013

[23] Havering Adult Social Care Market Position Statement 2016

8. How will we achieve the vision statement?

There is still much to be done in achieving the vision for dementia care in Havering. We will do this by:

- Developing a cohesive and whole system approach to the commissioning of dementia services via partnership working with health, public health and social care
- Co-production of service specifications and delivery with service users and carers, providers, and commissioners
- Commissioning and providing a range of high quality evidence based services which are accessible, integrated and in line with local levels of need, both now and in the future. This will need to take full account of the predicted increases in levels of need and demand on services.
- Developing robust data and reporting systems for services across the dementia pathway, in order to fully understand the impact of the predicted increase in demand and its impact on services
- Further awareness raising across the community, via the vehicle of sign up to the Dementia Action Alliance, which is the favoured model for the development of 'dementia friendly' communities and is effective in reducing stigma
- Ensuring that the workforce are trained to develop and acquire appropriate competencies and skills in dementia care and end of life care
- Providing access to high quality evidence based services in the community, including advice, information, housing support and leisure activities which enable people with dementia and their carers to live well.
- Ensuring that people have access to early intervention support and advice, as well as timely access to assessment and diagnosis

While much attention has been focused on bridging the so-called Dementia Diagnosis Gap, there are concerns that the focus on improving early access to diagnostic services has not been matched by attention to the need for adequate evidence based PDS. The DH *Joint Declaration on post diagnostic support* acknowledges its importance and **Fig 6** provides a

graphic illustration of the key elements or '8 pillars' of support that should be available to patients with a dementia diagnosis [24]. The evidence suggests that integrated PDS based on this model delivers good outcomes for patients and carers. This includes the provision of a 1:1 coordinator role, personalised care plans developed by dementia care mapping (DCM) and proven psychological interventions such as cognitive stimulation therapy.

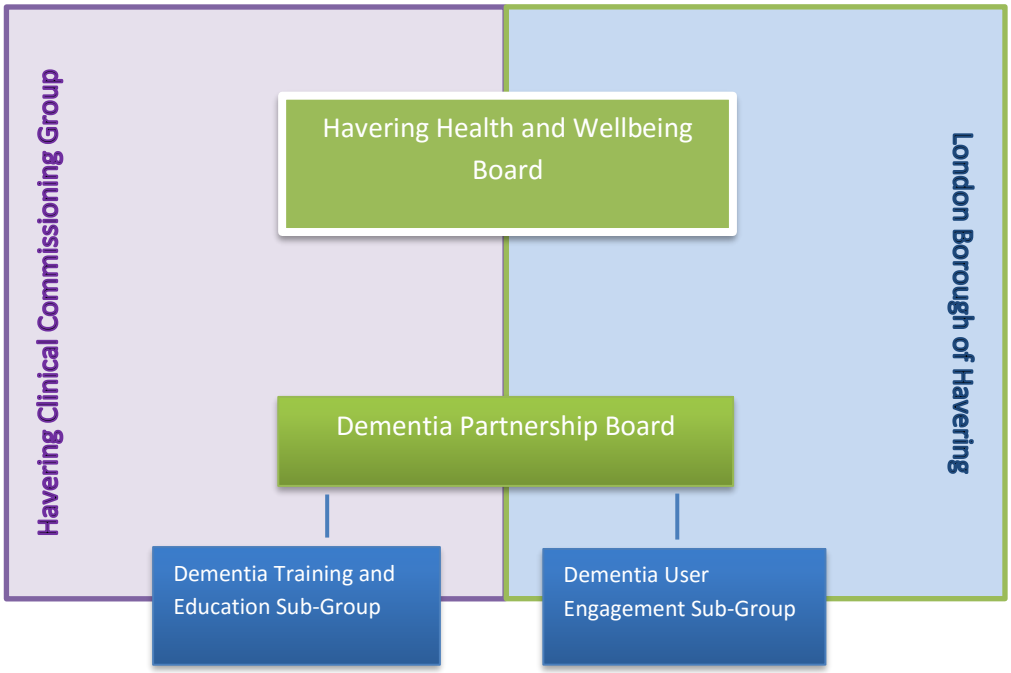
Fig. 6: '8 pillars' model of support for dementia

[24] Delivering Integrated Care: The 8 Pillars Model of Community Support

9. Governance

The local Dementia Partnership Board meets on a bi-monthly basis and is accountable to Havering's Health and Wellbeing Board. The Board brings together key commissioners across the health and social care economy. The Board will oversee and monitor the delivery of the strategy and implementation plan. In addition, any key commissioning decisions relating to either current dementia services or future service developments will be brought to the attention of the Board and recommendations made to key bodies with decision-making powers and functions.

Fig. 7: Governance arrangements for Dementia Care in Havering



On the basis of this strategy, an implementation plan aligned to our vision statements has been developed and is attached at Appendix 2. The delivery of the implementation plan will be monitored and overseen by the local Dementia Partnership Board.

10. Appendix

Appendix 1 **Draft Havering Dementia Strategy Dashboard**

Vision Statement	Measure	Target	Latest Performance
I was diagnosed early	Dementia Diagnosis Rate (Age 65+) – Source: https://www.england.nhs.uk/mental-health/dementia/monthly-workbook - number of people on GP practice Dementia Register divided by Estimated prevalence – Monthly	67.2%	61.6% (Feb 17)
	Havering Joint Dementia Survey? - % responding 'Yes' to Do you think you were diagnosed with dementia in a timely way? Source: Local Joint survey - Annual	*tbd*	77.4% (Dec 16)
I understand so I make good decisions and provide for future decision making	ASC clients with dementia with Self Directed Support (SDS) - Source: LBH ASC Framework Pack) – % of all clients with dementia receiving services - Monthly	*tbd*	*New metric*
	Havering Joint Dementia Survey – % Clients rating their overall experience as 'Good' - Source: Local Joint survey - Annual	*tbd*	57.5% (Dec 16)
I get the treatment and support which are best for my dementia and my life	a) Residential and nursing homes – number of new admissions for dementia clients - Source: LBH ASC Framework Pack - Monthly	*tbd*	*New metric*
	b) Residential and nursing homes – current placements for dementia clients - Source: LBH ASC Framework Pack - Monthly	*tbd*	332 (Feb 17)
	Havering Joint Dementia Survey – % Clients responding 'Yes' to Does your care meet your needs? - Source: Local Joint survey - Annual	*tbd*	74.1% (Dec 16)
Those around me and looking after me are well supported	Dementia Carers Assessments undertaken - Source: LBH ASC Framework Pack - Monthly	*tbd*	*New metric*
	Havering Joint Dementia Survey – % Carers rating their overall experience as 'Good' - Source: Local Joint survey - Annual	*tbd*	48.7 (Dec 16)%
	Carers Quality of Life – Source: composite measure based on responses to six questions in national Carers Survey - Biennial	*tbd*	8.4 (2014-15)
I am treated with dignity and	Numbers of safeguarding enquiries for dementia clients - Source: LBH Safeguarding Pack - Monthly	*tbd*	*New metric*

Vision Statement	Measure	Target	Latest Performance
respect	Havering Joint Dementia Survey – % Clients responding 'Yes' to Do you feel that care and health staff support and understand you? - Source: Local Joint survey - Annual	*tbd*	61.2% (Dec 16)
I know what I can do to help myself and who else can help me	Havering Joint Dementia Survey – % Clients responding 'Yes' to Do you know how to get help to get what you need? - Source: Local Joint survey - Annual	*tbd*	57.8% (Dec 16)
	Havering Joint Dementia Survey – % Clients responding 'Yes' to After your diagnosis, were you clear about where you go to for support if you have questions about living with dementia - Source: Local Joint survey - Annual	*tbd*	64.8% (Dec 16)
I can enjoy life	Havering Joint Dementia Survey – % Clients responding 'Yes' to Are you supported to do the things you enjoy? - Source: Local Joint survey - Annual	*tbd*	71.1% (Dec 2016)
I feel part of a community and I'm inspired to give something back	Havering Joint Dementia Survey – % Clients responding 'Yes' to Do you feel a sense of community? - Source: Local Joint survey - Annual	*tbd*	68.6% (Dec 2016)
I am confident my end of life wishes will be respected	Number of recorded EOL discussion offers with newly diagnosed clients – Source: NELFT Memory Clinic - Quarterly	*tbd*	*tbc*
	Deaths in usual place of residence for people with dementia 65+ Source: Public Health England Dementia Profile http://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia/data - annual	tbd	68.7% (2015)

Appendix 2 **Annual Implementation Plan 2017-2018**

Vision Statement	Objectives	Actions	Outcome	Measure	By Whom	By When
I was diagnosed early Links to: NICE QS 30.1: Discussing concerns about possible dementia PHOF 4.16:	Improve the local diagnosis rate	1. Work with Public Health, using the Dementia Prevalence Calculator, to fully understand the 'gap' between the local prevalence rate and those diagnosed with dementia	Achievement of the target 66%	Dementia Prevalence	LBH	March 2018

Vision Statement	Objectives	Actions	Outcome	Measure	By Whom	By When
Estimated diagnosis rate for people with dementia NHSOF 1.5: Excess under 75 mortality rate in adults with serious mental illness NICE QS1.2: Memory Assessment Services	Improve the local diagnosis rate	2. Work with GP's and primary care staff to continue to raise awareness of the target in relation to diagnosis rates, including providing information, education and guidance on read coding	Increased number of individuals who receive a timely diagnosis	Increased numbers of patients on GP Dementia Register	HCCG	March 2018
		3. Prevention interviews for mild cognitive impairment				
		4. Work with Havering Care Homes through Provider Forums and direct training to introduce the Dear-GP letter system	Increase in early diagnosis rates	Increased numbers of patients on GP Dementia Register	HCCG/GP Practices	March 2018
			Increase referrals to GP's for diagnosis requests Increased conversations between GP and Memory Clinic	Increased numbers of patients on GP Dementia Register	LBH	March 2018

Vision Statement	Objectives	Actions	Outcome	Measure	By Whom	By When
	Improve the local diagnosis rate (**early onset** dementia)	Implementation of the national toolkit to improve diagnosis in young onset dementia 5. Prevention campaign during Dementia Awareness week	Increased number of individuals who receive a timely diagnosis People more aware of preventative measures	Increase in the number of patients under 65 with a diagnosis of dementia	NELFT PH/LBH/Tapestry Health Champions	TBC (when toolkit becomes available) May 2017
I understand, so I make good decisions and provide for future decision making Links to: NICE QS 30: Supporting people to live well with dementia	Living Well with Dementia	Develop information packs for service users and carers (Alzheimer's Society booklet) to be used within GP practices, the Memory Service and other associated services Hold post-diagnostic four weekly groups	People with dementia, their families and carers receive high quality information, advice and support. People are supported post-diagnosis and introduced to community support organisations	Joint Patient survey: Patients and carers report that they are appropriately supported. Register of people attending groups and record of groups held throughout the year	LBH NELFT	December 2017 March 2018

Vision Statement	Objectives	Actions	Outcome	Measure	By Whom	By When
I get the treatment and support which are best for my dementia and my life Links to: NHSOF 2.1: Proportion of people feeling supported to manage their condition	Living Well with Dementia	Redesign of PDS (TBC)	People with dementia, their families and carers receive high quality information, advice and support.	Joint Patient survey: Patients and carers report that they are appropriately supported.	HCCG/LBH (Dementia Partnership Board)	Awaiting NHS England Guidance and local HCCG contractual decisions

Vision Statement	Objectives	Actions	Outcome	Measure	By Whom	By When
Those around me and looking after me are well supported Links to: ASCOF 1D: Carer reported quality of life ASCOF 3D: The proportion of people who use services and carers who find it easy to find information about services NHSOF 2.4: Health-related quality of life for carers	Living Well with Dementia	1Review the use of assistive technology to support individuals with dementia and their carers 2. Carers survey	People with dementia and their carers are supported and enabled to remain in the community for longer	Increase in the number of people accessing assistive technologies	Joint Commissioning Board	March 2018 December 2017

Vision Statement	Objectives	Actions	Outcome	Measure	By Whom	By When
I am treated with dignity and respect Links to: NICE QS1.1: Appropriately trained staff NICE QS 30.8: User and carer engagement	Living Well with Dementia	Adopt the use of these statements across Health and Social care, and appropriate methods and systems to capture evidence and the experience of people with dementia and their carers who access services	Services adhere to person centred care	Number of Person centred care plans in place	LBH/Havering CCG	On-going
	Living Well with Dementia	All staff should receive appropriate training and have access to dementia care training that is consistent with their roles and responsibilities	All staff, working in health, social care, private and voluntary sector, will have access to a rolling programme of appropriate training in dementia	Patient and carer feedback - Individuals are treated with dignity and respect	LBH/CCG/NELFT/BHRUT/Dementia Friends	On-going

Vision Statement	Objectives	Actions	Outcome	Measure	By Whom	By When
	Living Well with Dementia	Engage with people with dementia and their carers via established fora/ planned workshops when changes in services are planned	Range of opportunities to engage and listen to people with dementia and their carers are identified and acted upon	The numbers of people engaged with commissioners in providing feedback and commentary on their experience of services	LBH/HCCG/HDAA	On-going
I know what I can do to help myself and who else can help me Links to: ASCOF 1B: The proportion of people who use services who have control over their daily life	Living well with dementia	To provide Individuals with a written copy of their care plan	There is a clear person centred plan in place for every individual known to services	% of patients/carers with a care plan	LBH/CCG	Ongoing monitoring via Dementia Dashboard

Vision Statement	Objectives	Actions	Outcome	Measure	By Whom	By When
I can enjoy life Links to: ASCOF 1B: The proportion of people who use services who have control over their daily life NICE QS 30: Living well with dementia	Living well with dementia	1.Review the range, scope and quality of activities available in the community 2.Increase activities and membership of the Havering Dementia Action Alliance	Increase in the % of people who agree with the I statement Activities register produced and distributed	Patient and carer feedback - survey Increased number of Dementia Friends, more community members of HDAA	LBH/HCCG	December 2017

Vision Statement	Objectives	Actions	Outcome	Measure	By Whom	By When
I feel part of a community and I'm inspired to give something back Links to: ASCOF 1B: The proportion of people who use services who have control over their daily life	Living Well with Dementia	Redesign of Voluntary Sector services to include a strong peer Support element Increase activities and membership of the Havering Dementia Action Alliance Increase Dementia Friends offer to schools, scouts and Girl Guides, local business	Increase the % of people living with dementia who agree with the I statement Activities register produced and distributed Dementia Friends sessions offered community -wide	Voluntary Sector Review and Re-commissioning of dementia contracts Increased number of Dementia Friends, more community members of HDAA	LBH LBH LBH/Dementia Friends	September 2017 March 2018 March 20 18

Vision Statement	Objectives	Actions	Outcome	Measure	By Whom	By When
I am confident my end of life wishes will be respected Links to: ASCOF 1B: The proportion of people who use services who have control over their daily life	End of Life Care	Ensure that the needs of people with dementia are included within any work undertaken in relation to End of Life Care - EoLC lead will liaise with DPB	There is clear link between the work of the Dementia Partnership Board and the End of Life Steering Group	Number/% of people with dementia with Advance Directives in place	LBH/HCCG	Ongoing
		Dementia themed death cafe	Improved awareness of the need to discuss EoLC, use of Marie Curie and Hospice at Home services and therefore increased use Advanced Directives	Number/% of people with dementia with Advance Directives in place	HCCG/NELFT	March 2018

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HEALTH & WELLBEING BOARD

Subject Heading:	Integrated Care Partnership
Board Lead:	Alan Steward, Chief Operating Officer, Havering CCG Barbara Nicholls, Director Adult Social Care & Health, Havering Council
Report Author and contact details:	Keith Cheesman, keith.cheesman@havering.gov.uk 01708 433 742

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

- ☐ Theme 1: Primary prevention to promote and protect the health of the community and reduce health inequalities
- ☒ Theme 2: Working together to identify those at risk and intervene early to improve outcomes and reduce demand on more expensive services later on
- ☒ Theme 3: Provide the right health and social care/advice in the right place at the right time
- ☒ Theme 4: Quality of services and user experience

SUMMARY

This report provides an update on the progress being made with the development of the Integrated Care Partnership arrangements, especially the Havering Localities. It also describes the link with the development of Integrated Localities teams as part of the project within the Community Services Integration Programme.

RECOMMENDATIONS

The Health & Wellbeing Board is asked to:

1. Note the contents of this report.

This report is for information only. Members are asked to consider and note this update.

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REPORT DETAIL

Background
Our health and wellbeing system is facing significant challenges. The existing model of commissioning and providing prevention and care is struggling to meet the current levels of demand as a result of pressure from population growth, rising levels of long term conditions, variable levels of deprivation, and a constrained financial situation.

As a result of Devolution opportunities from central government and our subsequent development of a Strategic Outline Case for Barking and Dagenham, Havering and Redbridge (BHR), there is a much clearer picture of what can be done together to address these challenges. This work was previously referred to as the development of an Accountable Care Organisation.

The Integrated Care Partnership was formed as part of that work to become the leadership group, comprising senior political and clinical leaders from across the BHR partnership (see Appendix A).

Havering Localities
The development of a locality model of care is being explored which presents the opportunity of a more intelligent way of delivering health and care, built around a defined population rather than around institutions, with a focus on delivering better outcomes.

Locality boundaries have been agreed and partners are working to develop a key suite of supporting information to enable key decisions around workforce requirements in line with need to be made alongside informing the operational model. These are set out in Appendix B.

Work to map the services currently provided across the system is underway and 'locality profiles' are being developed by Public Health. High level locality activity and population profiles have been produced.

A 'Havering Locality Design Group' has been established to take forward development of the locality model. This group includes leads from; Havering Local Authority, Havering Clinical Commissioning Group, NELFT, The Local Pharmaceutical Committee, Havering Healthwatch and the Havering Community and Voluntary Sector Compact. Further details about this group are set out in Appendix A.

Services will be co-designed with local people and delivered closer to them. What this means in practice is local health and care services along with community and voluntary sector, and other services such as housing etc., working together as a

virtual team with the primary aim of improving the quality of life and circumstances of a person. The intention is to focus on what a person needs, rather than offering a set menu of services with criteria that the person may not meet.

In Havering, scoping is underway to define what this model could look like, and plan to involve stakeholders including the community and voluntary sector, GPs, patients, and health and care staff in the development of the proposals going forward. The design needs to ensure that the strong relationships that already exist across Havering between different organisations are built upon to facilitate closer working.

Havering Localities Design

The design principles and core design of the localities model for both Children's and Adults arrangements is much further advanced. It is expected that the locality model could deliver a large number of potential benefits, including:

- Improved outcomes for the local population
- Better use of resources and providers working together to address the needs of a defined population
- Trusted assessor agreements may begin to develop through relationships born of co-location
- Recruitment and retention may also be improved through better use of resources and directing people to the right service, first time, meaning that staff feel less overwhelmed by the volume of activity. There will also be greater opportunity for multidisciplinary working and shared learning, and with the possible creation of new workforce roles to ensure that those with the right skills are seeing the right people, more opportunity for staff to progress in their careers
- Increased clinical time with patients and service users (through better use of resources as noted above)
- Address the key health and wellbeing, care and quality and financial and productivity issues currently facing the Havering and the wider BHR and north east London system as a whole

Childrens Locality Model

The children's model focusses on children's emotional wellbeing, drawing in schools and GP's around earlier identification and intervention of issues.

It will take a whole family approach, rather than an individual one. Those looking to access the service will do so through a single access point, where their case will be quickly triaged by a virtual "multi-disciplinary team" who will assign a key worker to their case, dependent upon their individual needs. That key worker will then ensure the family have the support and information they need. It will feel more seamless and joined up, delivering better outcomes for our service users. It will focus on emotional health and wellbeing, building resilience in children and families, marking a move away from tiered services with strict criteria. It will aim to be much more preventative, avoiding the need for more intensive services later in life.

One of the key benefits of the children's model is the reduced duplication within the system, including the number of times that people have to repeat their 'story' and the

number of times that they are assessed for similar services. This will not only be a better experience for those using the services, but will reduce the burden of administrative duties on front line staff, increasing the amount of clinical time that they have with their service users and patients.

Adults Services

The adult's model is centred on a new 'intermediate care' tier of services which will seek to create a more seamless 'urgent' care offer for those who need urgent support. This will reduce duplication across the borough and create a more seamless service that makes best use of our resources. It is intended that services move from a position where a set menu of services is offered to address high levels of need, to a position that focuses on an individual's strengths and assets, as well as their networks (such as families and friends) as being integral within the care and support planning process, thereby reducing the level of support that may be needed from Adult Social Care. . The model again seeks to ensure a reduced duplication within the system, including the number of times that people have to repeat their 'story'

Integrated Localities Project

The Community Services Integration Programme (CSIP) has previously led the Integrated Localities development underway in Adult Social Care, in partnership with North East London Foundation Trust (NELFT).

There are clear connections and overlaps between the Integrated Localities work within this programme and the Havering Localities development; these have been explored in detail and will be brought together as soon as possible, using the project as the delivery vehicle for the Havering Localities changes. There are some logistical implications expected in terms of how staff work and are located, but there is no fixed or defined view at this point as what changes might be required to existing plans or arrangements. The ground work already completed in bringing the Adult Social Care community teams together with the NELFT community services teams will enable the new model to be built on that platform.

Feedback from the staff affected by the first phase – the co-location – is generally very favourable. The quality of referrals and handovers between the teams has improved, there is more interaction between the teams and relationships are improved.

There are a few areas that need further attention and the focus in this next phase will be on a review of therapy roles across organisations, improved communication and further reduction of duplication. There will also be further training and improvements in the access to each other's IT systems.

Both the Front Door redesign and Intermediate Care (IC) are also part of the CSI Programme's scope, so there are clear benefits in bringing these together with the Havering Localities delivery. As described above, the Havering Localities design for the Adults model embeds Intermediate Care to the heart of its design.

Intermediate Care Tier

Typically, IC services are those short-term treatment or rehabilitative community based services designed to promote independence, reduce the length of time you might be in hospital unnecessarily, or help you to avoid unnecessary admissions to hospital. If a person has care and support needs that do not need 'acute' hospital based medical support they are likely to be supported with intermediate care. These might be services such as Reablement which the Council commissions or rehabilitation, some community treatment via community matrons. These will be 'free' to use for up to six weeks and many people will not have a continuing need for care after these interventions.

IMPLICATIONS AND RISKS

Implications:

The outcome of the programme of work associated with the design work, may result in variations to existing contractual arrangements between commissioning and provider organisations, as well as new contractual arrangements (such as formal S75 agreements), to support the integrated model of care.

The redesign work is likely to require consultation (both formal and informal) with affected staff across primary care, community health services, and social care, as well as other council departments. Staff working in affected services are and will continue to be asked to participate in the design work.

An Equalities Impact Assessment will be carried out for the component parts of each of the models once the design phase is concluded. It is expected that the design and development will continue to include a range of representation of public and service user interests.

Risks:

Due regard is required as to the budget and financial position of partner organisations as the model develops, including savings and efficiency programmes such as QIPP. This may affect how rapid some proposals are implemented.

BACKGROUND PAPERS

None

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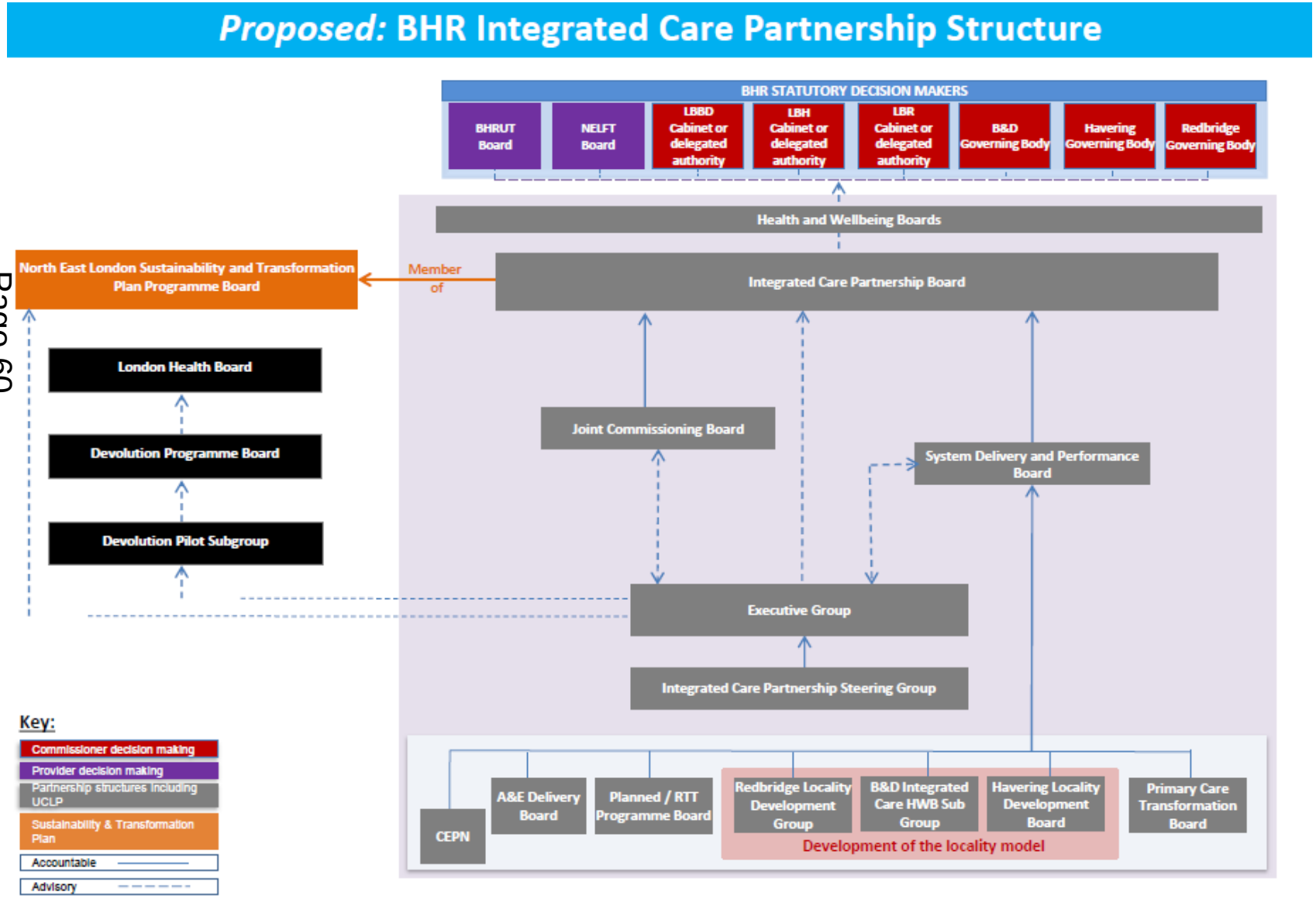
Appendix A – Governance Overview

The current governance structure and composition for the Integrated Care Partnership are as follows.



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Meeting	Description/remit	Attendees
Integrated Care Partnership	The remit of this group is in discussion, and attendees are being confirmed, where attendees are proposed you will see their names in the box to the right. *Proposed: Joint Committee for Health and Social Care with a remit including commissioning, transformation (including oversight of the development of the locality model in BHR) and system performance for the BHR health and social care economy.*	• London Borough of Barking and Dagenham: HWB chair Maureen Worby; Social Care Stat officer to be confirmed • London Borough of Havering: Cllr Wendy Brice-Thompson; Cllr Ramsey; Social Care Stat officer to be confirmed • London Borough of Redbridge: HWB chair Mark Santos; Cllr Jas Atwal; Social Care Stat officer to be confirmed • BHRUT: Chair Maureen Dalziel; Matthew Hopkins; Dr Nadeem Moghal • NELFT: John Brouder; Chair; Caroline Allum • BHR CCGs: Conor Burke; Dr Waseem Mohi; Dr Atul Aggerwal; Dr Anil Mehta; Kash Pandya; Richard Coleman; Steve Ryan
Joint Commissioning Board	The membership and remit of this group is currently in development. It is anticipated that this group will be established in 2017	
System Delivery and Performance Board	The membership and remit of this group is currently in development. It is anticipated that this group will be established in 2017	
Executive Group	The Executive is a partnership group that was established to oversee the development and submission of the Strategic Outline Case. Its remit includes ensuring that system level programme management requirements are in place to meet delivery needs. It is comprised of Executive leaders from across the BHR system and reports to the Integrated Care Partnership Group.	• BHR Clinical Commissioning Groups: Conor Burke • BHRUT: Matthew Hopkins • London Borough of Redbridge: Andy Donald • London Borough of Havering: Andrew Blake-Herbert • London Borough of Barking and Dagenham Chris Naylor • NELFT: John Brouder
Integrated Care Partnership Steering Group	The ICP Steering Group is a partnership group established to coordinate delivery of the Integrated Care Programme. The group will be responsible for: • supporting the Executive Group to coordinate the overall programme • supporting shared learning between localities It is comprised of partners from across the BHR system and will report	Jane Gateley, Director of Strategic Delivery (Chair); Basirat Sadiq, Divisional Manager for Specialist Medicine Division (BHRUT); Jacqui Van Rossum, NELFT Managing Director; Anne Bristow, Deputy Chief Executive and Strategic Director for service development and/or Mark Tyson, Commissioning Director, Adults Care and Support –Service Development and Integration; Caroline Maclean, Operational Director of Adult

	to the Executive Group. Partners within the group are accountable to their respective organisations and are responsible for disseminating information as appropriate.	Social Services (DASS) LBR; Barbara Nicholls, Assistant Director for Adult Commissioning and Social Care LBH; Kirsty Boettcher, –Deputy Director of Strategic Delivery; James Gregory, Senior Project Lead; Emily Plane, Strategic Delivery Project Manager

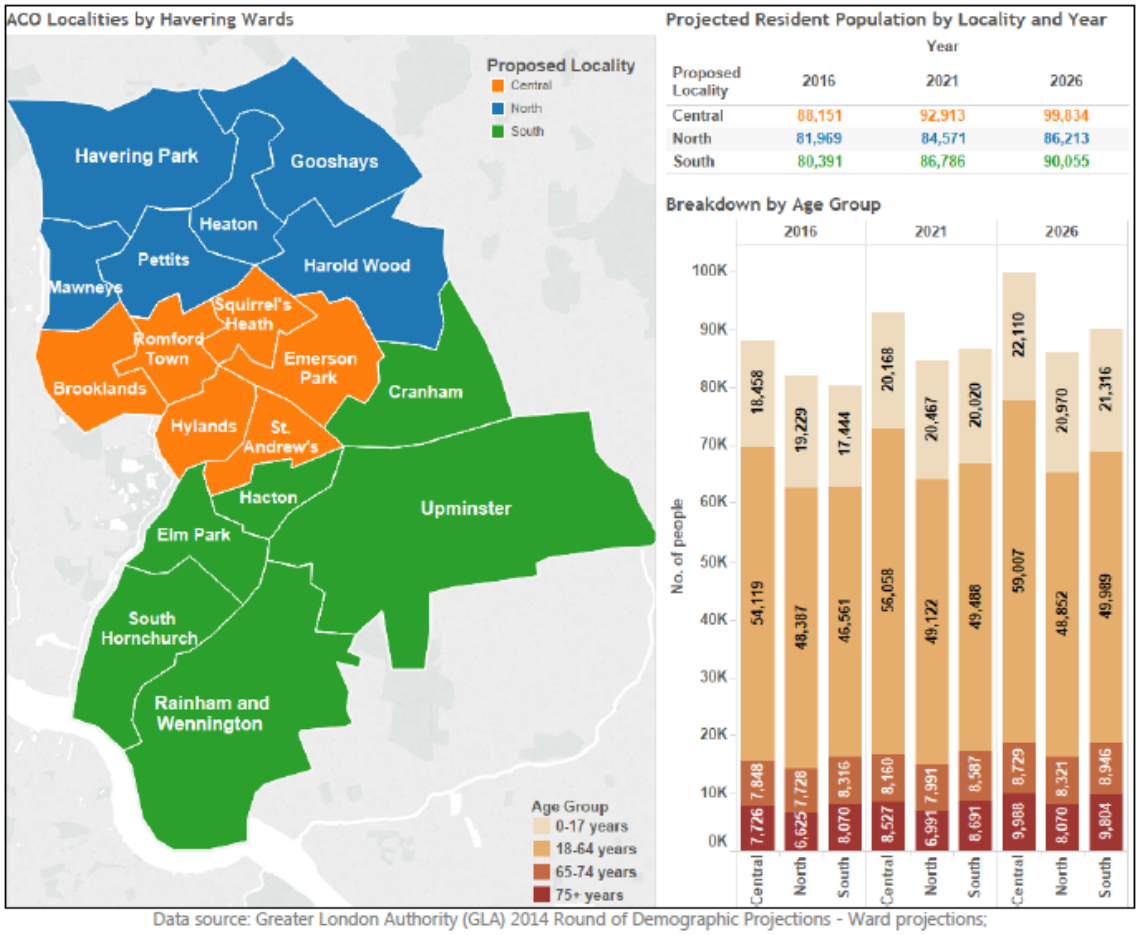
Havering Locality Design Group

Members are drawn from the eight participating organisations who are collaborating on the development of the Integrated Care Partnership across Barking & Dagenham, Havering and Redbridge in addition to partners key to the development of the locality model in Havering

Healthwatch Havering	Anne-Marie Dean and Ian Buckmaster
London Borough of Havering	Andrew Rixom
London Borough of Havering	Barbara Nicholls
NELFT	Carol White
Havering CCG Clinical Lead	Dr Ann Baldwin
London Borough of Havering	Tim Aldridge
BHRUT	Mairead McCormick
BHRUT	Elizabeth Sargeant
London Borough of Havering	Keith Cheesman
Havering Community and Voluntary Sector Compact	Tony Bloomfield
GP Provider lead	▪ Dr Gupta; Interest in Children / paediatrics ▪ Dr R Chowdry; Interest in Urgent care (particularly frequent attenders) ▪ Dr S Symon; Interest in Pathways (planned care)
Local Pharmaceutical Committee	Marc Krishek
Havering CCG	Alan Steward
BHR CCGs	None

Appendix B – Localities Map and Population Breakdown / Growth

Proposed Havering ACO localities, by ward and estimated resident population of all ages, children (aged 0-17 years), adults (aged 18-64 years) and older adults (aged 75+ years) for this year (2016), and in five years (2021) & ten years (2026)



Data source: Greater London Authority (GLA) 2014 Round of Demographic Projections - Ward projections; SHLAA-based; short term migration assumption; Capped Household Size model (for projected population data)

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HEALTH & WELLBEING BOARD 15 March 2017

Subject Heading:	**Update on North East London Sustainability and Transformation Plan**
Board Lead:	**Conor Burke, Accountable Officer, Barking & Dagenham, Havering and Redbridge CCGs**
Report Author and contact details:	**Ian Tompkins, Director of Communications & Engagement, East London Health & Care Partnership 07879 335180** ian.tompkins@eastlondonhcp.nhs.uk

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 report provides a further update to the Board on the development of the north east London Sustainability and Transformation Plan (known as the NEL STP) and and development of the East London Health & Care Partnership particularly in relation to finance, the governance arrangements and public engagement.

On 21 October we submitted an updated narrative, updated summary and delivery plans to address our local priorities to NHS England. Further work is continuing to develop the plan in more detail; additional updates will be presented to the Board as they become available. For more information go to http://www.nelstp.org.uk or email: enquiries@eastlondonhcp.nhs.uk

RECOMMENDATIONS

The Health and Wellbeing Board is recommended to:

Note the report.

No formal decisions are required arising from this report.

REPORT DETAIL

1. Background

1.1 In December 2015 NHS England planning guidance required health and care systems across the country to work together to develop sustainability and transformation plans (STPs).

1.2 For Havering, the work to develop the detail underpinning the STP is being taken forward jointly with Barking & Dagenham and Redbridge through the development of the business case for an Accountable Care Organisation. The issues that any ACO would need to address in order to achieve improved outcomes from health and social care, in the context of a financially sustainable health economy, will be reflected in the contributions from Barking & Dagenham, Havering and Redbridge to the NEL STP.

2. Proposal

2.1 See Appendix 1

3. Engagement

3.1 We recognise that the involvement of local people is crucial to the development of the STP. Since we submitted the original draft STP in June 2016 we have been engaging partners, including Healthwatch, local councils, the voluntary, community and social enterprise sector, and patient representatives. The initial feedback we received on the original draft was incorporated into the revised STP for the October 2016 submission.

3.2 Work to obtain further feedback is ongoing. A series of public engagement events and activity is planned for the summer of 2017 onwards (See Appendix 1). Local Healthwatch organisations and others are also helping us gather and understand the views of patients and communities. They will

focus on gauging public views on a) promoting prevention and self-care b) improving primary care and c) reforming hospital services.

4. Financial considerations

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

5. Legal considerations

5.1 The NEL STP Board is developing a plan as stipulated by the NHS England guidance.

6. Equalities considerations

6.1 An equality screening has been completed to consider the potential equality impact of the proposals set out in the NEL STP. This can be viewed at http://www.nelstp.org.uk and includes:

- An overview of all the initiatives included in the NEL STP narrative to determine at which level equality analyses should be undertaken i.e. NEL STP level, Local Area Level, CCG/borough level or London-wide level.

- An initial assessment of the NEL STP overarching 'Framework for better care and wellbeing'.

- Actions to be undertaken during further detailed equality analyses.

The screening recognises that the initiatives included in the STP will be implemented at different times, hence further equality analyses will need to be undertaken over the life of the STP programme.

Appendices

Appendix 1: General Update on the East London Health & Care Partnership April 2017

Appendix 2: East London Health & Care Partnership Governance Structure

Appendix 3: East London Health & Care Partnership Partnership Agreement

BACKGROUND PAPERS

None

- NHS Five Year Forward View https://www.england.nhs.uk/ourwork/futurenhs/
- Guidance on submission of Sustainability and Transformation Plans https://www.england.nhs.uk/wp-content/uploads/2016/05/stp-submission-guidance-june.pdf

Appendix 1: General update April 2017

Index

1. Background and context (our public narrative)

As more and more people choose to live and work in east London, the demand on health and social care services is at an all-time high. Our doctors, nurses, paramedics and other health and care professionals are looking after record numbers of people every day.

Despite the pressures, local hospitals are continuing to treat A&E patients as fast and effectively as any major western country. Our GP, mental health and community services are among the very best in the country, and local councils are providing vital care to the most vulnerable.

It's thanks to the dedication and hard work of the professionals involved, and the support of many thousands of voluntary carers, community and charity organisations across the area, we are getting the care we need.

But change must be allowed to happen, and things improved, if we are to protect the health and care services we value so much, not just for now but for future generations.

The NHS has constantly adapted and must continue to do so as the world and our health needs also change.

It is now able to treat people with new drugs and clinical care that wasn't available in the past. With it comes an increase in life expectancy, but also a rise in the ailments of old age. More people now have conditions like heart failure, arthritis and diabetes.

There are big opportunities to improve care by making common-sense changes to how the NHS has historically worked and bring it closer to the social care services run by local councils.

It's a chance to deliver improvements that matter – make it easier to see a GP; speed up cancer diagnosis; offer better support in the community for people with mental health conditions; provide care for people closer to their home.

If we do nothing and carry on providing services in the way we do now, without any changes, we will not only miss out on these improvements, we will fail to keep up with the growing demand and simply won't have enough money to keep services going.

In the east London area alone, there will be a £580m shortfall in funding within four years, by 2021. Services and facilities may have to close and standards of care suffer if not addressed.

Change is required, and fast, to help keep us healthy and well in the future and to receive care when we need it.

It's why neighbouring NHS hospitals, community and mental health trusts, family doctors, pharmacies, local councils and others have come together to plan for the future and redesign local health and care services to benefit us all – now and in the years ahead.

Working as the East London Health & Care Partnership, and backed by the leaders of all the organisations involved, they are combining their expertise and resources to develop ways of giving our nurses, doctors and care staff the best chance of success to look after us when we need them to.

The Partnership is to be officially launched on 15 June at an event for the key partners. This will be followed by a series of similar events throughout the summer for other key stakeholders and community representatives/groups.

With a shared goal to help people live happy, healthy and independent lives, the Partnership's mission is to protect vital services and provide better treatment and care built around the needs of local people, safely and conveniently, closer to home.

A top priority is to reduce the pressures on our hospitals and accident and emergency departments. A&E is all too often used as the only door into health and care services, when ideally people should be should be supported by community staff and resources in their own homes.

The Partnership also wants better outcomes for cancer patients, people with diagnosed with diabetes and improvements to mental health services, and to help people become independent with access to care at home.

Reshaping services to provide them in the right place, where people need them most and supported by the right team of staff from across health and social care, is a key and urgent requirement.

The response to the demand on services needs to offer better alternatives that help prevent people's health deteriorating. This isn't to just make the most efficient use of the resources and money available, but to provide a better quality of care and services in the community, where local people have told us they want them.

Attempting to improve the hundreds of health and care services for the two million people of east London – a population expected to grow by around 30,000 more people in 2017 alone – is a daunting and complex task, but many of the most beneficial changes can be made quite simply.

Significant improvements are already being made by joining services up and people are starting to feel the benefit. The area now has some of the best care provision and facilities in the country, but there's still much to do.

Although they operate safely, some our hospitals aren't fully equipped to meet the needs of modern healthcare. Waiting times for appointments and treatments must be reduced. And more has to be done to safeguard our most vulnerable people.

'Busting barriers'

The East London Health & Care Partnership isn't afraid to tackle these challenges. It will build on the successes achieved so far and bring health and social care providers even closer together, breaking down any barriers as necessary.

The good work already being done to meet more localised needs will continue. The Partnership is not there to undo what works, slash budgets or act secretly behind closed doors. Instead, it will drive forward wider benefits that can only be achieved by everyone working together, coming up with new ideas and better ways of working that can put a stop to duplication and unnecessary expense.

The East London Health & Care Partnership's *Sustainability and Transformation Plan* (STP) sets out how these ambitions, and those of the wider NHS through its national *Five Year Forward View*, will be turned into reality.

It describes how the Partnership will meet the health and wellbeing needs of east London by improving and maintaining the consistency and quality of care, and plug the shortfall in funding of services.

The plan proposes improvements across the whole of east London, such as the availability and quality of specialist clinical treatments, how buildings and facilities could best used, particularly those in need of renewal, and the introduction of digital technology to enhance services for local people.

The overall aim is to make local health and care services sustainable by 2021, but the partnership is looking further ahead for longer-lasting solutions.

The involvement of councils, for example, enables the vision for better health and care provision to be aligned with the development of housing, employment and education, all of which can have a big influence.

The Partnership is committed to being transparent and engaging fully with key stakeholders and the wider public in the development of its plans.

But the biggest single factor in the long term is to prevent ill health – something we can all play a part in, everyone living and working in east London. It's not just down to the authorities.

Public health information and advice will be strengthened. Information and support to help us live healthier lives will be made more widely available – online and through social media. It's up to us to enjoy life to the full by doing those little things each day that help us stay healthy and fit.

We can watch what we eat and drink and get more active. We can go to the pharmacist and get advice from telephone and online services first rather than immediately going to the doctor or calling for an ambulance when we don't need to. We can educate our children about healthcare and plan for care when we are older. We can all do our bit.

If we do this, and get behind the work of the East London Health & Care Partnership, the prize is that we are able to lead happy, healthy and independent lives – but get the care we can trust and rely on when we need it.

To win that prize is down to us all.

2. The STP in detail

The Sustainability and Transformation Plan (STP) sets out how local health and care services will transform and become sustainable over the next five years, building and strengthening local relationships and ultimately delivering the vision of the NHS Five Year Forward View.

Forty four such plans have been developed throughout England. They are geographically set around 'footprints' that have been locally defined, based on natural communities, existing working relationships, patient flows and taking into account the scale needed to deliver the services, transformation and public health programmes required.

Twenty organisations across eight local authorities have worked together to develop an STP for north east London. They are:

NHS

CCGs: Barking & Dagenham; City & Hackney; Havering; Newham; Redbridge; Tower Hamlets; Waltham Forest

'Provider' Trusts: Barking, Havering and Redbridge University Hospitals Trust; Barts Health NHS Trust; The Homerton University Hospital NHS Foundation Trust; East London NHS Foundation Trust; North East London NHS Foundation Trust

Councils

Barking & Dagenham; City of London Corporation; Hackney; Havering; Newham; Redbridge; Tower Hamlets; Waltham Forest

The STP has been defined as one for north east London by NHS England, because it has divided the capital into five 'footprints': north east; north west; south east; south west; and north central.

Originally drawn up in June 2016, and then redrafted following engagement with key stakeholders, the STP was submitted to NHS England and NHS Improvement on 21 October 2016.

The plan is currently only a 'draft'. It will continue to evolve as the organisations concerned develop it further, agree shared solutions, and as we receive feedback from stakeholders.

The STP describes how the organisations involved in the partnership will:

- Meet the health and wellbeing needs of its population
- Improve and maintain the consistency and quality of care for our population
- Close the financial gap.

All of the organisations involved in the STP face common challenges, including a growing population, a rapid increase in demand for services and scarce resources. By working together they will be best placed to drive change and make sure health and care services in north east London are sustainable by 2021.

The STP builds on existing local transformation programmes and supports their implementation including:

- Barking and Dagenham, Havering & Redbridge (accountable care system) and Hackney devolution pilots
- Newham, Tower Hamlets and Waltham Forest: Transforming Services Together programme
- The improvement programmes of our local hospitals, which include supporting Barts Health NHS Trust out of special measures.

- Vanguard projects eg Tower Hamlets Together

The organisations behind the STP are actively seeking to collaborate where it makes sense to do so, sharing learning from the devolution pilots and transformation programmes.

2.1 STP vision and priorities

The vision of the STP is to:

- Measurably improve health and wellbeing outcomes for the people of NEL and ensure sustainable health and social care services, built around the needs of local people.
- Develop new models of care to achieve better outcomes for all, focused on prevention and out-of-hospital care.
- Work in partnership to commission, contract and deliver services efficiently and safely.

To achieve this vision, we have identified a number of key priorities:

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

To deliver the STP we are building on existing local programmes and setting up eight work streams to deliver the priorities.

The work streams are cross-cutting NEL-wide programmes, where there are benefits and economies of scale in consolidating a number of system level changes into a single programme. These are:

- Promote prevention and personal and psychological wellbeing in all we do
- Promote independence and enable access to care close to home
- Ensure accessible quality acute services
- Productivity
- Infrastructure
- Specialised commissioning
- Workforce
- Digital enablement

Each delivery plan sets out the milestones and timeframes for implementation.

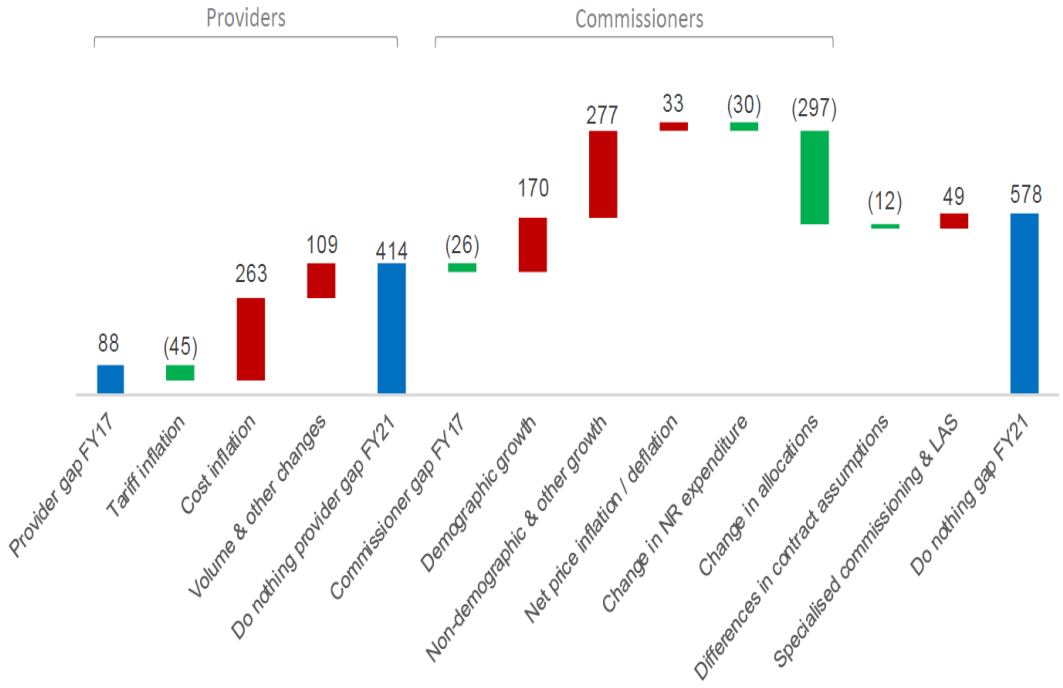
The full STP, and the eight delivery plans, can be found on our website www.nelstp.org.uk

2.2 STP Finances

2.2.1 'Do Nothing Scenario

The forecast EL provider deficit in FY16/17 is c£88m which will rise by £319m to £414m in FY20/21. EL CCGs are projecting a £26m surplus (including carried over surpluses from prior years) but CCG allocations uplifts of £297m are not sufficient to offset cost pressures over the planning period. Differences in contract assumptions net out to around £12m by FY21 overall and specialised commissioning and LAS add a £49m pressure, resulting in a total financial challenge of £578m in the 'do nothing' scenario to reach a break even position.

Achieving a 1% surplus target for commissioners increases the gap by another c£30m to around £610m.



2.2.2 'Do Something' Scenario

Our total financial challenge in a 'do nothing' scenario would be £578m by 2021. Achieving ambitious 'business as usual' cost improvements as we have done in the past would still leave us with a funding gap of £336m by 2021. Through the STP, we have identified a range of opportunities and interventions to help reduce the gap significantly.

This will be aided by Sustainability and Transformation Funding (STF) funding, specialised commissioning savings and potential support for excess Public Finance Initiative (PFI) costs. Significant work has started to evaluate the savings opportunities.

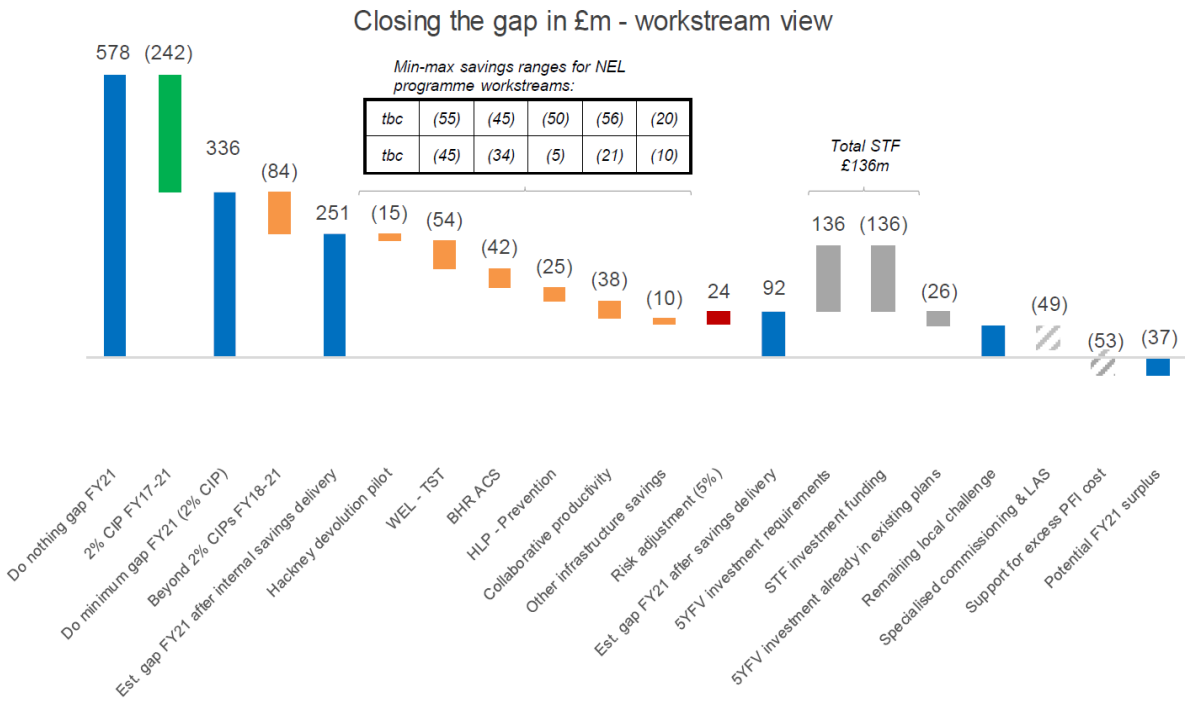
We have developed our governance structures to support the next stages of planning and implementation. Our robust governance structure allows individual organisations to share responsibility while balancing the need for autonomy, accountability and public and patient involvement.

The EL transformation journey has started. We are committed to meeting all NHS core standards and delivering progress in every priority. Together we will deliver a sustainable health and wellbeing economy across EL. It's a significant challenge, but one we welcome as it provides opportunities to make a real and lasting difference to the lives of local people.

Over the course of the last year, ELHCP STP has developed several work streams through which it has identified potential solutions to closing the financial gap.

2.2.3 STP Solutions

The ELHCP STP Work streams have been working closely with STP partners to develop solutions to close the gap. Some of those solutions are listed below.



2.2.4 2% CIP & Beyond 2% CIPs - £326m

Providers are normally expected to deliver business as usual savings of approximately 2%. This is in sync with the expected provider efficiencies within the current tariff guidance and assumptions made by other London STP's. Some providers have put forward CIP schemes over 2%.

2.2.5 WEL TST - £54m

Transforming Services Together sets out to improve and modernise healthcare services across three London boroughs – Newham, Tower Hamlets and Waltham Forest – addressing inequalities, helping patients take control of their own health and tackling the problems faced by health services across the area.

This area of east London has a growing and ageing population, with 270,000 more residents – the equivalent of a new borough or a city the size of Southampton – expected to arrive in the next 15 years.

TST seeks to avoid a projected deficit across the three boroughs in just over a decade. If no changes are made, 550 more hospital beds would be required, which is unaffordable and not the best way to provide services for local people.

Key TST schemes include but are not limited to:

- Expand integrated care to those at medium risk of hospital admission.
- Put in place a more integrated urgent care model.
- Improve end of life care, improving access, capacity and co-ordination in primary care.
- Establishing surgical hubs including interventional Radiology.
- Establishing acute care Hubs on each site.
- Increase proportion of natural births.
- Transform patient pathway and outpatients.
- Reduce unnecessary testing.
- Deliver shared care records across organisations.
- Explore the opportunity that physician associates may bring.
- Developing a strategy for future of mile end Hospital and Whips cross hospital.

2.2.6 BHR ACS - £42m

Accountable Care Organisations (ACO) are a new way of structuring health and social care services, which were referenced by NHS England chief executive Simon Stevens in his Five Year Forward View (5YFV).

The partners working together on the business case for an ACO in Barking and Dagenham, Redbridge and Havering are:

- The three local clinical commissioning groups (CCGs)

- Three local authorities – London boroughs of Havering, Redbridge and Barking and Dagenham.

- The acute hospital provider Barking, Havering and Redbridge University Hospitals NHS Trust

- The community and mental health provider NELFT NHS Foundation Trust. They are working together with UCL Partners, an academic and health partnership providing operational support and clinical leadership.

The primary aim is to improve the experience and quality of care for patients and service users by ensuring it is joined up and seamless, and leads to better health and wellbeing for our residents. However, it is clear that there is a major challenge in the coming years for health and social care to be financially sustainable. A key test for an accountable care organisation will be that it is more efficient, helping us tackle some of the financial challenges facing the NHS and local government and protecting the interest of patients and service users.

Key BHR ACO schemes include but are not limited to:

- Gastroenterology Virtual pathway
- MSK Service Re-design
- POLCE
- Dermatology service redesign
- KGH UCC
- Right Care
- Community Health Service re-design
- Acute provider productivity.

2.2.7 Healthy London Partnership (HLP) Prevention - £25m

HLP was born in March 2015 when London's NHS (32 Clinical Commissioning Groups (CCGs) and London Region of NHS England) agreed to come together using the recommendations set out in Better Health for London as a blueprint to meet the challenges set out in the Five Year Forward View.

A key strength of HLP is its partnership approach, including Public Health England, NHS England, London's 32 CCGs, London Councils and the Greater London Assembly, as well as members of the public and patient groups. We have come together to address the unique health challenges London faces and deliver this transformation.

Our aspiration is based on the belief that a truly great global city is a healthy city. The aim is to take London from seventh in the global healthy city rankings, to the number one spot. We want to make London a place that helps its residents to make healthier choices, improves the health of its most vulnerable, provides consistently excellent care for people when they need it most and enables its health service to prosper and flourish to the benefit of all its citizens.

2.2.8 Collaborative productivity - £38m

ELHCP STP expects to make significant productivity savings within its providers. Key areas expected to deliver these savings are:

- Bank and Agency spend
- Back office
- Procurement
- Theatre Productivity

2.2.9 Hackney Devolution - £15m

Hackney devolution is a shared vision of delivering an integrated, effective and financially sustainable system that covers the whole range of wellbeing-from public health initiatives for school children, timely and appropriate access to GP's and community pharmacists and top quality hospital treatment as well as supporting people to remain independent in their community for as long as possible.

Some of the expected benefits are:

- Giving parents easier access to immunisation for very young children by providing more community based services.
- Tackling Obesity through better co-ordinated services and greater local powers to create a healthy environment.
- Quicker progress towards parity of mental health and physical healthcare services.
- Providing tailored, more integrated support for people at the end of their life.

2.2.10 Conclusion

We have set out a bold plan for how we intend to work together as one system to deliver outstanding health and wellbeing services for all local people. We began by recognising the six key priorities that we needed to answer as a system. A summary of the actions we are going to take in response to each question is set out below:

1. The right services in the right place: Matching demand with appropriate capacity in EL to meet the fundamental challenge of our rapidly growing, changing and diverse population we are committed to:

    - Shifting the way people using health services with a step up in prevention and self-care, equipping and empowering everyone, working across health and social care.

    - Ensuring our urgent and emergency care system directs people to the right place first time, with integrated urgent care system, supported by proactive accessible primary, community and mental health care at its heart.

    - Establishing effective ambulatory care on each hospital site and mental health community based crisis care, to ensure our beds are only for those who really need admission, so we don't need to build another hospital.

    - Ensuring our hospitals are working together to be productive and efficient in delivering patient-centred care, with integrated flows across community and social care.

    - Addressing demand for acute and mental health inpatient services: streamlining outpatient pathways, introducing new technology, delivering better urgent and emergency care, coordinating planned care/surgery, maternity choice, improving psychosis pathways, and encouraging provider collaboration

    - Ensuring our estates and workforce are aligned to support our population.

2. Encourage self-care, offer care close to home and make sure secondary care is high quality We have a unique opportunity to bring alive our system-wide vision for better care and wellbeing. We are already working together on a system-wide clinical strategy:

    - Transforming primary care and addressing areas of poor quality/access, this will include offering accessible support in localities and hubs from 8am to 8pm (seven days a week), with greater collaboration across practices to work to support localities, and address workforce challenges.

    - Investing in mental health, community, Learning Disability, & substance misuse services to improve quality and tackle health inequalities. Ensuring parity of esteem and good mental wellbeing, embedding this throughout all of our services.

    - Ensuring our hospitals are working together to be productive and efficient in delivering patient-centred care, maximising new technologies and pathway redesign.

3. Secure the future of our health and social care providers, many of whom face challenging financial circumstances. They are committed to working together to achieve sustainability and changes to our EL service model will help to ensure fewer people either attend or are admitted to hospitals unnecessarily (and that those admitted can be treated and discharged more efficiently):

- We have significant cost improvement plans, which will be complimented by a strong collective focus on driving greater efficiency and productivity initiatives. This will happen both within and across our providers (for example procurement, clinical services, back office and bank/agency staff).

- The providers are now evaluating options for formal collaboration to help support their shared ambitions.

- ACS development (CH/BHR devo business cases Oct 31 2016) in development with LA and efficiencies being established.

4. Improve specialised care, by working together we will continue to deliver and commission world class specialist services. Our fundamental challenge is demand, and associated costs, are growing beyond proposed funding allocations. We recognise that this must be addressed by:

    - Working collaboratively with NHS E and other STP footprints, as patients regularly move outside of EL for specialised services.

    - Working across the whole patient pathway for our priority areas from prevention, diagnosis, treatment and follow up care – aiming to improve outcomes whilst delivering improved value for money.

5. Create a system wide decision making model that enables placed based care and clearly involves key partner agencies

    We are committed to establishing robust leadership arrangements, based on agreed principles that provide clarity and direction to the EL health and wellbeing system, and can drive through our plans.

    This will be achieved through genuine partnership between the health system and Local Authorities to create a system which responds to our population's health and wellbeing needs.

6. Using our infrastructure better

    We need to deliver care in modern, fit for purpose buildings and to meet the capacity challenges produced by a growing population. We are now working on a common estates strategy which will identify priorities for FY16/17 and beyond. This will contain a single EL plan for investment and disposals, utilisation and productivity and managing PFI, with a key principle of investing any proceeds from disposals in delivering the STP vision.

2.3 STP Governance

The launch of the Sustainability and Transformation Plan (STP) process signalled the move towards working in larger geographical areas and the need to develop governance arrangements to support strategy development and change at a system level. To achieve this, 20 organisations in East London have been working together to develop the East London Health and Care Partnership (ELHCP which previously known as NEL) STP.

Initial governance arrangements were put in place by the member organisations of the ELHCP to oversee and direct the development of the draft STP document, which was submitted to NHS England on 21 October 2016.

These arrangements were developed by a 'task and finish group' that included health organisations, local authorities and Healthwatch and included initial terms of reference for the key governance forums.

This governance structure (see Appendix 2) recognised and respected the statutory organisations, while providing the necessary assurance and oversight for system level delivery. In addition to reinforcing some of the existing governance forums (i.e. re-focusing the membership of the ELHCP STP Board), several new bodies were added to strengthen the level of assurance and engagement, most notably:

- ELHCP Community Group – A council of local people, voluntary sector, and other key stakeholders to promote system wide engagement and assurance
- ELHCP Mayors and Leaders Advisory Group - To provide a forum for political engagement and advice to the ELHCP STP
- ELHCP Social Care & Public Health Group – Directors of Children's and Adult Services and Directors of Public Health
- ELHCP Assurance Group – An independent group of audit chairs and local authority scrutiny members to provide assurance and scrutiny
- ELHCP Finance Strategy Group -To provide oversight and assurance of the consolidated East London (EL) financial strategy and plans to ensure financial sustainability of the EL system.

The ELHCP STP operated the governance arrangements in shadow form until 1 April when they implemented formally by the Partnership Board on the understanding they will be reviewed every three months and updated as appropriate.

The arrangements are underpinned by a Partnership Agreement (see Appendix 3) which, while not legally binding, intends to ensure a common understanding and commitment between the partner organisations of:

- The scope and objectives of the ELHCP STP governance arrangements
- The principles and processes that would underpin the ELHCP STP governance arrangements
- The governance framework / structure that would support the development and implementation of the ELHCP STP

The Partnership Agreement has now been circulated to the member organisations of the ELHCP for signature.

2.3.1 Engagement with Local Authorities

The ELHCP engaged widely with stakeholders to shape its governance arrangements. Engagement with local authorities has been paramount and has been achieved through various forums.

On 19 December 2016, Rob Whiteman, ELHCP Chair attended a joint meeting of all the Chief Executive Officers of Local Authorities to discuss the ELHCP STP including its governance arrangements. The meeting was hosted by Martin Esom, Chief Executive of Waltham Forest Council, who is a member of the ELHCP Partnership Board. The chief executives of Hackney and Havering Councils are also now members of the Board, meaning each of the three main transformation areas have a local government representative present.

On 26 January 2017, the directors/heads of communications from all East London NHS organisations and local councils met to discuss how they could work more closely together and join up their communication networks. They have since met twice again on 9 March and 4 May.

On 7 March 2017, the Directors of Children's and Adult Services and Directors of Public Health met to discuss how they want the ELHCP Social Care & Public Health Group to operate. The Partnership is awaiting their formal proposals on this.

On 8 March, political representatives from the eight councils met to talk about the ELHCP Mayors and Leaders Advisory Group and how that might work. A further meeting is scheduled for this group on 26 May.

Regular engagement is also taking place with all of the councils outside of these meetings, at various levels.

2.4 Equality

A screening to consider the potential equality impacts of the proposals has been completed. This is on our website www.nelstp.org.uk

The screening includes:

- An assessment of the level at which the analyses need to be conducted (London-wide, regional, local area or borough level)
- A screening of the overarching Framework for better care and wellbeing

- Description of the actions to be taken
- The screening recognises the initiatives included in the STP will be implemented at different times and that further analyses will need to be undertaken over the life of the programme.

3. Involving local people and stakeholders

STPs have been widely criticised for being put together too hastily with little consultation.

The timescale set by NHS England to produce the plans was tight. As a consequence, there was only a limited time for engagement. Some key stakeholders felt disengaged from the process, as did patient representatives. Also, much of the detail behind the plans was initially kept under wraps giving rise to accusations of secrecy and the STPs being seen as no more than 'hit lists' and cuts to services.

NHS England acknowledges this criticism, but it has caused significant reputational damage to what is a genuine and necessary attempt to deal with very real challenges.

The immediate priority of our communications and engagement strategy is to therefore repair that damage.

Most, if not all, of our key stakeholders recognise and understand the challenge. We now need to rebuild their trust and confidence and engage with them in a more positive way so they are involved in developing shared solutions.

A starting point is to talk about a partnership rather than a plan, certainly not an acronym. It's why we have changed our name to the East London Health & Care Partnership.

The STP itself will still be referred to as such, but it is just one of many things the organisations behind it can do together as a Partnership to protect and improve health and care services for the people of east London.

It was also felt east London was a more appropriate and familiar way of describing the area as a whole rather than north east London.

Next is to communicate in an open and honest way; unravel the jargon, speak in plain and simple language and be accessible and transparent. Most importantly, we must listen to what people have to say.

Relevance is also important. Our communications will reflect a knowledge and understanding of the many different audiences we want to reach and be targeted to suit each group. What does it all mean for them? How are their interests being taken into account? What part can they play?

Local relevance and insight is particularly important. We will work closely with our communications and engagement colleagues in the partner organisations at borough level to make full use of their knowledge and networks.

An online Briefing Room is being set up as a central source of information and materials for members of the Partnership to adapt and use in local communications and engagement activities.

This includes narratives around the STP (what it is and what it isn't); the various transformation plans and programmes (as they emerge); facts and figures; presentations (tailored for specific audience); information videos; and case studies.

At the heart of our stakeholder engagement will be the Community Group – a subgroup of the East London Health and Care Partnership.

Representing key partners and stakeholders, community organisations (including Healthwatch and patient and public involvement groups), the Voluntary, Community and Social Enterprise sector (VCSE), professional bodies and trades unions, the Group's purpose is to act as a reference arm of the Partnership – helping it develop plans and activities and recommending the most effective ways for it to communicate and engage with its target audiences.

An initial meeting of the organisations and people that will be invited to join the Community Group is planned for 28 June.

Another key audience is, of course, frontline staff – not just those in the NHS, but in councils too. Their buy-in is key and we intend running an intensive programme of engagement with them over the spring and summer to create understanding about what the partnership, and the STP, means to them.

We very much want staff to be involved in shaping services and our internal communications will reflect this. They will recognise the contribution everyone has to make, encouraging and valuing people's achievements, opinions and ideas.

If we are to give staff the effective help and support they need it's vital we listen to what they have to say, and demonstrate what we do as a result.

While staff and the other key stakeholders in the Community Group will take precedence in the immediate future, we eventually want to reach out and engage with as many people as possible, including the wider public.

With this in mind the Partnership is therefore planning to have a presence at all of the major summer festival events, including the Havering Show, working alongside council, public health and NHS colleagues to help boost the promotion of campaigns around health prevention and access to services.

The Partnership is also planning a series of public engagement across east London from the summer onwards. Some of these will take the format of TV's Question Time programme, giving people the opportunity to get answers to their concerns and debate popular topics.

Everyone has a part to play in building sustainable health and care services, particularly with regards to prevention.

Smoking cessation, preventing diabetes and improving workplace health are three early priorities for the Partnership, as is reducing obesity and social prescribing. All require attitudinal and behavioural change in a big way.

A lot of work has already been done at a local level to promote prevention, but its success has been limited. Through the Partnership there is now the opportunity to join forces and do much more, using high-impact campaigns specifically designed to grab mass attention and participation.

Building on what's shown to work, and taking into account materials already available locally and nationally, the partner organisations will work together to give a more powerful and coherent message, making full use of the many communications channels and networks across the area.

Running campaigns in this way, with a consistent approach, is especially important in east London where there is high population 'churn'. People need to see and hear the same message, wherever they are.

It's the same with the promotion of services. Too many people are going to the wrong place for treatment because of a lack of information. There is a need to simplify the signposting to services and explain things in a clearer and more meaningful way, free of jargon. The Partnership is planning to do this through an information campaign this summer.

Behavioural change won't, of course, be achieved overnight so these are long-term aims for the Partnership.

4. Other recent activities

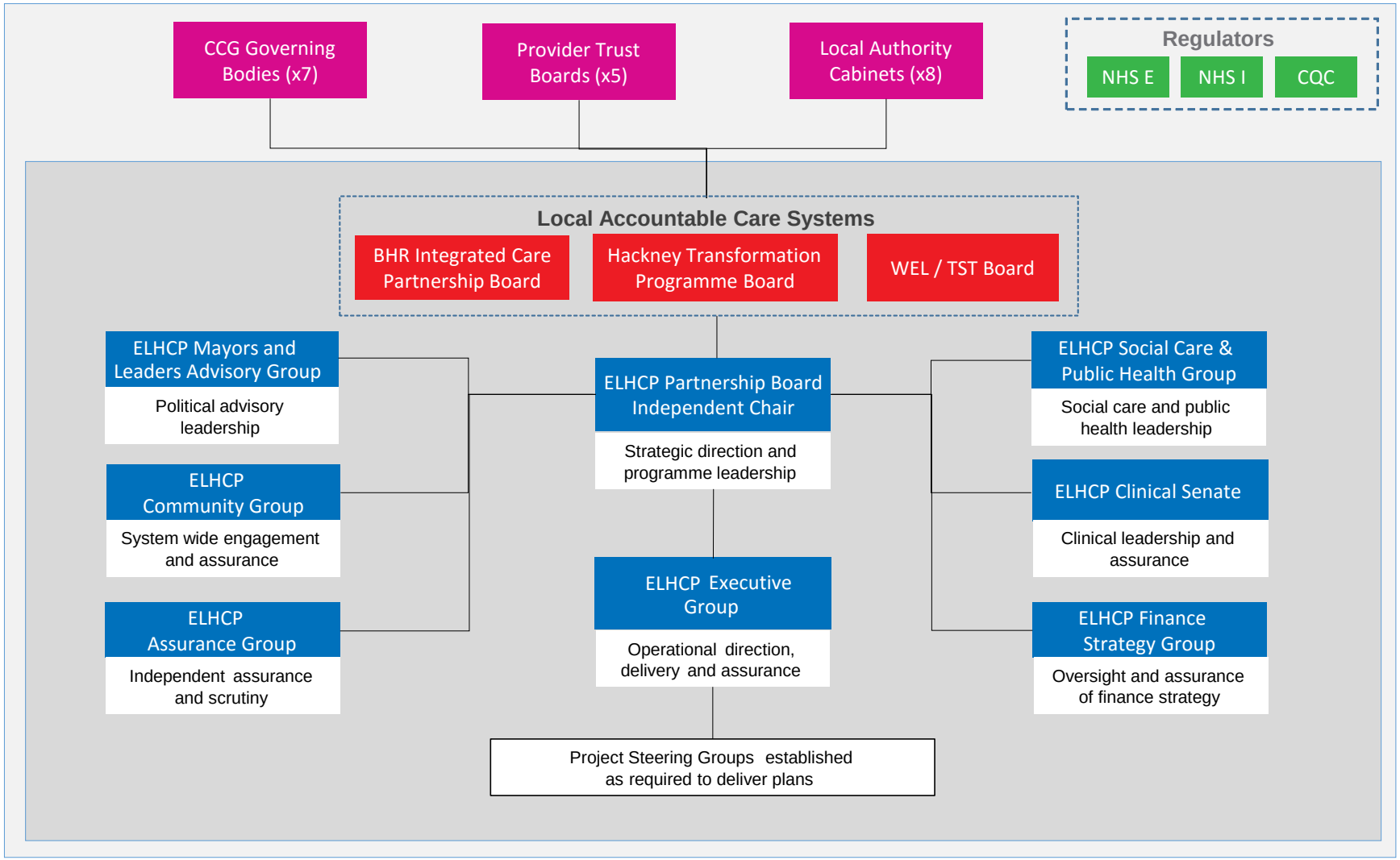
Healthy Workplace launch (Prevention workstream)

Dame Carol Black was the keynote speaker at the East London Health and Care Partnership's (ELHCP) Healthy Workplace launch on 29 March. One of the Partnership's aims is to transform workplace health as part of its role in delivering the north east London (NEL) STP. Trust and CCG directors joined public health leads, GPs and pharmacists in an effort to work together as a NEL-wide Community of Practice, to deliver the health and productivity benefits of healthy workplaces. The event was a significant step in the STP's ambition to adopt and progress the Mayor's London Healthy Workplace Charter in all 20 NHS and local government organisations across east London.

A range of workplace health organisations - including Mental Health First Aid, Step Jockey, Wellbeing Insight, Foodtalk, and the Partnership's own Smoking Cessation and Tobacco Control Working Group - engaged participants in lively discussions on how they could meet and exceed the Charter standards.

East London Health & Care Partnership

Governance structure



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East London Health and Care Partnership

Partnership Agreement

Version 2.10

31 March 2017

1. Purpose

This Partnership Agreement describes how the health and social care partners in East London (EL) (listed in **Appendix D**) will co-operate as The East London Health and Care Partnership (ELHCP), setting out the partnership arrangements to support the implementation of the East London Sustainability and Transformation Plan (EL STP).

This Partnership Agreement, built on the EL STP Memorandum of Understanding (MOU), is separate to the East London Sustainability and Transformation Plan (STP). Sign- off or endorsement of the overarching STP will take place on an individual organisational or borough level.

PART 1 – PARTNERSHIP ARRANGEMENTS

2. Introduction

Delivering the Forward View NHS Planning Guidance 2016-17 to 2020-21 released in December 2015[1] set out a requirement for local areas to come together develop a shared five-year sustainability and transformation plan.

The launch of the sustainability and transformation planning process signalled a new paradigm, with a move towards greater local co-operation including the need to work in the partnership to develop strategy and change at a local level.

In response to this guidance 20 organisations across East London – in The City of London, Barking and Dagenham, Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest - have been working together to develop the EL STP:

- The EL STP describes how these Parties will co-operate to turn the ambitions of the NHS Five Year Forward View into reality and deliver the vision of better health and wellbeing, improved quality of care and stronger NHS finance and efficiency.

The EL STP acts as a system level plan for change supported by and aligned to a number of local plans to address certain challenges, such as:

- City and Hackney (CH): Hackney devolution pilot, bringing providers together to deliver integrated, effective and financially sustainable services.
- Barking and Dagenham, Havering and Redbridge (BHR): bringing together health and social care services under a single local accountable care system (devolution pilot)
- Newham, Tower Hamlets and Waltham Forest (WEL): "Transforming Services Together" programme to improve the local health and social care economy.

[1] Delivering the Forward View, NHS Planning Guidance 2016-17 to 2020-21, NHS England, December 2015, https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

An initial set of governance arrangements was established to oversee and manage the development of the draft EL STP that was submitted to NHS England and NHS Improvement on 30 June 2016.

Following this submission the programme moved into the next phase, focused on detailed planning and the mobilisation and implementation of the delivery programmes. The partnership arrangement now needs to be updated to reflect these changes agreed by the STP Board in focus and branding, so that it supports the prioritisation of the different elements of the EL STP projects.

3. Objectives of the ELHCP Partnership arrangements

The objectives of the ELHCP Partnership arrangements are to:

- Support effective collaboration and trust between commissioners, providers, people and carers to work together to deliver improved health and care outcomes more effectively and reduce health inequalities across the EL system
- Provide a robust framework for system level decision making, and clarity on where and how decisions are made on the development and implementation of the EL STP
- To review and ensure clinical sustainability of services at STP level
- Provide clarity on system level accountabilities and responsibilities for the EL STP
- Enable opportunities to innovate, share best practice and maximise sharing of resources across organisations in East London
- Enable collaboration between Parties to achieve system level financial balance over the 5 year STP timeframe and deliver the system control total (once agreed), while safeguarding the autonomy of organisations
- Ensure learning and capacity building across the three accountable care systems.

4. Scope of the ELHCP Partnership arrangements

4.1. In scope

- Partnership arrangements for the East London STP
- Partnership arrangements for the implementation of the STP schemes defined in the East London STP
- Alignment with the wider health system plans and partnership , including devolution programmes and regional boards
- Development and operation of the partnership arrangements for the EL STP Financial Strategy to achieve the system control total
- Support the development of Accountable Care Systems to enable working towards a sustainable health economy by moving away from tariff based system to a capitation based system to achieve financial stability and to incentivise the right clinical behaviours

4.2. Out of scope

- Organisational governance arrangements for CCG Governing Bodies, Provider Trust Boards and Local Authorities
- Local partnership arrangements for the delivery of local (non-East London wide) programmes:
    - Hackney devolution pilot
    - Barking and Dagenham, Havering and Redbridge (BHR) Accountable Care System (devolution pilot)
    - Transforming Services Together programme.

5. Principles for the ELHCP Partnership

The development of effective system level partnership arrangements, mobilisation and implementation of the delivery programmes in the EL STP requires collaboration and active engagement (where relevant) from all Parties to ensure the interests of all Parties are appropriately represented.

A key aspect of this process is the agreement of a common set of principles for partnership ways of working and culture. Accordingly, the Parties have adopted the following as a basis for collaborative working between the parties:

- ELHCP Principles (as set out below)
- ELHCP Financial Principles (agreed by the Finance Strategy Group in March 2017 as set out at **Appendix B**)
- The Nolan Principles (as set out at **Appendix B**)

ELHCP Principles

- **Participation**: Representation and ownership from health and social care organisations ('The Parties'), local people and lay members to clearly demonstrate collaborative and representative decision making
- **Collaboration**: All Parties will work collaboratively to deliver the overall EL STP strategy, in the best interests of the wider system and local people
- **Engagement**: Local people will be engaged and involved in the ELHCP governance to ensure their views and feedback are considered in the decision making processes. This engagement should operate at 2 levels; individual level and organisational level (i.e. via patient representative forums and other local community groups)
- **Accountability**: Define clear accountabilities, delegation procedures, voting arrangements and streamlined governance structures to support continuous progress and timely decision making. Delegation of work to the groups with the relevant expertise and authority to deliver it

- **Autonomy**: Recognise the autonomy of the Parties (health and social care partners) of the ELHCP Partnership. Operate in a manner that is compliant with legal duties and responsibilities of each constituent organisation and the NHS and Local Authorities as a whole (e.g. legal responsibility for consultation on service changes). Ensure alignment with the local organisations' governance and decision making processes recognising statutory and democratic procedures

- **Subsidiarity**: Ensure subsidiarity so that decisions are taken at the most local level possible, and decisions are only taken at a system level where there is a clear rationale and benefit for doing so

- **Professional Leadership**: Demonstrate strong professional leadership and involvement from clinicians and social care to ensure that decisions have a robust case for change and senior level support

- **Accessibility**: Ensure complete transparency in all decision making to support the development of mutual trust and openness between organisations. Provide the necessary assurance to system partners on key decisions. Collaborative working and information sharing between working groups to ensure consistency.

- **Good Governance**: Recognise that good system level governance will require robust planning and horizon scanning to ensure that proposals are presented to the statutory organisations in a timely way, that align with their local governance and decision making processes. However, where necessary local organisations will try to be flexible to support the system level governance.

6. Governance structure

The current proposed governance structure for the ELHCP Partnership is included in **Appendix A**.

This appendix also includes draft summary terms of reference for the key governance groups in this structure, which will be refined further by the groups.

7. Voting rights and process

Voting rights and processes will be defined in relevant terms of reference.

8. Major system changes

The key system level decisions that will fall under the scope of the ELHCP Partnership arrangements are outlined below.

This list will be updated from time to time to reflect the latest set of EL system level decisions:

- Approval of the EL STP
- Budget for the EL STP programme
- System level financial strategy and system control total
- Whipps Cross Hospital re-development strategy

- Changes to King George Hospital Emergency Department
- The relevant elements of the East London Mental Health strategy
- The relevant elements of the East London Primary Care strategy
- East London system level estates plan
- The approach to specialised commissioning for the East London sector
- Risk pooling principles and financial arrangements
- Delegation in place to allow Tower Hamlets CCG Remuneration Committee to approve Very Senior Management posts on behalf of all the other ELHCP CCGs.
- Decisions about capital allocations

PART 2 – MISCELLANEOUS LEGAL PROVISIONS

9. Liability

This Partnership Agreement describes arrangements for aligned decision making of the Parties which they agree is necessary to achieve the objectives in Clause 3.

Parties agree that the governance bodies set up under this Partnership Agreement do not have any authority to make binding decisions on behalf of the Parties and that each Party (and not the governance bodies) will retain liability for the actions of the relevant Party.

10. Duration of the Partnership Agreement

This Partnership Agreement replaces shadow arrangement and takes effect from 1 April 2017.

The Parties expect the duration of the Partnership Agreement to be for the period of 2017-2021 in line with the duration of the STP or otherwise until its termination in accordance with Clause 14.

11. Effect of the Partnership Agreement

This Partnership Agreement does not and is not intended to give rise to legally binding commitments between the Parties.

The Partnership Agreement does not and is not intended to affect each Party's individual accountability as an independent organisation.

Despite the lack of legal obligation imposed by this Partnership Agreement, the Parties:

- Have given proper consideration to the terms set out in this Partnership Agreement; and
- Agree to act in good faith to meet the requirements of this Partnership Agreement.

12. Subsidiarity

The Parties acknowledge and respect the importance of subsidiarity.

The Parties agree for the need for many decisions to be made as close as possible to the people affected by them.

13. Dispute resolution process

All Parties will make every effort to work collaboratively in the best interests of the East London system, and to avoid disputes. Should disputes arise the parties will follow the agreed dispute resolution process to resolve the disputes as quickly as possible and to minimise impact on delivery.

Individual Party's concerns should be raised in the first instance with the Independent Chair of the ELHCP Partnership Board. This should be in writing clearly stating the basis of the concerns, including where applicable the concerns and the rationale behind the dispute.

The Independent Chair will endeavour to find an informal resolution to the dispute through discussion and mediation. Where agreement cannot be reached using informal resolution processes the Independent Chair will propose a formal resolution process, which may involve reference to national guidance and best practice.

14. Termination

Each Party may terminate its participation in this Partnership Agreement by giving the other Parties no less than 30 days' notice in writing.

The Independent Chair will endeavour to find an informal resolution to the dispute through discussion and mediation. Where agreement cannot be reached using informal resolution processes the Independent Chair will propose a formal resolution process, which may involve reference to national guidance and best Practice. Parties may terminate the Partnership Agreement with the written agreement of all of the Parties.

15. Law

This Partnership Agreement will be governed by the laws of England and the courts of England will have exclusive jurisdiction.

16. Review process

This Partnership Agreement will be reviewed and updated from time to time to enable good practice governance to be recognised and built upon to identify and address areas for development.

17. Code of conduct

The Finance Strategy Group has agreed ELHCP principles which are listed in **Appendix B**.

The Committee on Standards in Public Life (Nolan Committee) has set out seven principles of public life which it believes should apply to all in public service. The seven Nolan principles are listed in **Appendix B**.

The Parties are asked to adopt these above principles as the basis for collaborative working across the partnership arrangements.

18. Amendment

Parties agree that this Partnership Agreement may be varied only with the written agreement of all of the Parties. Such amendments will be included in an addendum/appendix to this Partnership Agreement.

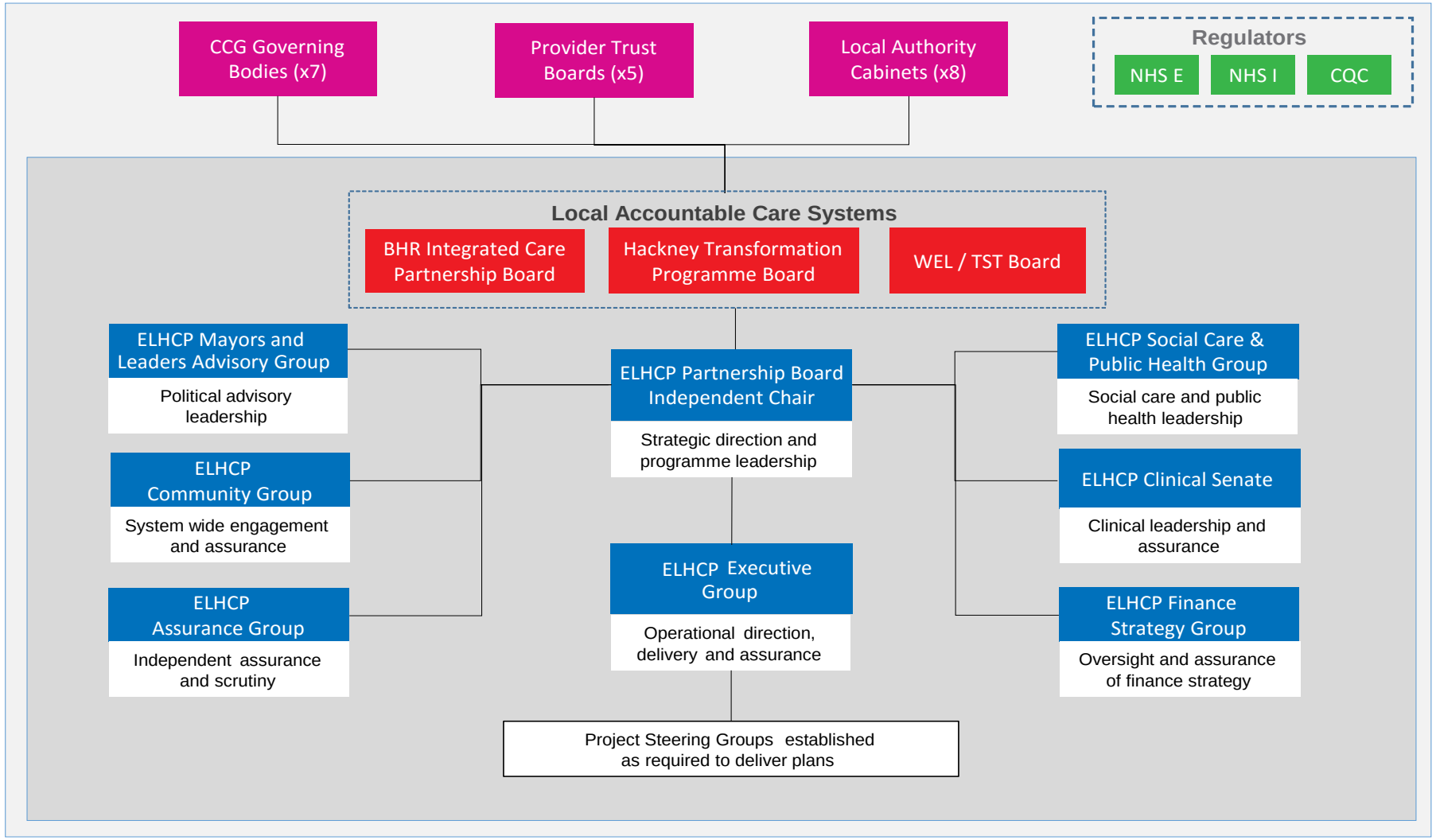
Appendices

Appendix A – Governance
Appendix B – Principles
Appendix C – Roles
Appendix D – Sign off by the Parties

Appendix A.1 Governance Structure for the East London Health and Care Partnership

East London Health & Care Partnership

Governance structure



Appendix A.2 Draft Terms of Reference for ELHCP Governance Groups

A 2.1 Draft Terms for Reference for the ELHCP Partnership Board

Purpose

- To provide strategic direction to the ELHCP STP programme (based on the decisions by the statutory organisations)
- To oversee and assure the delivery of all elements of the ELHCP STP Plan
- To address / resolve escalated system-level risks and issues
- To generate effective partnership working and a sense of common purpose between the system partners
- To provide oversight and assurance of the funding for the ELHCP STP programme
- To approve initiatives/frameworks/tests/plans/collaborative commissioning/standards

Membership

- 1 x Independent chair
- 1 x ELHCP STP Executive Lead
- 1 x Chief Executive of Barts Health NHS Trust
- 1 x Chief Executive of the Homerton University Hospital Foundation Trust
- 1 x Chief Executive of Barking, Havering and Redbridge University Hospital NHS Trust
- 1 x Chief Executive of East London Foundation Trust
- 1 x Chief Executive of North East London Foundation Trust
- Nominated Representative/s of East London Commissioners (CCGs)
- 1 x Chair of Local Workforce Action Board[1]
- 2 x Co-Chairs of the Clinical Senate
- 1 x Acute Sector Clinician[2]
- 1 x Mental Health Sector Clinician[2]
- 2 x Nominated representative from the Community Group
- 1 x Local Authority Chief Executive representative from Barking, Havering, Redbridge area
- 1 x Local Authority Chief Executive representative from City and Hackney area
- 1 x Local Authority Chief Executive representative from Tower Hamlets, Waltham Forest, Newham area
- 1 x Representative from the Mayors and Leaders Advisory Group
- 1 x Representative from a Director of The Social Care and Public Health Group

Additional Attendees / Advisory

- Representatives of GP federations
- 1 x HealthWatch observer
- 1 x representative from the ELHCP Finance Strategy Group
- 1 x NHS England representative (regulator)
- 1 x NHS Improvement representative (regulator)
- 1 x NHS England Specialised Commissioning representative
- 1 x Local Authority representative for prevention commissioning
- 1 x Health Education England representative
- 1 x UCLP

[1] The chair of the Local Workforce Action Board (LWAB) will be represented as an accountable office of one of the Parties

[2] Endorsed by the ELHCP Clinical Senate

Quorum

At least three quarters of the membership of the ELHCP Partnership Board, including:

- An Independent Chair (or an agreed deputy)
- 1 x acute trust representative
- 1 x mental health trust representative
- 1 x CCG representative
- 1 x Clinical Senate representative
- 1 x Local Authority representative
- 1 x Community Council representative

Voting arrangements

This is a unitary board, where motions will be passed by a majority vote, where a majority is defined as at least three quarters of the votes cast.

In advance of any vote all voting members must declare any potential conflicts of interest. The Independent Chair will decide on whether any potential conflict of interest should preclude a member from voting on a particular issue.

Reporting

This ELHCP Partnership Board reports and is accountable to the statutory organisations in the ELHCP system

Frequency

Monthly. Alternative month seminar meeting.

Under exceptional circumstances extra ordinary meetings of the ELHCP Partnership Board may be arranged.

Requests for extraordinary board meetings must be raised to the Independent Chair for consideration.

A.2.2 Draft Terms for Reference for East London Health and Care Partnership (ELHCP) Executive Group

Purpose

- Provide operational direction and assurance to the delivery of the STP plan, ensuring it provides high quality, sustainable integrated care for the people of East London (EL)
- Provide a forum for the Executive Group to identify and appraise solutions and options for addressing the major system-wide service, quality and financial challenges. Ensure a pipeline and forward plan/work programme of to take forward solutions.
- Provide oversight and assurance to the key governance groups in the ELHCP governance that report into the Executive Group, reviewing quality, operational delivery, transformation, performance and financial management.
- Hold Senior Responsible Officers (SROs) to account for the development and delivery of the STP delivery plans, addressing the service, quality and financial challenges
- Ensure opportunities for bidding for transformational funding are maximised and provide oversight to bid.
- Provide oversight and assurance to the Finance Strategy Group in developing the financial strategy
- Assure the collective delivery of Quality, Innovation, Productivity and Prevention (QIPP)/Cost Improvement Programme (CIP) across the system, providing oversight to the three system delivery Boards.
- Drive the delivery of the EL STP programme at pace
- Manage risk and mitigation plans, escalating key risks and issues to the East London Health and Care Partnership (ELHCP)Board
- Oversee the development of a programme of organisational development (at system level) to support the strengthening of the ELHCP and the delivery of the STP
- Identify the key messages and communications required to enable local people and staff in EL to understand the ambitions and impacts of the STP on health and care services and outcomes
- Ensure adequate resource is available to support the ELHC STP programme of work, including providing oversight to the sourcing of support external to EL from other parts of the wider system, e.g. Healthy London Partnership, NHS England/Improvement resources.
- Analyse the gap in the system

Membership

- 1 x ELHCP STP Executive Lead(Chair)
- 1 x ELHCP STP Finance Lead
- 1 x Chief Executive, Barking, Havering and Redbridge University Hospitals NHS Trust
- 1 x Chief Executive, Homerton University Hospital Foundation Trust
- 1 x Chief Executive, Barts Health NHS Trust
- 1 x Chief Executive, East London NHS Foundation Trust
- 1 x Chief Executive, North East London NHS Foundation Trust
- 1 x Chief Executive, London Borough of Waltham Forest, ELHCP LA Lead & representing the Waltham Forest and East London (WEL) system
- 1 x Chief Executive, London Borough of Hackney, representing the City and Hackney system
- 1 x Chief Executive, London Borough of Havering, representing the Barking, Redbridge and Havering system
- 1 x Chief Officer, Barking, Havering and Redbridge CCGs
- 1 x Chief Officer, Newham CCG
- 1 x Chief Officer, Tower Hamlets CCG
- 1 x Chief Officer, City and Hackney CCG
- 1 x Chief Officer, Waltham Forest CCG

- 1 x BHR & WELC POD Director, North East London and Anglia Commissioning Support Unit
- 1 x ELHCP STP Programme Director
- 1 x ELHCP STP Director of Communications
- 1 x ELHCP STP Director of Provider Collaboration
- 1 x representative from the Clinical Senate

Reporting

Reports and is accountable to the ELHC Partnership Board

The following groups report to the Executive Group:

- Operating Planning Group
- Finance and Activity Group
- Transformation Steering Group (TSG) (N.B. The steering groups associated with the 8 delivery plan work streams report into the TSG e.g. Local Workforce Action Board, Digital etc.)
- The delivery Boards for the three systems: City & Hackney, WEL, BHR

Frequency

Monthly

Quorum

Chair of the group or the delegated member to represent the chair.

2 x Chief Executives of provider trusts

3 x Chief Officers of CCGs

1 x Chief Executive of LA

3 x ELHCP Directors

Deputies

Where members of the group are unable to attend a specific meeting, deputies with executive level accountabilities may be substituted.

Standing Items

Reports from:

- Operating Delivery Group
- Finance and Activity Group
- Transformation Steering Group (N.B. The steering groups associated with the 8 delivery plan work streams report into the TSG e.g. Local Workforce Action Board, Digital etc.)
- The delivery Boards for the three systems: City & Hackney, WEL, BHR
- Items as required on: communications and engagement, OD, governance

A.2.3 Terms for Reference for ELHCP Clinical Senate

Purpose

- To develop the clinical strategy that will deliver the requirements set out in the East London Sustainability and Transformation Plan, considering the three main areas that the STP addresses:
    - The health and wellbeing gap
    - The care and quality gap
    - The financial gap
- Not only addressing current issues but addressing needs beyond the horizon of the 5-Year Forward View
- To ensure that this strategy reduces the variation in care with the aim of giving every resident of East London access to the same standard of care and chances of good health and good healthcare outcomes; it being understood that local delivery systems will vary in structure and function
- The Clinical Senate will look for cost-effective solutions that free up resource to be directed to appropriate priority areas
- Their advice should support the development of appropriate commissioning and contractual arrangements
- To ensure that quality and safety of care is properly considered in its work and recommendations and provide relevant assurance especially around reconfiguration and service redesign
- To oversee arrangements for measuring the access to and quality of care on a systematic basis across key results areas to enable benchmarking
- Discuss options for changes to services, making joint recommendations to the Boards of the various NHS Organisations across East London, both commissioner & provider;
- To monitor system issues or vulnerable services
- To work together to identify system solutions
- To design and recommend clinical change to the Transformation Steering Group for initiative work-up

Principles

- To be ambitious for the population we serve and act as their advocates
- To be a collaborative coalition of professionals who can think, advocate and advice beyond the walls of our individual organisations to support this common purpose, in so doing gaining understanding of the whole care pathway
- Provide a forum where collective knowledge on clinical issues and strategic options for reconfiguration and transformation can be shared and discussed
- Provide a mechanism for increased participation and advice from clinicians and other professionals in strategic direction setting in East London
- Thus being able to lead transformational change across the whole care pathway
- To attend regularly, contribute regularly and be encouraged and supported to do so and to build a powerful, authoritative, collaborative body
- To be focused, use our time wisely and complete our business effectively
- Seek and commission expert advice from within East London and beyond as necessary and look to learn from successes here and elsewhere
- To commit to develop as leaders and visibly support the development of clinical leadership among the wider body of clinicians in East London
- To demonstrate that we can deliver recommendations for transformational change to build confidence in our capability

Membership

Co-chair, Appointed from CCG Chairs below

Co-chair, Appointed from Medical Directors below

CCG Chair, City & Hackney CCG

CCG Chair, Tower Hamlets CCG

CCG Chair, Newham CCG

CCG Chair, Waltham Forest CCG

CCG Chair, Havering CCG

CCG Chair Barking and Dagenham CCG

CCG Chair, Redbridge CCG

Medical Director, Barts Health NHS Trust

Medical Director, Homerton University Hospital Foundation Trust (HUH)

Medical Director Barking, Havering and Redbridge University Hospital NHS Trust (BHRUT)

Medical Director, East London Foundation Trust (ELFT)

Deputy Medical Director North East London Foundation Trust (NELFT)

NHS England Medical Director for North East London

NHS England Medical Director for Specialised Commissioning London

Director of Nursing, Barts Health NHS Trust

Director of Nursing, HUH

Director of Nursing, BHRUT

Director of Nursing, ELFT

Director of Nursing, NELFT

A GP provider lead – nominee to be agreed by GP Federations

A Director of Adult Social Services

Director of Public Health, Newham STP PH Lead

SRO, Transformation Programme ELHCP STP

STP and Accountable Officer BHR CCGs

Queen Mary University London Representative

UCL Partners

CAG Medical Directors Barts Health Hospital Sites (N=3)

Nurse Directors Barts Health Hospital sites (N=3)

Decision Making & Quorum

Quorum: At least 1 Co-chair 2 CCG Chairs and 2 Provider Directors (Medical or Nursing), SRO (or their representatives), and ensuring all three of the local areas are represented

Administration and Handling of Meetings

The ELHCP STP PMO will be responsible for providing administrative support to the meeting and for circulating agenda and papers at least seven days in advance of the meeting taking place.

Frequency, conduct and reporting of Meetings

- There should be an annual planned work programme that sets out the priorities based on the Sustainability and Transformation Plan that is agreed with the STP Programme Board.
- Meetings should be held 2-monthly to synchronise with the STP Board.
- In alternate months the Clinical Senate should meet to discuss key clinical issues related to other STP programmes, for political awareness and horizon scanning and to support its development
- The Chair and the SRO for Transformation supported by any other Clinical Senate Members present, will present findings and recommendations to the STP programme board so that accountable officers can consider and enact them as individual organisations and in the collaborative systems emerging in north eat London
- Each paper presented should have clear rationale in regard to the above and clearly set out what decisions are required
- A clear annual work programme based on transformation programme with clear links to STP deliverables; this should include “quick wins”
- Ensure appropriate interaction and alignment with other work programmes the particularly the Workforce Programme through specific papers but through regular updates and attendance which could be scheduled into the work programme
- The clinical senate should continuously reflect on its effectiveness and could briefly review this at the end of each meeting and could use local resources such as the Staff College to support this
- Action notes from each meeting will be taken and approved at the subsequent meeting. Action notes will be forwarded to the Integrated Care Coalition (ICC), Transforming Services Together Board (TSTB) and Hackney Health and Social Care Transformation Board.

Resources

- Members of the Clinical Senate will be supported in their attendance and work by their individual organisations and these roles are not additionally remunerated
- Administrative and analytic support will be provided by the STP Programme and through its PMO.
- The Co-chairs are expected to commit one day a month each to the programme, again resourced by

their organisation

Accountability/Governance

The clinical Senate is accountable to the East London Health and Care Partnership Board.

A.2.4 Terms for Reference for Social Care and Public Health Group

Purpose

- To provide professional leadership and assurance in social care and public health
- ToR to be confirmed by the Group in 2017.

Membership

- Directors of Public Health
- Directors of Social Care
- Other TBC

Quorum

To be confirmed

Reporting

Advisory to ELHCP Partnership Board.

The Group will provide a social care and public health view on all issues before these are presented to the ELHCP Partnership Board (and these meetings will be scheduled to enable this flow of business).

Frequency

To be confirmed

A.2. 5 Draft Terms for Reference for ELHCP Finance Strategy Group

Terms for Reference for ELHCP Finance Strategy Group

Purpose

- To lead the development of the ELHCP integrated financial strategy
- To provide strategic direction on the approach to achieving the overall system control total making recommendations to the ELHCP Board for onward recommendation to partner governing bodies/boards.
- To oversee and make recommendations on the allocation of the Sustainability and Transformation Funding including Estates and Technology Transformation funding
- To manage the central CCG risk pool and other matters as requested by the STP Board

Membership

- 1 x ELHCP STP Independent Chair
- 1 x ELHCP STP Executive SRO
- 1 x ELHCP STP Finance Lead
- 5 x Trust Directors of Finance
- 3 x CCG representatives
- 2 x Audit Chair
- 1 x NHSE London Finance Director
- 1 x NHSI representative
- 3 x nominated Local Authority Director of Finance

Reporting

Reports and is accountable to the ELHCP Partnership Board

Frequency

Bi-monthly / quarterly

A.2.6 Draft Terms for Reference for the ELHCP Community Group

Purpose:

The Community Group is established as a subgroup of the East London Health and Care Partnership. Representing key partners and stakeholders, community (patient and public involvement groups) and the Voluntary Community Social Enterprises sector, its purpose is to act as a reference group to the Partnership – helping it to develop strategies, plans and activities and recommending the most effective ways for it to communicate and engage with its target audiences.

The Group will be formed of key organisations and individuals, who through their pooled knowledge, skills and expertise of the east London health and care landscape, can bring a unique perspective on the changes that may be needed in order to achieve the Partnership's goal of helping the people of east London live happy, healthy and independent lives.

In its capacity, the Group will have the scope to contribute to decisions taken at Board or Executive level, through Group member representation at the Board and any other relevant committees or groups.

Aims:

1. To collaborate with the wider Partnership (i.e. Board, other committees and member organisations) acting as a reference group for the development of strategies, plans and activities;
2. To recommend the most appropriate ways in which the Partnership should seek to engage, involve, consult and collaborate with local people;
3. To support effective Partnership communications and engagement activity, especially through the Group members' existing channels;
4. To support the Partnership's STP delivery plans and priorities

The STP delivery plans are: Delivery plan 1 - Promote prevention and personal and psychological wellbeing in all we do; Delivery plan 2 - Promote independence and enable access to care close to home; Delivery plan 3 - Ensure accessible quality acute services ; Delivery plan 4 - Provider Productivity; Delivery plan 5 - Estates Infrastructure; Delivery plan 6 - Specialised Commissioning; Delivery plan 7 - Workforce; Delivery plan 8 - Digital Enablement

Objectives:

An initial objective of the Group will be to review and agree the purpose, proposed structure and ways of working. This will also be reviewed and agreed on an annual basis.

More broadly, and once the Group is formally established, its longer terms objectives as a reference group and communications and engagement network are outlined below.

1. Devise an effective working model for the Group to engage with the wider Partnership;
2. Ensure the interests of the organisations and groups/bodies the Group represents are epitomised;
3. Work closely with the Partnership's communication and engagement leads to ensure information and communication/ engagement activity and inputs are well designed and effective, adhere to best practice, and reach intended audiences;
4. Contribute to policy development through the creation of time limited reference groups, which considering how specific goals and challenges of the STP can best be met, taking information and views from external groups.

Accountability and Reporting Arrangements:

The Group is accountable to the Partnership Board.

The Group will have two nominated representatives at every Partnership Board; however, there may be occasions where representation from more than two Group members is required, for example, to present/update on a specific piece of work.

The Board will nominate one representative (other than the Group representative) to attend Group meetings. Equally, a nominated representative from one of the other committees may be required to attend Group meetings.

Membership:

The proposed membership takes account of the various patient/public groups, voluntary, community and third sector organisations, specialist charities, education, business and professional representatives (such as the Police). Each organisation is invited to put forward two members that will represent them at the Community Group. Members should be at a senior level within their organisations, and have a comprehensive understanding of the health and social care agenda, at a local, regional and national level.

The full Group will be expected to meet at least twice a year. Outside of the formal Annual General Meeting type meetings, there is an expectation that relevant members will meet to deliver or support more focused pieces of work, including undertaking equalities impact assessments e.g. around Prevention.

The membership has been grouped within their relevant sector.

1. Patient/public groups	2. Voluntary/third sector/specialist orgs	3. Community group
• Healthwatch • Patient Advisory Board • Patient Participation Networks	• Age UK • Stroke Association • Diabetes UK • Cancer Research UK • Macmillan Cancer • British Heart Foundation • Mind • Alzheimer's Society • Community Waltham Forest	• Faith Groups
4. Education	**5. Business**	**6. Professional/other**
• Queen Mary University • Youth Parliament • University of East London • Local Colleges • Local Schools	• Chambers of Commerce • East London Business Alliance • Canary Wharf Group • City of London	• London Ambulance Service • Police • Fire Service • Local Medical Committee • Local Pharmacy Committee • Local Opticians • Staff-side Representatives/Unions • Independent Influencers • Foundation Trust Council/s • Equalities Group/s

Nomination and the Role of the Chair, Vice Chair and Sub-Group Leaders:

The Community Group must nominate a chair and vice chair. It will ultimately be for the Group to decide the process for doing this; however a suggestion could be through a ballot process.

The Group might also want to nominate two chairs; one representing the patient voice and the second, representing the professional, statutory and business organisations. These are essentially the two overarching and distinct membership groups of the Group. They might comprise both a chair and vice chair.

The Chair/s or vice chair/s represent the Group at Programme Board level, and as such represent the interests and consensus view of the Group.

Sub-group leaders will be selected by members for discreet, targeted pieces of work. They will be responsible for leading the delivery for a specific project, and will feed back to the Programme Board and the wider Group on the outcomes/outputs of their work.

Quorum:

While the Group is not a formal decision making body, and more of a reference group, it is suggested there be a quorum for meetings of the whole Group – namely 50% membership, including at least the Chair or Vice Chair.

Frequency of Meetings:

It is suggested the Group will meet twice a year unless otherwise agreed. Any sub-groups of the Group may meet more often as appropriate.

Authority:

The Group is authorised to investigate any activity within its terms of reference. It is authorised to seek and may secure the information it requires from any Partnership organisation and all employees are directed to co-operate with any request made by the Group.

Monitoring Effectiveness:

In so far as is required, in order to support the continual improvement of the Group will complete an annual self-assessment of the effectiveness of the Partnership; present a report to each Partnership Board meeting; and undertake an annual review of the terms of reference for the Group, reaffirming its purpose and objectives. This Group will review the results of the assessment of its effectiveness and adjust its terms of reference accordingly.

Review of Terms of Reference:

The terms of reference will be reviewed annually and sent to the Board for ratification.

Additional:

The Partnership communications and engagement team will coordinate and provide administrative support to the principal meetings of the Group. However, any sub-groups of the Group may need to nominate one of its members (on a rotational or static basis) to coordinate and administer its own activities.

The Group will have access to the East London Health and Care Partnership's dedicated online resource – the Briefing Room – and will be able to use all available materials for their communication and engagement activity. Members of the Group will be able to submit content to the Briefing Room but would need to adhere to the site's editorial style and protocol and seek approval from the Partnership communications and engagement.

A small budget may be available from the East London Health and Care Partnership for the facilitation of meetings.

A.2.7 Draft Terms for Reference for ELHCP Assurance Group

Purpose

- To provide independent challenge and assurance to the ELHCP STP Board on the STP Plan and its delivery.
- To provide independent assurance to the constituent organisations within the ELHCP STP about the objectivity and transparency of the STP Plan and its delivery.

Membership

- NHS Trust audit chairs (5 members).
- CCG audit chairs (7 members, currently 4).
- Local Authority audit chairs (7 members).

Reporting

- To the ELHCP STP Board.
- To the Boards, Governing Bodies and Councils of the constituent organisations within the ELHCP STP. This would be through the audit chair of each organisation or other arrangements to be determined locally.

Remit

- Assess the effectiveness of the Board Assurance Framework established by the ELHCP STP, including commenting as necessary on developing governance and accountability arrangements.
- Assess compliance with the Memorandum of Understanding (MoU) agreed by the ELHCP STP.
- Assess the adequacy of the arrangements established to account for the funds available to the ELHCP STP from the NHSE and constituent organisations.
- Ensure that there are effective arrangements in place for the external and internal audit of the resources available to the STP.
- Assess the arrangements established by the ELHCP STP to secure economy, efficiency and effectiveness in the use of resources.
- Assess the effectiveness of the arrangements established to manage conflicts of interests that might arise.

The Group may, as necessary, request the attendance of any ELHCP STP officer or Board member to a `meeting of the Group to seek explanations about the issues under consideration.

Frequency

- At least four times a year.

Quorum

- A minimum of three members, including at least one audit chair from an NHS Trust, a CCG and a local authority.

Resources

- ELHCP STP officers to provide support and advice to the Group as requested.

A.2.8 Terms for Reference for Mayors and Leaders Advisory Group

Purpose

- To provide a forum to represent the views of political leaders in East London on the ELHCP Partnership
- To provide feedback to the ELHCP Partnership Board on elements of the plan
- To provide a forum for political engagement on the EL STP

Membership

- Leader or nominated representative of London Borough of Waltham Forest[1]
- Mayor or nominated representative of London Borough of Hackney[1]
- Chair of Policy & Resources Committee or representative of City of London Corporation[1]
- Mayor or nominated representative of London Borough of Tower Hamlets[1]
- Mayor or nominated representative of London Borough of Newham[1]
- Leader or nominated representative of London Borough of Barking and Dagenham[1]
- Leader or nominated representative of London Borough of Havering[1]
- Leader or nominated representative of London Borough of Redbridge[1]
- Independent EL STP Chair

Reporting

Advisory to the ELHCP Partnership Board

Frequency

Quarterly

[1] To be nominated by the respective local authority

Appendix B – Principles

In addition to the ELHCP Principles in Section 5, the Parties have adopted the following:

- ELHCP Financial Principles (agreed by the Finance Strategy Group in March 2017)
- The Nolan Principles

B.1. ELHCP Finance Principles

The following principles were approved by the Finance Strategy Group in March 2017:

All members of the ELHCP Partnership pledge the following:

B.1.1 System Control:

Commitment to delivering a system control total.

B.1.2 Openness and transparency:

Openness and transparency, with all parties agreeing to share information.

B.1.3 Shared objectives:

A shared objective of mutual support. Joint and shared accountability for system income & expenditure (I&E) between providers and commissioners and shared mutual responsibility and accountability for the control of operational expenditure.

B.1.4 Accountability:

That providers and commissioners are equally accountable for planning and managing the delivery of care in a way that meets demand and delivers constitutional standards.

B.1.5 Clinical strategy:

That commissioning, service planning and transformation must be based on a clinical strategy that is constrained within a determined financial envelope.

B.1.6 Incentives:

Current payment systems do not incentivise delivery of improved outcomes. Changes to the reimbursement of patient pathways is needed to incentivise whole system efficiency and effectiveness and improved outcomes delivered through better system integration.

B.1.7 Transformation Programme:

A clinical transformation programme must be jointly owned by providers and commissioners. It must be operationalised and delivered by provider clinicians and operational professionals and they must be properly resourced, incentivised and held to account for delivery.

B.1.8 Compensation:

Where key strategic decisions may be in the best interests of the patient but may have a differential impact on individual organisations, the beneficiaries of any change must fairly compensate the losing entity.

B.1.9 Transitional support:

Transitional support must enable acute providers to deal with stranded costs associated with moving to new models of care.

B.1.10 Prevention:

Prevention and upstream investment need to be prioritised to enable our residents to lead healthier lives.

B.2 The Seven Nolan Principles

B.2.1 Selflessness:
Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

B.2.2 Integrity:
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

B.2.3 Objectivity:
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

B.2.4 Accountability:
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

B.2.5 Openness:
Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

B.2.6 Honesty:
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

B.2.7 Leadership:
Holders of public office should promote and support these principles by leadership and example.

Appendix C – Roles of the governance bodies

1. Partnership Board

The ELHCP Partnership Board will:

a) approve the EL STP;
b) review and update the EL STP, when necessary;
c) prepare a EL STP programme plan, which will:
    - convert the high level EL STP into individual projects;
    - prioritise the projects taking into the account, for example, the following:
        - **benefits** - which projects are "low hanging fruit', which can be implemented quickly and simply
        - to achieve a material benefit and which projects will lead to the greatest benefits;
        - **funding** - which projects do not require funding, which projects do require funding, but the
        - funding can be procured and which projects require funding and the funding will not be
        - available at this stage;
        - **dependencies** - which projects have dependencies upon the implementation of other projects;
        - **complexity** – which projects are complex and might be better implemented once the Parties have more experience of working together;
    - allocate projects to different phases, starting with phase 1;
    - offer an initial view as to which Parties may be interested in each relevant project or whose services may
    - be affected by the project e.g. if the project affects acute care;
    - communicate the programme plan and the reasoning behind it clearly to the Parties;

d) prepare a communication plan, which will generate effective partnership working and a sense of common purpose between the Parties;
e) circulate "Lessons Learned" reports from the ELHCP Project Boards, with its comments.

2. ELHCP Clinical Senate/ ELHCP Finance Strategy Group/ ELHCP Community Group/ ELHCP Assurance Group

The **ELHCP** Clinical Senate/ **ELHCP** Finance Strategy Group/ **ELHCP** Community Group/ **ELHCP** Assurance Group will:

a) provide advice to the EL STP on all matters referred to in Paragraph 1; and
b) on request, provide advice to the EL STP Project Boards.

Appendix D – Sign Off by the Parties

Through signing this East London Health and Care Partnership Agreement the Parties listed below will:

- Agree to the objectives in this document and work collaboratively to achieve these
- Agree to the partnership principles and processes outlined in this document
- Recognise the partnership structure outlined in this document for the ELHCP and support this locally

The signatories to this Partnership Agreement should be properly authorised to represent their respect organisations in entering into the commitments outlined in this document.

Signed on behalf of:	Signature:	Name:	Title:	Date:
Barking and Dagenham CCG				
Barts Health NHS Trust				
Barking, Havering and Redbridge University Hospitals NHS Trust				
City and Hackney CCG				
City of London Corporation				
East London NHS Foundation Trust				
Havering CCG				
London Borough of Barking and Dagenham				
London Borough of Hackney				
London Borough of Havering				
London Borough of Newham				
London Borough of Redbridge				
London Borough of Tower Hamlets				
London Borough of Waltham Forest				
Newham CCG				
North East London NHS Foundation Trust				
The Homerton University Hospital NHS Foundation Trust				
Tower Hamlets CCG				
Redbridge CCG				
Waltham Forest CCG				

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HEALTH & WELLBEING BOARD

Subject Heading:	Extension of Health and Wellbeing Strategy
Board Lead:	Mark Ansell, Acting Director of Public Health
Report Author and contact details:	Elaine Greenway, elaine.greenway@havering.gov.uk

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

- ☒ Theme 1: Primary prevention to promote and protect the health of the community and reduce health inequalities
- ☒ Theme 2: Working together to identify those at risk and intervene early to improve outcomes and reduce demand on more expensive services later on
- ☒ Theme 3: Provide the right health and social care/advice in the right place at the right time
- ☒ Theme 4: Quality of services and user experience

SUMMARY

The Health and Wellbeing Strategy 2015-18 was signed off by the Havering Health and Wellbeing Board in April 2015. Subsequently, during 2016-17, the Strategy was reviewed and refreshed to take into account developments within the local health and social care economy and so ensure the Strategy remained fit for purpose.

The Health and Wellbeing Board is asked to support an extension to the lifetime of the strategy to June 2019, with a new strategy developed for the four year period July 2019 – June 2023. Thereafter, the strategy life-cycle to be set at four years.

This proposal takes into account the following:

- Local elections May 2019 and establishment of a new Cabinet
- The possibility that there could be a change in elected member representation to the Board
- The first meeting of the Health and Wellbeing Board following local elections will be July 2018

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Extending the current strategy to June 2019 will allow a period of eleven months for a new Health and Wellbeing Strategy to be developed from the date of the first meeting of the Health and Wellbeing Board under the new Administration. This would mean that, following local elections, Council Members (especially those new to Health and Wellbeing Board) will have the opportunity to shape the new strategy with partners.

Setting the next strategy, and subsequent strategies, at four year periods will bring the strategy life-cycle in step with the sequence of local election timescales.

RECOMMENDATIONS

That the Health and Wellbeing Board

- agree that the current (refreshed) Health and Wellbeing Board Strategy be extended to June 2019
- that the new strategy be for the period July 2019 – June 2023

REPORT DETAIL

No further detail

IMPLICATIONS AND RISKS

No additional implications and risks identified

BACKGROUND PAPERS

No background papers

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HEALTH & WELLBEING BOARD

Subject Heading:	Health and Wellbeing Strategy 2015-18 Indicator Set
Board Lead:	Mark Ansell, Acting Director of Public Health
Report Author and contact details:	Elaine Greenway, elaine.greenway@havering.gov.uk

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

- ☒ Theme 1: Primary prevention to promote and protect the health of the community and reduce health inequalities
- ☒ Theme 2: Working together to identify those at risk and intervene early to improve outcomes and reduce demand on more expensive services later on
- ☒ Theme 3: Provide the right health and social care/advice in the right place at the right time
- ☒ Theme 4: Quality of services and user experience

SUMMARY

It had previously been agreed by the HWB that the refreshed HWB Strategy should be supported by a high-level indicator set that reflects the priorities and themes of the Strategy.

The attached document “Health and Wellbeing Board Strategy 2015-18 Indicator Set draft v0.1” presents options to provide the HWB with:

- high-level information on the health and wellbeing status of the local population
- ongoing information on the topic areas that are of special and current interest to the HWB – it is expected that these may be removed and/or additional indicators added, according to the interest/concerns of the HWB
- complements an annual cycle of reports and information from (a) partnership groups accountable to the HWB, (b) individual organisations represented on the HWB, and (c) other groups that have a key role to play who will be invited to present on relevant issues.

The document sets out:

- a short list of core key indicators - these have been proposed because they provide a good overview of the health of residents and the quality of care services available to them. A rationale for proposing each indicator is included in the notes column
- additional indicators of "special interest"
- a long list of all indicators. The reasons why they have / have not been included on the short list are summarised in the notes column.

It should be noted that the agreed Indicator Set will be valid for the remainder of the strategy timescale (currently set to end December 2018). This will provide an opportunity to test and evaluate whether the indicator set is sufficient/ appropriate for the HWB's needs, and thus inform our approach to the development of the next HWB Strategy.

The Indicator Set will complement an annual cycle of reports and information. The attached document "Health and Wellbeing Governance organogram" outlines the groups that will be invited to present updates to the HWB on progress against priorities and themes of the HWB strategy. There are some priorities and themes in the HWB Strategy that cannot be directly mapped to an agency/group in the governance structure. Where this is the case, it is proposed that HWB invite additional groups or a single agency to report on relevant work.

HWB is also asked to consider the information given in respect of the priority 4.3 "Reduce variations in access to services" on the final page of the draft indicator set document. This summarises the challenges in providing a separate suitable indicator for this priority area, and recommends undertaking one health equity audit per annum on an identified and specific condition.

If the HWB agrees to the approach set out in this report, then at the next meeting in July 2017, papers will be presented as follows:

- The first populated Health and Wellbeing Board Strategy Indicator Set
- A proposed calendar of annual reports (both from groups accountable to the HWB and on topics not currently covered by the governance structure)
- Potential topics for health equity audit

RECOMMENDATIONS

That the Health and Wellbeing Board agrees

- the above approach in principle
- that HWB members will provide comments by 31 May to the Chairman via the report author on the content of the indicator set. Comments to include
    - which indicators from the long list should be added to the final indicator set
    - acceptability of the approach to an annual cycle of reports

    - acceptability on the proposal for health equity audit and any suggestions for topics that should be considered
- that the Chairman may then take action to agree the final indicator set which takes into account feedback received

REPORT DETAIL

No further detail

BACKGROUND PAPERS

Document Draft Health and Wellbeing Board Indicator Set v0.1
Health and Wellbeing Governance organogram

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Health and Wellbeing Board Strategy
2015-18 Indicator Set Draft v0.1

Short list

This is a list of nine indicators that are proposed for the Core Indicator Set. They have been proposed because they provide a good overview of the health of residents and the quality of care services available to them and are spread across the four strategy themes. A rationale for proposing each indicator is included in the notes column. Where available, information has provided to enable comparisons between Havering, London and England.

There is scope to add additional indicators to the short list including:

- Ongoing information on the topic areas that are of special and current interest. These may be removed and/or additional indicators added in accordance with the interest/concerns of the HWB. One example has been included below (RTT)
- Selecting additional indicators from the long list below. The indicators that HWB members may wish to consider more closely are flagged up in the notes column including, for example the air quality indicator (priority 1.4), support for people with LTCs indicator (priority 2.3).

Themes /Proposed Indicators		Havering		Comparators		Data period	Rationale / notes
		Count	Rate/%	London	England		
1	Healthy life expectancy (males)		65.8	64.1	63.4	2013-15	Healthy life expectancy is an extremely important summary measure of mortality and morbidity in itself. It complements supporting indicators by showing overall trends in a major population health measure, setting the context for assessing other indicators and identifying the drivers of healthy life expectancy. Healthy life expectancy at birth indicates the average number of years a person would expect to live in good health based on contemporary
2	Healthy life expectancy (female)		64.8	64.1	64.1	2013-15	

Themes /Proposed Indicators		Havering		Comparators		Data period	Rationale / notes
		Count	Rate/%	London	England		
							mortality rates and prevalence of self-reported good health. **Relates to Theme 3 of the strategy**
3	% of physically active adults in Havering (Higher is better)		55.4	57.8	57	2015	Although data are 2 yrs old, this is good indicator of underlying health behaviour and allows comparisons with London and England. Also included in annual Obesity Strategy update report. **Relates to Theme 1 of the strategy**
4	% of children overweight or obese, Year Six (Lower is better)	993	37.3	38.1	34.2	2015/16	This is a good indicator of population-wide child-health. This is also included in annual Obesity Strategy update report at which time trend data for Havering, London and England could also be considered. **Relates to Theme 1 of the strategy**
5	School readiness - % of children achieving a good or better level of development at age 5 (EYFSP) (Higher is better)		71%				An LBH Corporate Indicator, this will be monitored by LBH. However, this is a good indicator of early intervention and inequalities, so it is suggested that this be included on the HWBS indicator set. LBH Target 17/18: 73% (Outturn 16/17: 71%). Information available annually. **Relates to Theme 2 of the strategy**
6	Good blood sugar control in people with diabetes (Higher is better)		51.6	58.2	60.1	2015/16	This is a good indicator of secondary

Themes /Proposed Indicators		Havering		Comparators		Data period	Rationale / notes
		Count	Rate/%	London	England		
	(could also include blood pressure measurements)						prevention, and of the quality of health services. In 2015/16 achievement in Havering for good blood sure control in people with diabetes was worse than London and England. Another good indicator is blood pressure measurements – this could also be included on the short list if wanted. Further and detailed information on primary care provision, including secondary prevention, could be presented to the HWB on an annual basis through the current governance structure (via BRH Integrated Partnership Board or CCG **Relates to Theme 2 of the strategy**
7	Numbers of people attending A&E but discharged with no investigation and no significant treatment	7,905				2016/17	Although this focuses on attendance at A&E, this is a useful indicator that local residents are getting the right advice in the right place at the right time. Data for 2015/16 are also available, so possible to follow trends. **Relates to Theme 3 of the strategy**
8	NHS Friends and Family Test. Would recommend the services they used to their loved ones?						The Friends and Family Test is a good indicator of NHS Services and can be

Themes /Proposed Indicators		Havering		Comparators		Data period	Rationale / notes
		Count	Rate/%	London	England		
							used to understand progress over time. Friends and Family test data are available at organisational level, such as Acute Trusts and at lower levels including A&E, Ambulance, Community, GP, Inpatient, Maternity, Mental Health, Outpatient. **Relates to Theme 4 of the strategy**
9	Adult Services Survey response "Overall how satisfied are you with the care and support services that you receive?" or the ASC Indicator currently in development for LBH relating to residents reporting good outcomes from their community service (home care service)						Two options are suggested for Adult Social Care (taken from draft LBH KPIs). Although the agreed indicator will be monitored by LBH as a corporate indicator, it is suggested that HWB also receive updates as an overview of quality of adult social care services. **Relates to Theme 4 of the strategy**

Additional indicators of special Interest

This is ongoing information on the topic areas that are of special and current interest to the HWB. It is expected that these may be removed and / or additional indicators added, according to the interest / concerns of the HWB. One indicator is included below, as an example.

Themes /Proposed Indicators	Havering		Comparators		Data period	Rationale / notes
	Count	Rate/%	London	England		
Referral to Treatment					tbc	The HWB may wish to continue its oversight of this topic until the end of the financial year 17/18

Long list

This is the full list of potential indicators, with notes outlining why they have/have not been included on the short list, and where the particular priority area does/does not map across to groups and boards that are accountable to the HWB.

Themes /Proposed Indicators	Havering		Comparators		Data period	Rationale / notes
	Count	Rate/%	London	England		
Theme 1: Primary Prevention to improve and protect the health of the community and reduce health inequalities. Healthy life expectancy can be increased by tackling the **common socio-economic factors for poor health**						
1.1 Getting people into work **Proportion of businesses showing employment growth (Source: ONS Business Register and Employment Survey)**	78,780				tbc	An LBH Indicator .Baseline is 78,000. The 17/18 target is +1% above baseline. Although outturn is beyond Local Authority control, it is a good overall indicator of business growth. This indicator is being monitored by

Themes /Proposed Indicators	Havering		Comparators		Data period	Rationale / notes
	Count	Rate/%	London	England		
						LBH. But as employment is such a driver of health and wellbeing, It is suggested that HWB invite an annual report. Currently there are no groups reporting to the HWB that have responsibility, so this to be agreed during 17/18.
1.2 Helping people to achieve (education and skills) **Pupil progress in 8 subjects, from the end of primary school to the end of secondary school ("Progress 8" score)**						An LBH Indicator. Last year's outturn was - 0.14. It is recognised across the sector that this PI is hard to predict. This indicator is being monitored by LBH. But as education is a major driver of health and wellbeing, It is suggested that HWB invite an annual report. Currently there are no groups reporting to the HWB that have responsibility, so this to be agreed during 17/18.
1.3 Ensuring people have a good home **% of council homes that meet the decent homes standard which ensures standards of fitness, structure, energy efficiency and facilities in council properties.**						An LBH Indicator. By government definition, 98% is the level at which an authority's stock can be defined as decent. This indicator is being monitored by LBH. But as housing is a major driver of health and wellbeing, It is suggested that HWB invite an annual report on the topic. Currently there are no groups reporting to the HWB that have responsibility, so this to be agreed 17/18.
1.4 Socio-economic factor: Providing an environment in						An LBH Corporate Indicator. The Local

Themes /Proposed Indicators	Havering		Comparators		Data period	Rationale / notes
	Count	Rate/%	London	England		
which it is easier for our residents to make healthy choices **Local plan progressed and successfully adopted in accordance with the timeframe set out in the Local Development Scheme**						Plan sets out local planning policies. The built and natural environments are major determinants of health and wellbeing. As this is being overseen by LBH – it is suggested that no regular report be received.
Fraction of mortality attributable to particulate air pollution (lower is better)						Poor air quality impacts on use of health services, and is responsible for early deaths with greater impact on children's health and older people. The Health Protection Forum receives an annual report on air quality which is included in the HPF report to HWB. HWB may wish to move this indicator to the short list, because of the impact of air quality on health and wellbeing, and health and social care services.
1.5 Increasing community and individual ability to take control over their own health and care **Number of adults and older people who can choose how their support is provided to meet agreed health and social care outcome in the year (self-directed support)**						An LBH Corporate Indicator. Target 86%.This indicator is being monitored by LBH. The Adult Commissioning Forum is accountable to the HWB and so will be invited to submit an annual report.

Themes /Proposed Indicators	Havering		Comparators		Data period	Rationale / notes
	Count	Rate/%	London	England		
Theme 1: Primary Prevention to improve and protect the health of the community and reduce health inequalities. Healthy life expectancy can be increased by tackling the **behavioural risk factors for poor health**						
1.6 Mental health promotion **Increase access to talking therapies (higher is better)**	325	15.8	1.2	14.4	as of Sept 16	The Mental Health Partnership Board is accountable to the HWB and so will be expected to provide an annual report.
1.7 Reduction of Harm from Tobacco **% of women who smoke at time of delivery**	252	7.7	5.0	10.6	2015/16	The multi-agency Tobacco Harm Reduction Partnership reports to the HPF annually. It is recommended that the HPF report be extended to provide additional information about progress of the tobacco harm reduction agenda
Prevalence/proportion of smoking among persons 18 years and over		17.3	16.3	16.9	2015	
1.8 Reduction of Harm from Alcohol **% of first alcohol treatment interventions where the person waited over 3 weeks to commence treatment**	Less than 5	1.7	1.1	4.1	2015/16	There is no one strategic group that oversees delivery of the alcohol harm reduction agenda. It is already scheduled that an annual report on progress against the Drug and Alcohol Harm Reduction Strategy be presented to the HWB. It is recommended that this continues.
% of alcohol users that left drug treatment successfully who do not re-present to treatment within 6 months	102	34.8	41.3	38.4	2015	
Alcohol-specific mortality (Males) All ages, directly age-standardised rate per 100,000 population (Lower is better)	39	11.5	13.2	15.9	2013-15	
Alcohol-specific mortality (Females) (Lower is better)	Number too small for stats	-	4.5	7.3	2013-15	
1.9 Diet, physical activity and healthy weight management **% of physically active adults in Havering (Higher is**		55.4	57.8	57	2015	Two of the indicators are on the short list above. Children overweight or

Themes /Proposed Indicators	Havering		Comparators		Data period	Rationale / notes
	Count	Rate/%	London	England		
better) This is Included on short list above						obese in year 6 has been suggested (rather than reception year), as the biggest problem relates to year 6. It is already scheduled that an annual report on progress against the Obesity Strategy be presented to the HWB and it is recommended that this continues.
% of children overweight or obese in reception year (Lower is better)	706	23.2	22.0	22.1	706	
% of children overweight or obese, Year Six (Lower is better) This is included on short list above	993	37.3	38.1	34.2	2015/16	
1.10 Improving sexual health						These indicators are heavily influenced by the quality of commissioned services. It is recommended that the HWB receives an annual report form the Public Health Service on sexual health, including progress against these indicators.
New STI diagnosis rate / 100,000	1,655	673	1,391	768	2015	
Under 18s conception rate / 1,000	102	22.8	21.5	22.8	2014	
Under 25s repeat abortions	150	32.1	31.0	26.5	2015	
1.11 Increase uptake of immunisations						HWB receives an annual report from Health Protection Forum which covers immunisation. These indicators have been selected for monitoring on a quarterly basis by HPF as they provide information across age-ranges and because MMR at age 5 continues to be a challenge across England.
Proportion of 65 years and over Influenza	**31,021**	**66.6**	**66.4**	**71.0**	**2015/16**	
Proportion of Dtap/IPV/Hib at 1 year	**3,147**	**96.1**	**89.2**	**93.6**	**2015/16**	
Proportion of MMR for two doses by age 5	**2,949**	**90.3**	**81.7**	**88.2**	**2015/16**	
1.12 Increase uptake of screening						HWB receives an annual report from the Health Protection Forum which covers immunisation and screening.
Newborn hearing screening coverage (%)	**3,242**	**96.1**	**98.5**	**98.7**	**2015/16**	

Themes /Proposed Indicators	Havering		Comparators		Data period	Rationale / notes
	Count	Rate/%	London	England		
Breast cancer screening coverage (%)	**20,638**	**76.4**	**69.2**	**75.5**	**2016**	The report includes performance of screening programme.
Bowel cancer screening coverage (%)	**17,983**	**52.4**	**48.8**	**57.9**	**2016**	

Themes /Proposed Indicators	Havering		Comparators		Data period	Rationale / notes
	Count	Rate/%	London	England		
Theme 2: Working together to identify those at risk and intervene early to improve outcomes and reduce demand on more expensive services later on						
2.1a Vulnerable children and families – identify them and intervene earlier **School readiness - % of children achieving a good or better level of development at age 5 (EYFSP) (Higher is better) (On short list above)**						An LBH Corporate Indicator, this will be monitored by LBH. However, this is a good indicator of early intervention and inequalities, so it is suggested that this also be included on the HWBS indicator set. As early intervention influences health and wellbeing outcomes, it is suggested that HWB invite an annual report. Currently there are no groups reporting to the HWB that have responsibility, so this to be agreed during 17/18.
2.1b NEET **% of 16-18 year olds who are known not to be in education, employment or training (including 'not knowns')**						This will be monitored by LBH as a corporate indicator. As NEET influences health and wellbeing outcomes, it is suggested

Themes /Proposed Indicators	Havering		Comparators		Data period	Rationale / notes
	Count	Rate/%	London	England		
						that HWB invite an annual report on the topic (potentially combined with another relevant topic area). Currently there are no groups reporting to the HWB that have responsibility, so this to be agreed during 17/18.
2.2 Provide effective support for children with health needs **Hospital admissions for asthma (under 19 years) (Crude rate per 100,000 persons) (Lower is better)**	**95**	**165.9**	**194.9**	**202.4**	**2015/16**	Ensuring effective support for children with health needs will depend on a wide range of factors across the system – including support provided by schools, primary care, and secondary care. If HWB wish to include an indicator on the long list, then this is an option, and one that is influenced by system wide and environmental factors (i.e. air quality). However, as this indicator does not reflect on all health needs, it is suggested that the report be received by the HWB on this topic (potentially combined with another relevant topic area). This to be agreed during 17/18
2.3 Provide effective support for people with long term conditions and their carers so they can live independently for longer **Support for people with long-term conditions: % of**	**973**	**54.9**	**57.6**	**63.1**	**2015/16**	This is taken from GP patient survey. It is a useful indicator as there are distinct links between physical and mental health. People with LTCs are at particular risk of developing mental

Themes /Proposed Indicators	Havering		Comparators		Data	Rationale / notes
	Count	Rate/%	London	England	period	
people with long-term conditions visiting GP who feel they have had enough support from local services in last 6 months						health disorders. Supporting them to manage their condition is of benefit to both physical and mental health. Although this is on the long list, HWB may wish to add this to the short list as performance in Havering is significantly lower than in London and England. Alternatively, HWB may wish to receive an annual report on the care and support of people with LTCs.
Carers receiving a needs assessment or review and a specific carer's service, or advice and information	**450 (estimated)**				**2016/17**	This indicator is being monitored by LBH, with a target of 465 for 17/18. As this is being closely monitored by LBH it is proposed that this information is not submitted to HWB.
2.4 Provide effective support for people with learning disabilities / dementia and their carers so they can live independently for longer						As Learning Disability influences inequity in health and wellbeing outcomes, it is suggested that HWB invite an annual report. Currently there are no groups reporting to the HWB that have responsibility, so this to be agreed during 17/18.
People (all ages) with learning disability known to GPs (%)	**771**	**0.32**	**0.34**	**0.44**	**2014/15**	
New dementia diagnosis with blood test recorded between 12 months before and 6 months after entering onto the register	**358**	**56.4**	**54.1**	**56.5**	**2015/16**	
2.5 Low level mental health issues						As per 1.6, The Mental Health Partnership Board is included in the governance structure. It is suggested that the MHPB provides an annual report to the HWB.
Increase access to talking therapies (higher is better)	325	15.8	1.2	14.4	as of Sept 16	

Themes /Proposed Indicators	Havering		Comparators		Data period	Rationale / notes
	Count	Rate/%	London	England		
2.6 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 **Good blood sugar control in people with diabetes (higher rates is better) This appears on the short list above** **Blood pressure**	**7,059**	**51.6**	**58.2**	**60.1**	**2015/16**	Good blood sugar control in people with diabetes is a good indicator of secondary prevention, and of the quality of health services, along with measures of blood pressure. In 2015/16 achievement in Havering was worse than London and England. Further and detailed information on primary care provision, including secondary prevention, could be presented to the HWB on an annual basis through the current governance structure (via BRH Integrated Partnership Board or CCG
2.7 Promote earlier presentation of signs and symptoms, e.g. "be clear on cancer" **Cancer diagnosed at early stage (experimental statistics) (%) (Higher is better)**	406	41.3	48.2	50.7	2014	This is a good indicator of quality and clinical care, and of secondary prevention. "Experimental statistics" denote that this is a measure that is undergoing development. Early diagnosis features in STP plans. There appears to be no-one group focusing on this topic. If Health and Wellbeing Board wishes to receive regular reports, an "owner" would need to be assigned.

Themes /Proposed Indicators	Havering		Comparators		Data period	Rationale / notes
	Count	Rate/%	London	England		
Theme 3: Provide the right health and social are/advice in the right place at the right time						
3.1 Provide improved and, where appropriate, integrated						Healthy life expectancy at birth: the

Themes /Proposed Indicators	Havering		Comparators		Data	Rationale / notes
	Count	Rate/%	London	England	period	
care pathways especially for the major causes of morbidity and mortality; a) diabetes; b) CVD; c) cancer; d) mental ill health **Healthy life expectancy (males) (included on short list)** **Healthy life expectancy (female) (included on short list)**		65.8 64.8	64.1 64.1	63.4 64.1	2013-15 2013-15	average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health. This indicator is an extremely important summary measure of mortality and morbidity in itself. It complements supporting indicators by showing overall trends in a major population health measure, setting the context for assessing other indicators and identifying the drivers of healthy life expectancy. Both measures included on the short list.
3.2 Reduce avoidable A/E attendances, by changing "health seeking" behaviour in our residents and providing alternatives **Numbers of people attending A&E but discharged with no investigation and no significant treatment (included on short list)**						Although this focuses on attendance at A&E, this is a useful indicator that local residents are getting the right advice in the right place at the right time. Data for 2015/16 are also available, so possible to follow trends.
3.3 Reduce avoidable admissions to hospital or long term care homes **Rate of permanent admissions to residential and nursing care homes per 100,000 population (aged 65+)**						This is an LBH Corporate Indicator and being monitored by LBH. Target for 17/18 proposed at 660.
3.4 Improve access to primary health care **Success in getting an appointment (able to get an appointment to see or speak to someone the last time they tried) (higher is better)**	-	**72**	-	**73**	**2016**	These measures are taken from the GP Patient Survey. They are similar to London and England. It is suggested that the HWB receives an annual

Themes /Proposed Indicators	Havering		Comparators		Data period	Rationale / notes
	Count	Rate/%	London	England		
Patient Satisfaction with GP (higher is better)	**-**	**80**		**85**	**2016**	report on primary healthcare (anticipated from the BHR Transformation Board).
3.5 Promote wellbeing and self care **People with a low happiness score - percentage of respondents scoring 0-4 on the question "Overall, how happy did you feel yesterday?" (lower is better)**		**7.0**	**8.3**	**8.8**		An LBH Corporate Indicator and a good indicator of wellbeing. Respondents can score 0-10, where 0 is "not at all satisfied/happy/anxious, and 10 is "completely satisfied/ happy/worthwhile". This measure relates to people who score 0-4 (lower marks). It is better to have fewer people scoring 0-4. According to this measure, people in Havering are not unhappy/ dissatisfied. It is recommended that this is not transferred to the short list.
3.6 Ensure appropriate end of life care **Death in usual place of residence (%) (aged 75-84 years)**	**295**	**45.8**	**35.3**	**43.1**	**2015**	The End of Life Partnership Board oversees this priority. The EoLPB is accountable/reports to the HWB, thus will be providing an annual report. Usual place of residence can include nursing home, residential home, etc.

Themes /Proposed Indicators	Havering		Comparators		Data period	Rationale / notes
	Count	Rate/%	London	England		
Theme 4: Quality of services and user experience						
4.1 To ensure that services provided/commissioned are of good quality, are effective and provide the best possible						These quality indicators have been included in the short list above. The

Themes /Proposed Indicators	Havering		Comparators		Data	Rationale / notes
	Count	Rate/%	London	England	period	
service user's experience **Friends and Family Test. Would recommend the services they used to their loved ones?** **Adult Services Survey response "Overall how satisfied are you with the care and support services that you receive?" or the ASC Indicator currently in development for LBH relating to residents reporting good outcomes from their community service (home care service)**	**295**	**45.8**	**35.3**	**43.1**	**2015**	Friends and Family Test is a good indicator of NHS Services. Two options are suggested for Adult Social Care (taken from draft LBH KPIs) In addition, the HWB will be receiving reports throughout the year on services delivered. It is suggested that authors be asked to include in their reports (a) information about what processes/measurements are in place to ensure quality of service and (b) information gathered about service user experience.
4.2 Reduce variations in quality and practice across primary and secondary care and social care **Good blood sugar control in people with diabetes (higher rates is better) This appears on the short list above**	**7,059**	**51.6**	**58.2**	**60.1**	**2015/16**	See 2.6, and included on the short list. A good indicator of quality of services, of secondary prevention. In terms of Adult Social Care and children's/family services, there are a range of groups and boards that will report to the HWB on an annual basis. It is recommended that authors include in their reports what action is being taken to reduce variation in quality and practice, and to what extent that action is successful
4.3 Reduce variations in access to services **Whilst high level indicators are available that describe outcomes (as per Healthy Life Expectancy) and experience (as per Friends and Family test),**						Further to proposal left, a HEA is a review that examines how health determinants, access to relevant services and related outcomes are

Themes /Proposed Indicators	Havering		Comparators		Data period	Rationale / notes
	Count	Rate/%	London	England		
there are no good indicators identified that could illustrate variations in access to the broad range of services delivered to Havering residents. **It is proposed to the HWB that instead of including an indicator for this priority, that one health equity audit (HEA) be undertaken annually on one specific condition to identify where there are variations in access to services**						distributed across the population, relative to need. If this suggestion is acceptable to the HWB, then a paper will be brought to the Board proposing options for a HEA which the Public Health Service will advise and lead on, in partnership with relevant services and agencies.

NOTE: It should be noted that any LBH Corporate Indicators proposed above will be considered by the Overview and Scrutiny Board on 3 May.

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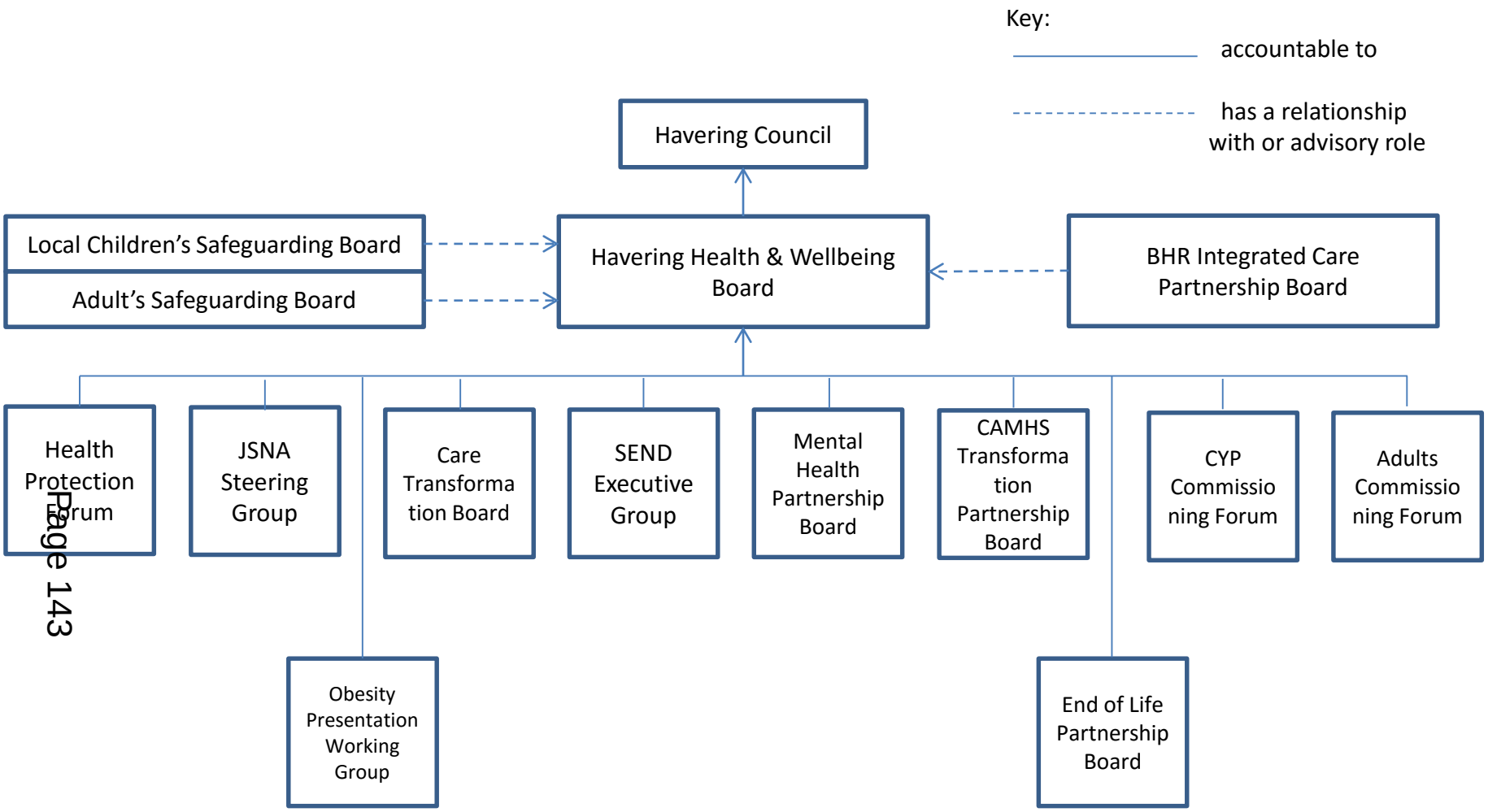
Key:
accountable to
has a relationship with or advisory role
Havering Council
Local Children's Safeguarding Board
Adult's Safeguarding Board
Havering Health & Wellbeing Board
BHR Integrated Care Partnership Board
Health Protection Forum
JSNA Steering Group
Care Transformation Board
SEND Executive Group
Mental Health Partnership Board
CAMHS Transformation Partnership Board
CYP Commissioning Forum
Adults Commissioning Forum
Obesity Presentation Working Group
End of Life Partnership Board

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Havering Health and Wellbeing Board - Forward Plan 2017/18

All meetings will start at 1pm (until 3pm) Rooms to be confirmed for each meeting.

HWB Meeting 19 July 2017. Deadline for papers **7 July 2017** To be held in room tbc	
Update on Referral to treatment delays	Sarah Tedford / Louise Mitchell
Update on STP	Ian Tompkins
Final Better care fund report	Barbara Nicholls
BHRUT-Numbers of Children Self-Harming Report	Jacqui Van Rossum
CCG - Consultation on Service Restriction and Prior Approval	Alan Steward
CAMHS Transformation Plan Report	Jacqui Van Rossum
Transforming Care Partnership: Six Month Update	Barbara Nicholls
Report from End of Life Steering Group (tbc)	Gurdev Sani
Drugs and Alcohol Strategy Update	Elaine Greenway
Local Plan Development	Neil Stubbings
CCG System Delivery Plan (originally scheduled for May Meeting)	Alan Steward

Havering Health and Wellbeing Board - Forward Plan 2017/18

Forward Plan	
HWB Meeting 20 September 2017. Deadline for papers **8 September 2017** To be held in room tbc	
Update on Referral to treatment delays	Sarah Tedford / Louise Mitchell
Update on STP	Ian Tompkins
Forward Plan	
HWB Meeting 15 November 2017. Deadline for papers **3 November 2017**To be held in room tbc	
Update on Referral to treatment delays	Sarah Tedford / Louise Mitchell
Update on STP	Ian Tompkins
Forward Plan	
HWB Meeting 31 January 2018. Deadline for papers **19 January 2018** To be held in room tbc	
Update on Referral to treatment delays	Sarah Tedford / Louise Mitchell
Update on STP	Ian Tompkins

Havering Health and Wellbeing Board - Forward Plan 2017/18

Forward Plan	
HWB Meeting 14 March 2018. Deadline for papers **2 March 2018** To be held in room tbc	
Update on Referral to treatment delays	Sarah Tedford / Louise Mitchell
Update on STP	Ian Tompkins
Forward Plan	
HWB Meeting 10 May 2017. Deadline for papers **28 April 2017** To be held in room tbc	
Update on Referral to treatment delays	Sarah Tedford / Louise Mitchell
Update on STP	Ian Tompkins
Integrated Care Partnership	Barbara Nicholls/ Alan Steward
Dementia Strategy- for sign off	Andrew Rixom, on behalf of CCG
Health and Wellbeing Strategy: extension to June 2019	Mark Ansell
Refreshed Health and Wellbeing Board Strategy Dashboard/indicator Update	Mark Ansell
Forward Plan	

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