Public Document Pack

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD
AGENDA

1.00 pm	Wednesday, 8 May 2019	Committee Room 2, Town Hall

Members: 16, Quorum: 6

BOARD MEMBERS:

Elected Members:	Cllr Jason Frost (Chairman) Cllr Gillian Ford Cllr Robert Benham Cllr Damian White
Officers of the Council:	Andrew Blake-Herbert, Chief Executive Tim Aldridge, Director of Children's Services Barbara Nicholls, Director of Adult Services Mark Ansell, Director of Public Health
Havering Clinical Commissioning Group:	Dr Atul Aggarwal, Chair, Havering Clinical Commissioning Group (CCG) Dr Gurdev Saini, Board Member Havering CCG Ceri Jacob, BHR CCG Steve Rubery, BHR CCG
Other Organisations:	Anne-Marie Dean, Healthwatch Havering Jacqui Van Rossum, NELFT Christopher Brown, BHRUT Danny Batten, NHS England

For information about the meeting please contact:
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What is the Health and Wellbeing Board?

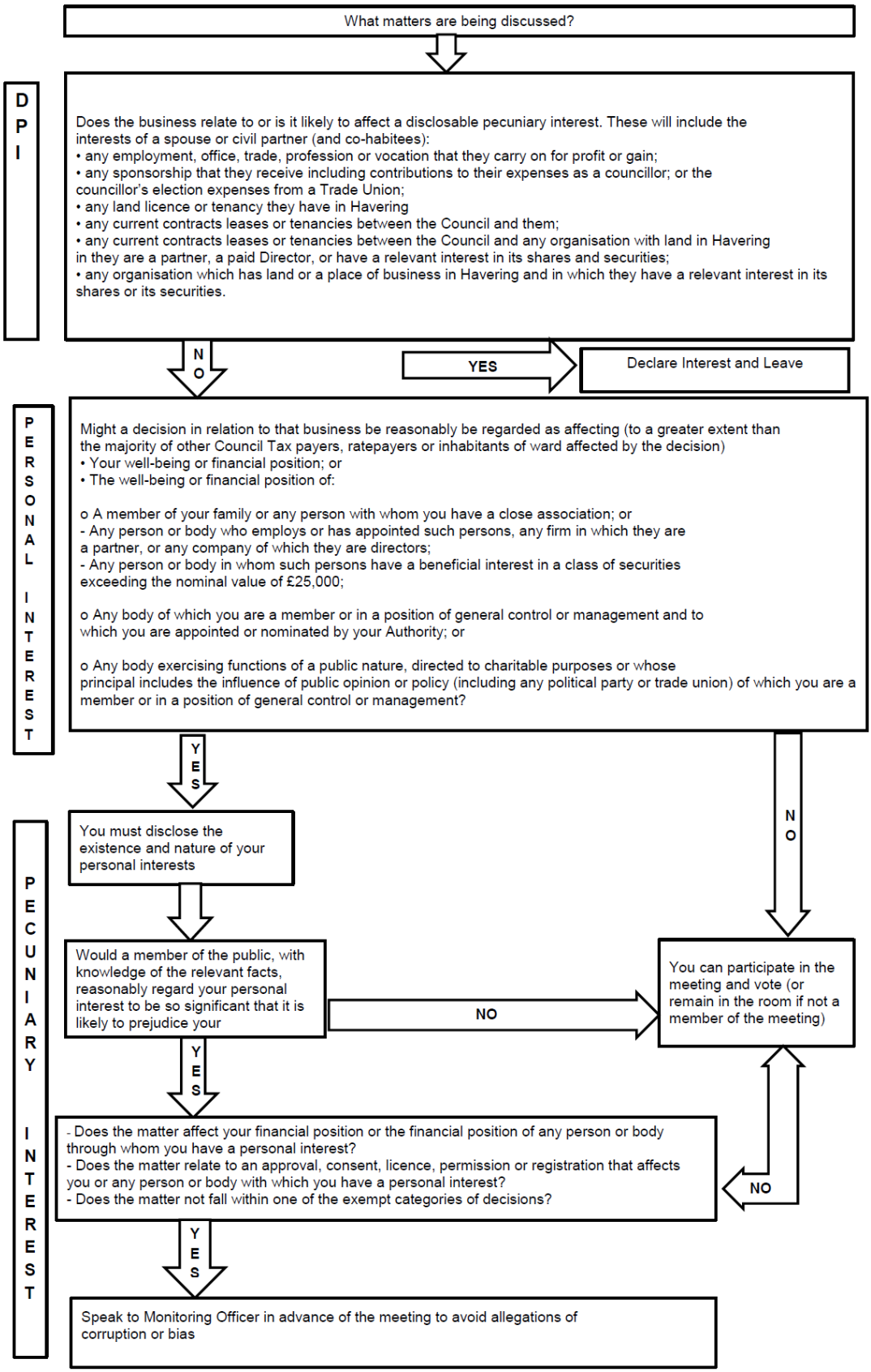
Havering's Health and Wellbeing Board (HWB) is a Committee of the Council on which both the Council and local NHS and other bodies are represented. The Board works towards ensuring people in Havering have services of the highest quality which promote their health and wellbeing and to narrow inequalities 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

DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF



AGENDA ITEMS

1. **CHAIRMAN'S ANNOUNCEMENTS**

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

2. **APOLOGIES FOR ABSENCE**

   (If any) – receive

3. **DISCLOSURE OF INTERESTS**

   Members are invited to disclose any interest in any of the items on the agenda at this point of the meeting.

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

4. **MINUTES** (Pages 1 - 12)

   To approve as a correct record the minutes of the Committee held on the 13th March 2019 and to authorise the Chairman to sign them.

5. **DRAFT JOINT HEALTH AND WELLBEING STRATEGY** (Pages 13 - 26)

6. **JOINT HEALTH AND WELLBEING STRATEGY CONSULTATION** (Pages 27 - 32)

7. **BHR OLDER PEOPLE AND FRAILTY TRANSFORMATION PROGRAMME** (Pages 33 - 52)

8. **PROGRESS AND UPDATE ON THE HAVERING DEMENTIA STRATEGY** (Pages 53 - 66)

9. **UPDATE ON REFERRAL TO TREATMENT** (Pages 67 - 72)

10. **DATE OF NEXT MEETING**

    Wednesday 24 July 2019, commencing at 1.00 pm, at Havering Town Hall.

MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD
Town Hall
13 March 2019 (1.00 - 3.30 pm)

Present:

Elected Members: Councillor Jason Frost (Chairman)

Officers of the Council: Tim Aldridge, Director of Children's Services; Mark Ansell, Director of Public Health; and Barbara Nicholls, Director of Adult Services

Havering Clinical Commissioning Group: Dr Gurdev Saini, Board Member, Havering Clinical Commissioning Group, Steve Rubery, Barking, Havering & Redbridge Clinical Clinical Commissioning Group

Other Organisations: Anne-Marie Dean, Executive Chairman, Healthwatch Havering; and Richard Pennington, Barking, Havering and Redbridge University Trust

Also Present: Claire Alp, Senior Public Health Specialist; Elaine Greenway, Public Health Consultant; Gerry Flanagan, Commissioning Programme Manager; Sharon Morrow, Barking, Havering & Redbridge Clinical Clinical Commissioning Group; and Doug Tanner, Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

One member of the public was also present.

All decisions were taken with no votes against.

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

1 **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman gave details of arrangements in case of fire or other event that may require the evacuation of the meeting room or building.

2 **FORWARD PLAN**

It was noted that there is no annual forward plan and that this would be drafted once the Joint Health and Wellbeing Strategy has been agreed. As an interim measure, it was agreed that the next meeting would focus on the theme of the health and wellbeing of older people.

3 **APOLOGIES FOR ABSENCE**

Apologies were received for the absence of Councillors Damian White, Robert Benham and Gillian Ford. Apologies were also received from Andrew Blake-Herbert, London Borough of Havering, Ceri Jacob, BHR

CCGS, Jacqui Van Rossum, NELFT and Chris Bown, BHRUT (Richard Pennington substituting).

4 DISCLOSURE OF INTERESTS

There were no disclosures of interest.

5 MINUTES, ACTION LOG AND INDICATOR SET

The following items were noted in respect of the action log:

4 – Update on referral to treatment – The target from NHS England was for BHRUT to have fewer people awaiting treatment on 31 March 2020 than had been the case two years previously. An update on progress on this target could be brought to the May meeting of the Board. It was accepted that recruitment difficulties for consultants and nurses could impact on meeting this target.

BHRUT was currently modelling what additional capacity was needed to meet these targets and there were plans to extend the triage system to other specialities. More details regarding the triage system could be given at the next meeting of the Board. BHRUT was putting the expected population growth into commissioning plans and discussions had taken place re the cost of delivery and capacity to deliver.

7 – SEND Action Plan Update was distributed (appended to the minutes).

8 – Health analytics - It was confirmed that every GP practice was required to sign a data sharing agreement. It would be clarified whether data from the 21 Havering practices who had signed could now be accessed.

The minutes of the meeting of the Board held on 16 January 2019 were agree as a correct record and signed by the Chairman.

6 CHILDREN AND ADOLESCENT MENTAL HEALTH

It was noted that the CAMHS local transformation programme was currently entering the fourth year of a five year agenda. A hub model using iTHRIVE principles has been developed for the main providers in order to seek to deliver earlier interventions. The service's future direction was reinforced by the new NHS Long Term Plan with its emphasis on investment in areas such as prevention, early intervention in psychosis and eating disorder services. Funding for CAMHS is received on a borough-wide basis but some funding is top sliced in order to fund BHR-wide work e.g. a single point of access.

A steering group has been established to look at local need and come up with local solutions. In the past year, the transformation programme has funded work across a range of settings and services including the Early Help Service to increase perinatal mental health support, CAD team to

deliver Five to Thrive and ELSA training, Youth Services to deliver the Go Girls programme, Havering Mind and AddUp charities to deliver parent support sessions and Children's Services to develop the Adolescent Safeguarding Hub.

These programmes link to wider work which has included the funding of mental health first aid courses and suicide prevention training for school staff. School counselling was purchased by schools directly although officers were working with schools in order to map which Havering schools offered counselling and develop practical checklists for use by schools when appointing counselling services. It was suggested that the Council could coordinate joint purchasing of counselling services via its traded services. Officers would clarify which counselling services were currently available via traded services.

Healthwatch powers did not cover children's issues but Healthwatch did wish to support this work. A Healthwatch report on mental health issues from another area could be shared with the Board for information.
The availability of IAPT services for children and young people was currently an issue at STP level and funding for services after year 5 of the transformation agenda was yet to be decided. The Council had also invested in mental health work within children's services and wished to see children and families supported more in their own environment, rather than in clinics etc.

7 AUTISM STRATEGY

It was emphasised that there was now a wish to prioritise children's autism needs, in addition to those of adults. A new Government strategy for autism was due at the end of 2019 and some work had been undertaken locally to get a better sense of what people with autism and their families were saying. Some services were highly regarded including post-diagnosis support for adults with learning disabilities and hospital staff being aware of patients with autism.

A draft strategy was being completed this week that would need sign up from all partners at a senior level. There were around 500 Havering residents with a primary autism diagnosis with a further 70 having a secondary diagnosis. Key issues for families included housing and unemployment and it was felt there should be an improved pathway between children's and adults services. There was also a need to better signpost where help and support was available. An additional priority was to provide support to ensure people with autism could safely use public transport.

The Healthwatch representative felt it was important that children with autism received annual healthchecks and agreed that the CCG had improved greatly in this area. Work was also in progress with BHRUT to bring the skills of Trust staff with assisting people with autism etc out into the community.

The strategy covered large groups of people with varying needs and also looked at needs for supported housing. The families of people with autism wished to be more involved but it was felt more input was required from the Council and its partners. It was felt that the Council's leisure provider and libraries could support work on dementia awareness and the action plan would include details of proposed work on raising autism awareness.

The Board discussed whether the Autism Partnership Board was the best place to take the strategy forward and it was agreed that Healthwatch Havering could be engaged to support consultation on the autism strategy.

8 BHR MENTAL HEALTH TRANSFORMATION PROGRAMME

The Board was advised that it was wished that local work on mental health transformation fitted with the national programmes for this area. The recently published NHS Long Term plan focussed on mental health and there was a need to explore the primary care model for people with moderate to severe mental health issues. The Long Term Plan aimed to provide better community support for mental health and the CCG was currently investing in perinatal mental health. Improving access to IAPT services was also a priority whilst work was also in progress on improving the access of rough sleepers to mental health support, support for people with gambling problems and for suicide reduction.

National must do actions for the CCG included meeting IAPT treatment targets although the increased recruitment this required could be difficult to achieve. Havering was not meeting its target for formal diagnosis of dementia and the estimate of numbers of people in Havering with dementia may not be accurate. It was noted that GPs were not allowed to diagnose dementia, this had to be done by a consultant.

The CCGs were working on ensuring that all patients with acute mental health issues received a full physical healthcheck. Out of area placements had increased recently and more people from outside Havering were also receiving treatment at local facilities. The CCGs had put investment into CAMHS and further investment was planned for 2019/20. A stakeholder workshop had been held on 28 February.

It was felt that a BHR-wide needs assessment exercise could assist with future planning for mental health and that a more coordinated approach to suicide prevention was also required. The Local Area Coordination model used in Thurrock had picked up a lot of issues that could lead to mental health problems such as debt, employment problems and housing issues. This gave a different way of working with communities and it was important that the aims of the mental health transformation programme fitted in with localities. Officers were also keen to work across BHR on substance misuse and mental health, as well as on homelessness issues.

9 SUICIDE PREVENTION

Training on suicide prevention and mental health first aid had been delivered by the Council's Safeguarding and Workplace Wellbeing teams. The three-borough strategy on suicide prevention had been in place for one year and a lot of activity had taken place during this period at local, pan-London and national levels. Commissioning intentions for suicide prevention across BHR had been collated and published and work on discharge from in-patient settings was being led by NELFT. It was important for people with long-term conditions to have access to talking therapies. In addition, a 'Good Thinking' site had been commissioned across London with the aim of providing tools and resources to help tackle problems such as stress.

A Thrive London programme had been established with improving the mental health and wellbeing of all Londoners. The Samaritans had also produced resources for use in schools.

Priority work included the arranging of an annual BHR summit and workshop on lessons learned from suicide. Public health officers also met with the coroner twice a year to discuss suicide inquests. Inquests into the suicides of Havering residents who died elsewhere would be undertaken by the coroner for that area although information could be gleaned from death registrations.

Work in progress this year covered areas such as training on suicide prevention, crisis response & places of safety and the provision of support to individuals in crisis. A review of the care of patients that self-harmed could be carried out at the BHR level of via the STP steering group. It was noted that self-harm was a very high risk factor for suicide and it was felt hat the impact of self-harming on A & E services should also be considered. The role of school counsellors was also important in preventing young people self-harming.

10 FUTURE MEETING DATES

The next meeting was scheduled for 1 pm, 8 May 2019 at Havering Town Hall.

Chairman

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Health and Wellbeing Board Action Log (following March 2019 Board meeting)

No.	Date Raised	Board Member Action Owner	Non-Board Member Action Owner	Action	Date for completion	RAG rating	Comments
4	16.01.19	Steve Rubery		An update on the referral to treatment.			Agenda item 10 refers.

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Health and Wellbeing Board Indicator Set: 2018/19

The following high-level indicator set reflects the priorities and themes of the Health and Wellbeing Board Strategy. The first 10 core indicators provide an overview of the health of residents and the quality of care services available to them. Below the core indicators are additional indicators covering those topics of current and special interest to the Board which will change over time.

#	Indicator (Healthy Life expectancy)	What is *Good*?	Trend	Havering	Comparators						Period	Update status	Update commentary
				Number of Years	London	RAG	England	RAG	Target	RAG			
1	Healthy life expectancy, male	High	-	66	64		63		-		2015-17	**Updated**	Remains similar
2	Healthy life expectancy, female	High	-	65	64		64		-		2015-17	**Updated**	Remains similar

#	Indicator (Other)	What is *Good*?	Trend	Havering		Comparators						Period	Update status	
				Count	Rate (%)	London	RAG	England	RAG	Target	RAG			
3	Physically active adults	High	-	-	59	65		66		-		2016/17	Unchanged	
4	Overweight (including) obese children, Year 6	Low	↑	1053	37	38		34		-		2017/18	**Updated**	No sig difference from last year; long term worse
5	Achieving a good (or better) level of development at age 5 (EYFSP)	High	↑	-	72	74		72		73		2017/18	**Updated**	RAG Significance added
6	Good blood sugar control in people with diabetes	High	→	-	56	60		60		-		2017/18	Unchanged	Remains similar
7	A&E attendees discharged with no investigation and no significant treatment	Low	↓	9,113	-	-		-		-		2017/18	Unchanged	
8	NHS friends and family recommendation of NHS Havering GPs	High	-	439	90	87		90		-		Feb-19	**Updated**	Remains similar
9	Satisfaction with Adult Social Care services	High	-	-	62	60		64		-		2015/16	Unchanged	
10	Mortality attributable to air pollution	Low	-	-	6.1	6.5		5.1		-		2017 (Calendar year)	**Updated**	
11	Prescribed Long acting reversible contraception (LARC) excluding injections	High	-	1,195	2.4	3.4		4.7		-		2017 (Calendar year)	Unchanged	
12	Referral to treatment	High	↓	17,930	85					92		Feb-19	**Updated**	Monthly Perf c. 85% since Dec 18

Trend rating: ↑ Increasing / better; ↓ Decreasing / better; ↑ Increasing / worse; ↓ Decreasing / worse; → Steady/similar

RAG rating: Significantly better than comparator; Significantly worse than comparator; Similar to comparator; Comparison not made

There are over 250K Havering residents. An increase of 10% in the last 10 years, with similar growth projected for the coming decade. Havering has the oldest population in London (46K residents aged 65 and older, 14K aged 80 or older) but the number of births each year has increased by 33% in the last 10 years to nearly 3.3k. Havering is gradually becoming more ethnically diverse, but 83% of residents are White British; a higher proportion than both London (45%) and England (80%). Havering is relatively affluent, but 10K children and young people aged <20 live in low income families and there are pockets of significant deprivation to the north and south of the borough. Average life expectancy is better than the national average with a significant gap berween the least deprived and deprived areas. Most residents enjoy good health but 18% of working age people have a disability or long term illness.

#	Indicator	Description
1	Healthy life expectancy, male	The average number of years a male newborn would expect to live in good health based on mortality rates and self-reported good health
2	Healthy life expectancy, female	The average number of years a female newborn would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health
3	Physically active adults	Percentage of adults achieving at least 150 minutes of physical activity per week in accordance with UK Chief Medical Officer recommended guidelines (current method)
4	Overweight (including) obese children, Year 6	Proportion of children aged 10-11 classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex
5	Achieving a good (or better) level of development at age 5 (EYFSP)	Percentage of pupils achieving at least the expected level in the Early Learning Goals within the three prime areas of learning and within literacy and mathematics; this is classed as having a good level of development; The local target set by the Havering childrens team is 73%
6	Good blood sugar control in people with diabetes	The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol (equivalent to HbA1c of 7.5% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 12 months
7	A&E attendees discharged with no investigation and no significant treatment	Havering GP-registered patients who attend BHRUT A&E who are discharged without an investigation and with no significant treatment; this suggest that attendance at A&E was not appropriate
8	NHS friends and family recommendation of NHS Havering GPs	The Friends and Family Test asks patients how likely, on a scale ranging from extremely unlikely to extremely likely, they are to recommend the service to their friends and family if they needed similar care or treatment
9	Satisfaction with Adult Social Care services	The percentage of adult social care survey respondents who expressed strong satisfaction with the care and support services they received
10	Mortality attributable to air pollution	Percentage of annual all-cause adult mortality attributable to human-made particulate air pollution (measured as fine particulate matter <2.5µm)
11	Prescribed Long acting reversible contraception (LARC) excluding injections	Percentage of LARC excluding injections prescribed by GP and Sexual and Reproductive Health Services per 100 resident females aged 15-44 years; a high figure suggests that there is access to a choice of contraceptive methods
12	Referral to treatment	Percentage of Havering GP-registered patients referred to BHRUT, treated within the expected timescales

See **This is Havering** for further key geographic and socio-economic facts and figures https://www.haveringdata.net/joint-strategic-needs-assessment/

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HEALTH & WELLBEING BOARD

Subject Heading:	Draft Joint Health and Wellbeing Strategy
Board Lead:	Mark Ansell, Director of Public Health London Borough of Havering
Report Author and contact details:	Mark Ansell, Director of Public Health London Borough of Havering mark.ansell@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

This paper outlines the process followed to date to develop a new Havering Joint Health and Wellbeing Strategy.

The first draft of the strategy is shared.

Next steps towards final adoption of a new strategy are recommended.

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RECOMMENDATIONS

1. Members of the Health and Wellbeing Board are asked to consider whether the draft strategy is sufficiently advanced to be the subject of the public consultation (plans for that consultation are the subject of a separate paper).

2. Assuming that members are content for the consultation to proceed; suggest any minor amendments they might wish to the strategy before the consultation is undertaken.

3. Give the Chair authority to approve an updated version of the draft strategy reflecting any amendments suggested, to be used in the proposed consultation.

REPORT DETAIL

The existing Joint Health and Wellbeing Strategy will expire at the end of 2019.

Members of the Health and Wellbeing Board have participated in two development sessions to consider the form and content of a new JHWS.

At the first, members considered the role of the H&WB, particularly in the light of the continuing development of a Barking Havering and Redbridge Integrated Care System.

At the second, members endorsed the proposal that the new strategy should reflect the ‘four pillars’ approach to population health and identified a number of potential priorities for inclusion having considered the health needs of local residents as described in the Joint Strategic Needs Assessment and where leadership by the HWB at borough level might add significant additional value.

Subsequently, a draft of the strategy reflecting these discussions was prepared and shared with individual members of the Board for comment.

Based on comments received by email, and via face to face meetings held with NHS partners, the draft strategy is viewed as being fundamentally sound.

A further draft of the strategy has been prepared to reflect comments received about some matters of detail: -

- More information has been included about the priorities of the ICPB thereby making clear that mental health is a priority – but work is currently being led at ICS level
- The wording has been amended to make it clear that the HWB will take a lead role in developing an effective, comprehensive multi-agency response to all health and housing related issues.

This draft is attached.

Members are asked to consider whether any further amendments are needed and / or whether the draft is fit for public consultation.

IMPLICATIONS AND RISKS

No specific implications and risks are identified – any decisions relating to the implementation of the JHWS will be subject to the relevant governance arrangements in the individual agencies participating in the HWB.

BACKGROUND PAPERS

None

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Draft

Havering

Joint Health and Wellbeing Strategy

2019/20 – 2023/24

The Havering Joint Health and Wellbeing Strategy 19/20 – 22/23 on a page

Our vision

Havering Health and Wellbeing Board (HWB) is working so that *'everyone in Havering enjoys a long and healthy life; and has access to the best health and social care services'*.

Our priorities

Achieving this vision will require action on the part of many stakeholders. The Havering Joint Health and Wellbeing Strategy (JHWS) sets out what the HWB will do, as a partnership between Havering Council, local NHS bodies and Havering Healthwatch to improve the health of local residents. To this end, over the next 4 years, the HWB will prioritise action to address the concerns listed below , which span the four 'pillars' underpinning good health.

1. The wider determinants of health

- Increase employment of people with health problems or disabilities
- Develop the Council and NHS Trusts as anchor institutions that consciously seek to maximise the health and wellbeing benefit to residents of everything they do.
- Prevent homelessness and minimise the harm caused to those affected, particularly rough sleepers and consequent impacts on the health and social care system.

2. Lifestyles and behaviours

- The prevention of obesity
- Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups
- Strengthen early years providers, schools and colleges as health improvement settings

3. The communities and places we live in

- Realising the benefits of regeneration for the health of local residents and the health and social care services available to them
- Targeted multidisciplinary working with people who, because of their life experiences, currently make frequent contact with a range of statutory services that are unable to fully resolve their underlying problem.

4. Local health and social care services

- The development of integrated health, housing and social care services at locality level, across all ages.

An action plan will be prepared for each priority. Each plan will specify a lead officer and detail relevant milestones and quantitative targets. Regular reporting against these measures will demonstrate progress overtime and the added value of the Joint Health and Wellbeing Strategy and the leadership provided by the Havering Health and Wellbeing Board.

Havering Joint Health and Wellbeing Strategy

2019/20 – 2022/23

Introduction

Health and Wellbeing Boards (HWB) were established under the Health and Social Care Act 2012 to act as a forum in which leaders from the local health and care system can work together to improve the health and wellbeing of local people.

Each HWB has a statutory duty to produce a Joint Health and Wellbeing Strategy (JHWS) setting out its priorities to address the health and wellbeing needs of local residents as captured in the Joint Strategic Needs Assessment (JSNA). This document sets out how the Havering Health and Wellbeing Board has identified a small number of key strategic priorities for action that will make a real impact on the lives of local people.

Our vision for the health and wellbeing of local residents

Havering Health and Wellbeing Board is working so that *'everyone in Havering enjoys a long and healthy life; and has access to the best health and social care services'*.

Delivering our vision

The health of the population is determined by the interaction of a variety of different factors. A recent paper[1] by the King's Fund describes these factors in terms of four pillars underpinning good population health -

- *The wider determinants* – a reasonable income; good employment; secure, high quality housing etc. are the most important drivers of health and wellbeing. Action to improve these factors at borough level will improve the health of the population as a whole. Targeted action to help people living with significant health problems or disability e.g. to gain or maintain good employment or better adapt their home to meet their needs can significantly increase independence and wellbeing.
- *The communities and places we live in* – where we live, both the physical (e.g. access to green space and leisure services, exposure to air and noise pollution, etc.) and social environment (e.g. the extent to which we support and are supported by family, friends and the wider community) affect our risk of ill-health and the extent to which we are resilient and able to cope with adversity.
- *Our behaviours and lifestyles* - Individual behaviours and lifestyle choices e.g. regarding smoking, alcohol consumption, diet etc. directly affect our risk of developing physical and mental illness. As such, many of the conditions that cause the bulk of early deaths and disease are essentially preventable. Lifestyle related risks are affected by the community we live in and by levels of disadvantage and are the immediate cause of a significant proportion of health inequalities.

[1] A vision for population health: Towards a healthier future. King's Fund 2018.

- *Integrated health and social care services* – Studies suggest that health and care services contribute about 20-25% to the health of the population – the remainder being attributable to the other three pillars. Traditional models of care are struggling to meet the needs of a large and growing number of residents who live with multiple long-term conditions and require integrated health and social care tailored to their needs that cut across organisational silos. Effective integration will improve both user experience and the cost effectiveness of health and social care services.

Achieving our vision for health and wellbeing in Havering will require further improvement regarding all four pillars and hence action on the part of many stakeholders from individual residents to national government; statutory services, voluntary sector organisations and private business.

The Havering Joint Health and Wellbeing Strategy (JHWS) sets out what the HHWB will do, as a partnership between Havering Council, local NHS bodies and Healthwatch Havering to improve the health of local residents.

Deciding on our priorities

The Joint Strategic Needs Assessment (JSNA) describes the health and wellbeing needs of local residents.[2]

A short pen portrait of the borough, based on information contained within the JSNA and structured with regard to the four pillars of population health is presented as Table 1 below.

The JSNA outlines many significant problems but also opportunities to improve the health and wellbeing of local residents. By inclusion in the JHWS, the Health and Wellbeing Board has prioritised for action those issues it believes: -

- are otherwise likely to be neglected

  and/or

- where an effective response would benefit from :-
  - joint planning between partners represented on the HHWB
  - combining resources including staff and money
  - better links between health and social care services and the community served, including the community and voluntary sector and / or other assets within the borough

As importantly, the JHWS does not include priorities where robust plans are already in place. This is particularly pertinent with regard to plans for high quality, integrated health and social care services as explained below.

[2] https://www.haveringdata.net/joint-strategic-needs-assessment/

Relationships with the BHR Integrated Care Partnership Board

Since 2015, organisations participating in the HHWB have been working with others to establish an integrated care system (ICS) across Barking, Havering and Redbridge. This work is led by the BHR Integrated Care Partnership Board (ICPB), which brings together Cabinet members and officers from Havering Council and counterparts from the London Boroughs of Barking and Dagenham and Redbridge with clinicians and managers from BHR CCGs, BHRUHT and NELFT.

The ICPB has already set out a clear strategy[3] to establish an ICS built on the development of integrated health and social care services at locality level.

More recently, a number of Transformation Boards have been established to develop and implement detailed plans regarding key care groups and health conditions: -

- Older people and frailty
- Children and young people
- Maternity
- Mental health
- Long term conditions
- Cancer

These plans will:-

- be consistent with the JSNAs of the three boroughs
- be based on the best available evidence of effectiveness
- include comprehensive plans to prevent as well as treat ill-health
- be informed by local service user and professional opinion (medical, nursing, social care, public health, pharmacy etc).

Given the above, and the participation at all levels of LBH councillors and officers, and clinicians working within the borough, the Havering HWB is confident that the needs of Havering residents will be adequately captured in plans developed by the BHR ICPB. As such, the HHWB consider the strategy and plans developed under the auspices of the BHR ICPB to be an integral part of the Havering JHWS.

Progress regarding plans developed by the ICPB will be reported to the HHWB periodically.

Priorities included in the Joint Health and Wellbeing Plan

Having considered the challenges and opportunities identified in the JSNA; the extent to which robust plans already exist and the particular strengths of the HWB as a borough level partnership between the Council, NHS partners and Healthwatch, the HWB has identified the issues set out below in Table 2 as its priorities for the next 4 years.

[3] http://democracy.havering.gov.uk/documents/s34823/Update%20Health%20and%20Care%20Transformation.pdf

Table 1: What the JSNA tell us about Havering with regard to the four pillars underpinning population health.

Global assessment of health			
Life expectancy is better than average and has increased in recent decades but there are significant inequalities between communities and population groups; the rate of increase in life expectancy has slowed and much of the additional years of life gained is lived in poor health.			
Wider determinants of health	**The communities we live in**	**Lifestyles & behaviours**	**Health & social care services**
Havering is more affluent than the national average. Rates of employment are high but average income, % with higher qualifications or employed in a profession is lower than the London average. Some communities and some population groups e.g. residents with LTCs, mental illness, physical and learning disabilities experience significant socio-economic disadvantage that puts them at risk of further decline in health. The consequences of disadvantage are evident at (pre) birth; on entry to school and on life chances thereafter. House ownership is high but renting, sometimes in HMOs, is increasing. Housing costs are cheap for London but rising. Homelessness including rough sleeping is of increasing concern.	The population has grown and become more diverse and will continue to do so. The population is relatively old and getting older; a large number of care homes increases the need for health and social care still further. More recently, the number of births and young children in the borough has also increased. Havering is a collection of distinct communities with their own history and character. Regeneration will provide significant additional (affordable) housing; an opportunity to refresh town centres and develop community hubs, housing joined up services at locality level. High quality green space is an asset but poor north / south public transport results in car dependency, physical inactivity and poorer air quality. School (non)readiness, vulnerable adolescents, domestic violence, loneliness and social isolation are all current concerns. Action to promote self-help, build resilience and support vulnerable residents at the edge of care are priorities. A strong community and voluntary sector is already contributing and could do more.	A significant proportion of premature death and ill-health (and associated use of health and social care services) is preventable. Significant improvement is possible if changes in smoking, diet, activity, drug & alcohol use can be achieved. Variation in behaviour partly mediates impact of disadvantage on health - the opportunity / challenge increases with increasing disadvantage e.g. smoking remains particularly prevalent in disadvantaged communities and amongst vulnerable groups. Clinical intervention can assist with change or partially mitigate harm but action re. the environment and changing community norms is essential.	The increasing population size and age structure drives high demand for care. An increasing number of CYP have SEND needing integrated health / social care / education support. An increasing number of CYP have mental health problems. Many adults are affected by cancers, LTCs and / or MH problems. Some are identified late / miss out on effective interventions or have a poor experience of care. Urgent / unplanned care services are under pressure year round. Much of this activity could be dealt with elsewhere; but primary care is itself under pressure and needs development. Social care and community services are already working together (including co-location between adult social care and community nursing) but fully integrated locality services are still to be established. The BHR system as a whole has a significant financial deficit and issues with recruitment / premises.

Table 2: - Priorities for Joint Health and Wellbeing Strategy

Wider determinants of health	The communities we live in	Lifestyles and behaviours	Health and social care
Priority - Assisting people with health problems (back) into work. *Rationale* Being in good work is good for health. For many people, health problems are a barrier to gaining or retaining a job. The HWB can bring together private, public and third sector stakeholders to assist excluded groups into work; benefitting them and the public purse. **Priority – Further developing the Council / NHS Trusts as 'anchor institutions'**. *Rationale* – Councils / NHS bodies have huge scope to benefit local people e.g. as an employer or by procuring services from local businesses. Anchor institutions recognise their importance to local economy and seek to maximise the benefit to the local community in all they do. **Priority – Provide strategic leadership for collective efforts to prevent homelessness and the harm caused**. *Rationale* – homelessness in all its forms is bad for health - life expectancy for street sleepers is under 50 yrs; homeless people are high users of urgent and acute health care which rarely result in a solution to their complex underlying issues.	**Priority – Realising the benefits of regeneration for health and social care services.** *Rationale* - The agreed model of care across BHR is dependent on more / better community facilities so that acute hospitals can focus on more urgent / acute / specialist problems. The private / public partnerships established to deliver housing regeneration offer an alternative means of improving health and social care premises as an integral and essential part of community infrastructure at locality level. **Priority – Improve support to residents whose life experiences drive frequent calls on health and social care services**. *Rationale* – Some people repeatedly contact health care services with problems that are caused or made worse by the context in which they live and life experiences. Action to support such residents before they present to services (e.g. through local area coordination) coupled with mechanisms to guide people away from health care services to more effective forms of support (e.g. social prescribing) will improve outcomes and free up capacity for people that would benefit more from treatment services.	**Priority – obesity**. *Rationale* - 1 in 5 children are overweight or obese by the time they start school and rates continue to rise. 2 in 3 adults are overweight or obese. The HWB is best placed to coordinate and sustain action in the long term to tackle the obesogenic environment; shift cultural norms and encourage individuals to make the healthier choice. **Priority - Reducing tobacco harm** *Rationale* – Smoking remains common in some communities / groups and is the immediate cause of a significant proportion of health inequalities. E-cigs provide new opportunities to reduce the harm caused where smoking remains entrenched. **Priority – Early years providers, schools / colleges as health improvement settings.** *Rationale* – CYP are making healthier choices than ever before (e.g. re. smoking). But other health issues (e.g. mental ill-health) and safety concerns (e.g. CSE, knife crime) have increased necessitating new partnerships including schools and colleges to build resilience for all CYP and support the vulnerable.	**Priority - Development of integrated health and social care services for CYP and adults at locality level.** *Rationale* – With a fully functional ICS in place, decisions re. high level strategy, effective models of care and treatment options will increasingly be made at BHR level. But the majority of care will be delivered at locality level by integrated teams of primary, and community health care professionals and social care counterparts, working with other statutory partners e.g. housing, DWP and the CVS. The precise offer at locality level will vary to reflect the specific needs of the population served and make best use of assets available in the community. Effective community engagement will be essential to maximise self-care and support for vulnerable residents in and by the community.

Next steps - our approach to developing and implementing plans to address priorities identified in the joint health and wellbeing strategy.

A member of the Board will be identified to lead action regarding each priority.

They will be supported by a senior manager and programme management support drawn from organisations participating in the HWB.

This team will develop a detailed action plan for each priority within 12 months of the adoption of the strategy.

Wherever possible, plans will adopt innovative, evidence based approaches that will be of interest further afield and therefore offer the additional benefit of showcasing Havering and / or the 'BHR' patch as an attractive location to live, work and invest.

Each plan will include clearly identified milestones and quantitative performance indicators.

Progress will be reported to the HWB at least once a year.

Reporting against these measures will demonstrate progress overtime and the added value of the Joint Health and Wellbeing Strategy and leadership by the Havering Health and Wellbeing Board.

Glossary and list of Acronyms

- *Anchor Institutions* – see here for examples of NHS Trusts acting as anchor institutions
- *BHR CCGs* – Barking, Havering and Redbridge Clinical Commissioning Groups – the local commissioner of NHS services
- *BHRUHT* - Barking Havering and Redbridge University Hospital Trust – the provider of acute hospital services at Queens and King George Hospitals
- *CSE* – child sexual exploitation
- *CVS* – community and voluntary sector
- *CYP* – Children and Young People
- *HWB*- Health and Wellbeing Board
- *HMO* – house in multiple occupation
- *ICPB* – Integrated care partnership board
- *ICS* – integrated care system – see here what NHS Long Term plan says re. ICS.
- *JHWS* – Joint health and wellbeing strategy
- *LTCs* – long terms conditions – may be physical (e.g. diabetes) or mental. As treatment has improved, many more people are living with conditions that were previous life limiting e.g. some cancers and HIV.
- *MH* – mental health
- *NELFT* – North East London Foundation Trust – the provider of mental health and community services in the borough.
- *SEND* – special education needs and disability

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Joint Health and Wellbeing Strategy Consultation
Board Lead:	Dr Mark Ansell, Director of Public Health London Borough of Havering
Report Author and contact details:	Elaine Greenway, Public Health Consultant, London Borough of Havering 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

This paper sets out the proposal for consultation on the draft Joint Health and Wellbeing Strategy. Health and Wellbeing Board members are asked to agree the recommendations.

RECOMMENDATIONS

1. The consultation period to last for a period of one calendar month, commencing end of May 2019.

2. The consultation will be hosted on the Council's consultation hub https://consultation.havering.gov.uk/ - where a dedicated section will be

established for Health and Wellbeing Board that will deal with this and any future HWB consultation business.

3. There will be separate questions (a) for residents and (b) for organisations (see report detail below).

4. The consultation will include presenting the draft strategy to the Integrated Care Partnership Board, to ensure that all parties across the BHR geography are sighted on Havering plans, and the implications for the Integrated Care System.

5. All HWB member agencies will use their communication channels to promote the consultation to their staff (who live, work or study in Havering), local residents, and organisations that have a stake in the borough, including statutory agencies such as Fire Service and Police, voluntary and community sector, and GPs/health services representation (in advance of the emerging network arrangements).

6. Whilst preferable for responses to be made electronically (through the consultation webpage), hard copies of the consultation documents will be made available where electronic completion is not feasible. Hard copies should be returned to the Public Health Service.

7. All comments and feedback will be collated by the Havering Public Health Service and a report produced that summarises the feedback. A final draft of the strategy incorporating changes made as a result of consultation will be presented to the Health and Wellbeing Board for approval on 25 September 2019.

REPORT DETAIL

8. Consultation Overview

The introductory text (or overview) which explains the purpose of the consultation is proposed as follows:

> *"Health and Wellbeing Boards are partnerships of key leaders from the local health and care system who work together to improve the health and wellbeing of the local population. They have a statutory duty to produce a joint health and wellbeing strategy for their local population.*

"The Havering Health and Wellbeing Board comprise representatives from the Council, the Clinical Commissioning Group, Healthwatch (which gives people a voice in shaping health and social care policies and services), Barking Havering and Redbridge University Trust (acute hospital) and North East London Foundation Trust (provider of the majority of community health services).

"All partners have worked to draft a joint health and wellbeing strategy, and the Board is now inviting local residents and organisations for their views on the content."

9. Consultation questions for residents/individuals

Any of the response fields may be left blank (i.e. part-completed responses will be accepted).

Q1 Do you agree about the approach set out in the draft strategy, which is to focus on a limited number of priorities? [Y / N / don't know]

Q2 To what extent do you agree with the priorities that have been proposed:

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know
Increase employment of people with health problems or disabilities						
Develop the Council and NHS Trusts as anchor institutions that consciously seek to maximise the health and wellbeing benefit to residents of everything they do.						
Prevent homelessness and minimise the harm caused to those affected, particularly rough sleepers and consequent impacts on the health and social care system.						
Increase employment of people with health problems or disabilities						
The prevention of obesity						
Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups						
Strengthen early years providers, schools and colleges as health improvement settings						
Realising the benefits of regeneration for the health of local residents and the						

health and social care services available to them						
Targeted multidisciplinary working with people who, because of their life experiences, currently make frequent contact with a range of statutory services that are unable to fully resolve their underlying problem.						
The development of integrated health, housing and social care services at locality level, across all ages.						

Q3 Is there a different priority that you think should have been included? [Y/ N/ don't know}

Q4 [If yes to Q3] Please describe what this is [50 words]

Q5 The draft strategy says that health and wellbeing is affected by many influences, and that it needs individuals and many different organisations to bring about improvement. Can you see the part that you can play (or continue to play) to help to improve health and wellbeing in the borough? [Y/ N /don't know]

Q6 [If yes or no to Q5] You can choose to explain this further if you wish [50 words]

Q7 The draft Health and Wellbeing Board strategy deliberately avoids duplicating the priorities of the Integrated Care Partnership. [A list of ICPB priorities to be available.] Instead, the strategy focuses on those priority topics where improvements are considered to be best achieved at borough or locality (sub-borough) level. To what extent do you agree with this approach? Tick one of the following.

- I agree with this approach.
- I do not agree with this approach [this will take the respondent to a box for self-completion: maximum word count 75 words]
- I don't know

Q8 Equalities questions (as per protected characteristics)

10. Consultation questions for organisations

Q1 Overall, does your organisation agree with the vision and approach described in the draft strategy? [Y/ N / not sure]

Q2 Would your organisation support the implementation of the strategy? [Y/ N/ don't know]

Q3 Are there any specific priority areas that are of particular interest to your organisation? Please select as many as you wish

	Tick as many as you wish
Increase employment of people with health problems or disabilities	
Develop the Council and NHS Trusts as anchor institutions that consciously seek to maximise the health and wellbeing benefit to residents of everything they do.	
Prevent homelessness and minimise the harm caused to those affected, particularly rough sleepers and consequent impacts on the health and social care system.	
Increase employment of people with health problems or disabilities	
The prevention of obesity	
Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups	
Strengthen early years providers, schools and colleges as health improvement settings	
Realising the benefits of regeneration for the health of local residents and the health and social care services available to them	
Targeted multidisciplinary working with people who, because of their life experiences, currently make frequent contact with a range of statutory services that are unable to fully resolve their underlying problem.	
The development of integrated health, housing and social care services at locality level, across all ages.	

Q4 Do you think there are any important health and wellbeing issues that have been overlooked? [Y/N/don't know]

Q5 [If Y to Q4] Please describe what you consider has been overlooked [100 words]

Q6 The draft Health and Wellbeing Board strategy deliberately avoids duplicating the priorities of the Integrated Care Partnership. [A list of ICPB priorities to be available.] Instead, the strategy focuses on those priority topics where improvements are considered to be best achieved at borough or locality (sub-borough) level. To what extent do you agree with this approach? Tick one of the following.

- I agree with this approach.
- I do not agree with this approach [this will take the respondent to a box for self-completion: maximum word count 100 words]
- I don't know

Q7: Who should we contact for further information (name, email and telephone number)

IMPLICATIONS AND RISKS

No specific implications and risks anticipated as a result consultation process.

BACKGROUND PAPERS

None

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	BHR Older People and Frailty Transformation Programme
Board Lead:	Dr A Aggarwal
Report Author and contact details:	Sharon Morrow, Director of Transformation and Delivery (Unplanned Care and Mental Health) BHR CCGs Sharon.morrow2@ns.net

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 Older People and Frailty Transformation Programme was established in June 2018 to co-ordinate transformational change across older people's services. The programme aims to improve quality and patient outcomes and to ensure services are as efficient as possible and integrated around the patient.

Older People's health and social care has been identified as an area where cost savings can be made which will contribute towards the BHR recovery plan. Specifically, cost savings could be made by a reduction in non-elective admissions and increasing the number of patients who die in their preferred place of death

The key objectives of the programme are:

- To help older people to live healthier lives

- For all older people to have a good experience of their care, living well for longer and supported to remain independent for longer
- To embed integrated care interventions that minimise frailty and where possible avoid unnecessary long-term increases in care and/or health need
- To acknowledge a person's wishes, and support their end-of-life needs in their preferred place of care

A programme board is in place with clinical, professional and officer representation from BHR partner organisations. Some external support has been secured to support mobilisation of the programme and establish the programme infrastructure to support delivery.

A strategic group of clinicians and professionals has put forward a new model of care, informed by wider patient and stakeholder engagement. A number of workstreams have been established to take forward initiatives that will support the delivery of the new model of care and deliver improved quality and financial outcomes. Business cases for investment are being developed and the next stage of work will be to focus in whole system delivery of the new model of care.

RECOMMENDATIONS

The Board is asked to:

- comment on the report and direction of travel
- agree how the Board would like to be updated on progress

REPORT DETAIL

Attached.

IMPLICATIONS AND RISKS

Non elective admissions for older people in BHR have increased by 15% in the last two years and A&E attendances have increased by 5%, which has

outstripped demographic growth. There has been a disproportionate increase in costs. Transformation is required to ensure a sustainable health and social care system that delivers better outcomes for patients.

BACKGROUND PAPERS

Attached.

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Older People & Frailty Transformation Programme

Havering Health and Wellbeing Board

April 2019

Whole system case for change

Whole system case for change

Nationally, older people are the fastest-growing population in the community, with the number of people over 85 expected to double within two decades. It is also recognised across BHR that significant signs of frailty can be observed in those as young as 50 years of age and there is a need to make sure that models of care address the needs of the wider frail populations and not just those over 65 years.

Older People's health and social care has been identified as an area where cost savings can be made to contribute towards the BHR recovery plan. Specifically, a reduction in non-elective admissions and increasing the number of patients who die in their preferred place of death

•BHR has seen a 22% increase in NEL admissions in the last 3 years in the 65+ age group. A review of all emergency care admissions for 65+ age group patients shows a 5% increase in activity and therefore demand in 2018/19 compared to 2017/18.
•40% of the 65+ age group are admitted via LAS conveyance
•Havering has the largest number of Nursing Home residents in NEL and has seen a 13% increase in the number of nursing homes beds in the past 5 years
•A recent local audit suggests that 18% of the ambulance conveyances to hospitals can be avoided and could be managed at home. Locally, we see an average readmission rate of 27% following hospital discharge from our geriatric acute hospital beds
•BHR has the 3rd, 4th and 8th highest hip fracture prevalence of all London boroughs, with the average cost of all acute hospital falls activity being almost 17% higher than the NCEL average in 2017/18. Falls result in a loss of independence and increased long-term dependence on care and health services.
•In 2018, on average 54% of predictable deaths across BHR in people aged 65+ occurred in hospital, compared with the England average of 47%

It is estimated that by reducing the non-elective admissions by 12 per day across BHR and decreasing predictable deaths in an acute setting from 45% to 35% would provide £15.1 million net over two years. The opportunities for managing demand on social care services is currently being worked through and the business case will be updated when this information is available.

Whole system case for change .. contd

There is a need to change the way health and social care is delivered across BHR in way that reduces demand on specialist services and brings care closer to home whilst allowing people more control over their health and wellbeing throughout their life course. Integrated care systems (ICSs) have been proposed as the future model for the health and care system in England

Whilst some integration of services has been achieved across BHR, a stakeholder mapping and review of the “as is” model of care as identified that the system is not operating in an integrated way. Activities are duplicated as people move between social care, health care and community partners and communication and co-ordination across organisations is not consistent. This is impacting on patients experience and access to services across BHR.

Interventions to support healthy ageing are not embedded into the current service model. National estimates from 2015 suggest 19% of people are seeing their GP for non-health reasons, whilst local GPs suggest that up to 40% of GP appointments do not need to see a GP and are seeking support for wider issues that can be better solved elsewhere.

There is a wide evidence base that outlines the benefits and successes in delivering integrated care, with the following themes identified to support successful system working:

- Working through primary care networks – whether it is social prescribing, hospital at home or community based teams
- The ability of community teams to access to specialist support
- Professionals working across the health and social care having access to technology that makes sharing actions and care records as seamless as possible
- Central co-ordination of system delivery to ensure quality and equity in care

Vision and overarching Model of care

Our vision

The Older Peoples and Frailty Transformation programme was established to co-ordinate transformational change across older people's services to improve quality, patient outcomes and to ensure services are as efficient as possible and integrated around the patient. The Transformation Board, with input from stakeholders and local residents has developed an overarching vision for the programme:

'For our Older and Frail residents of Barking and Dagenham, Havering and Redbridge to live healthier for longer, in their preferred place of residence - through our integrated services proactively supporting their health and care needs.'

A patient reference group was set up to provide feedback on patient experience of services for older people and advise on the development of a new model of care. The group developed ten principles that they felt should underpin all transformation initiatives, which are summarised as the **"Ten C Principles"**

Key objectives

The key intention of the Older People & Frailty Transformation Programme will be to offer a sustainable transformation platform that meets and controls the current and future demands on the local BHR wide health and social care resources. By achieving this it will ensure that the system consistently delivers good quality of care that meets individuals needs and supports individuals to maximise their own independence.

The board agreed to take forward the four key objectives to focus the transformation developments.

1. Help local people to live healthier lives

2. For all older people to have a good experience of their care, living well for longer and supported to remain independent for longer

3. Embed integrated care interventions that minimise frailty and where possible avoid unnecessary long-term increases in care and/or health needs

4. To acknowledge a persons wishes, and support their end-of-life needs in their preferred place of care

So as to meet these four key objectives the programme has identified the following as areas that will require highlighting throughout the various work streams.

•**Prevention of Frailty**: There is a commitment to embedding the prevention of frailty throughout the programme recognising the current and future impact this can have on reducing demands and utilisation of provider resources. Through supporting community assets and increasing community connectivity our local residents will be supported to remain independent for longer by taking responsibility for their own and their communities' health and well-being.

•**Integrated Care**: Through the development of a truly integrated care system the local area will see an improvement in the quality of health and care. These new ways of working across traditional organisational boundaries will enable our health and care resources to consistently deliver the Right Care, in the Right Place, at the Right Time (as upheld by the 2019 NHS Long Term Plan).

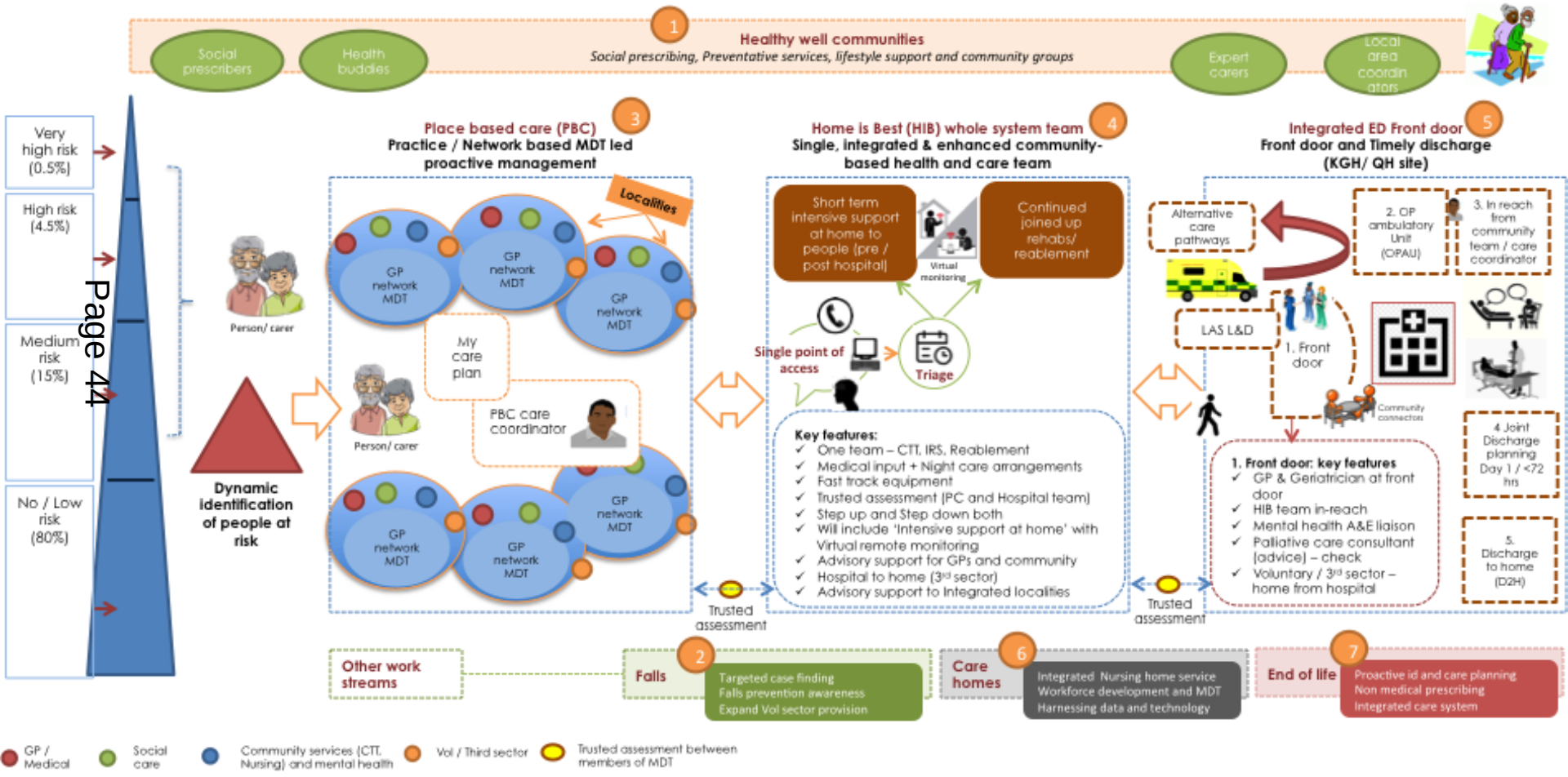
•**Personalised Support**: Through early identification and proactive intervention, the integrated care approach will ensure that the needs actually meaningful to the individuals are supported to be met. Effective care-coordination enhanced by the introduction of a single multi-agency care plans that are co-designed with the individual, will truly personalise the support provided.

•**Optimising Independence**: We will introduce a proactive and multi-agency approach to our populations frailty management needs that enables individuals to remain independent for longer within the community. Additionally, the new ways of working will see enhanced co-ordinated support following any life-crisis that continues through to recovery and, where possible, avoid longer-term needs.

•Supported **End of Life Care:** By redesigning our end-of-life services, the integrated palliative care model will offer a consistent access to good quality palliative care that meets the needs of the local population and reflects the national standards of palliative care.

•**Improved Efficiencies:** By fostering appropriate use of our limited resources, reducing duplication, and respecting others' discussions, the whole-system will see improved efficiencies and increased satisfaction across organisations, the workforces and by those using or affected by the services.

Overarching model of care



Model of Care – Key Work Streams

A number of work streams (set out below) have been set up to support the implementation of the new model of care. Over time it is anticipated that these will reduce as new delivery models such as placed based care become more developed.

1. Healthy Well Communities	This work-stream will support the local community to take meaningful steps to improve the longer-term well-being of local residents focusing on initiatives that prevent frailty, tackle social isolation and consider the wider determinants for health, such as housing and the local environment.
2. Falls Prevention	This workstream will deliver a BHR falls prevention strategy with an initial focus on improving the recognition and recording of falls to enable those at risk to be supported to access falls prevention initiatives, including a full-holistic assessment and management for those at high risk of falls.
3. Place-Based-Care	This workstream will see the development of a new way of working for community health and care services, integrating care across GP networks. Multi-disciplinary teams will use a risk stratification approach to proactively identify older and frail people in need of support and provide seamless person centred care. New care navigator roles will be developed to both improve patient outcomes and reduce the demand for specialist health services.
4. Home Is Best Model	This workstream will establish a single, integrated and enhanced community based health and care team which will provide short intensive support to people at home pre/post discharge. This will be achieved by bringing existing services together to deliver a new service model with enhanced medical leadership and support.
5. Integrated Emergency Department Front Door	This workstream will initially develop a single-integrated team at the front-door of our main emergency department. Recognising that any extended stay in the hospital environment often results in unnecessary deconditioning for an older person, the frail attendees will be fully assessed to determine if and how with the full-support of appropriate community services the individual could return home to recover at home. Subsequent evaluation of the initiative may expand the service to other sites.
6. Care Homes	This workstream will focus on the delivery of *New models of care, the framework for enhanced health in care homes"* All care homes will receive enhanced primary care support delivered by the GP Federations. Other initiatives supported by Healthy London Partnership include training care home staff to recognise and appropriately respond to the signs of deterioration in their residents, the expansion of the "Red-Bag" scheme and the introduction of "Care Home Trusted Assessor" roles.
7. End of Life	This worsktream will develop a BHR-wide ICS model for end-of-life and palliative care, enhancing and streamlining the current end-of-life services to ensure that local residents and their families experience good quality and supportive care through the later stages of life. In the short term there will be a focus on rolling out the shared-care-record (Co-ordinate my Care) across BHR and implementing non-medical prescribing in the local hospice-at-home service.

Impact on quality and outcomes and savings

Quality Improvement

The table below provides a summary of how the model of care will impact on quality domains across the system.

Leadership	• An opportunity to develop and embed well-led cross-organisation new ways of working • Clinically led improvements that reflect local population needs • Development of new roles and responsibilities across the workforces leading to improved job satisfaction.
Integration	• Multi-agency new models of care and whole-system integration of care offers opportunities to showcase innovation across the system • Opportunities to develop / adapt new model of care to meet local need. • Streamline the interface between traditional organizational boundaries, reducing duplication, sharing risks and implementing excellence.
Innovation	• Adoption of digital innovations to support service delivery • Use of communication technology to support efficiencies i.e. video-conferencing • Develop a cross-organisation shared records platform • Use of live agile data bases to support access to meaningful care when required.
Patient and Service User Experience	• Local residents will benefit from the timely delivery of coordinated multi-agency services and be supported to implement their own personalized shared care plan that reflects their actual needs and has been co-designed by themselves and their care-coordinator. • Leading to positive reported outcome and experience measures (PROM & PREM's) and improved Friends & Family satisfaction with local services as demonstrated by BHR system wide HealthWatch service experience appraisals.
Safety	• Multi-agency peer review and support that fosters ownership and measures of an individuals safety that avoids unintended or unexpected harm • Learning from critical appraisal of reported "near-miss" incidents to improve future service delivery • Plan-Do-Study-Action development cycles will be embedded into all areas where multi-agency new ways of working are introduced enabling: testing, re-modelling and delivery at scale of the new models of care derived from transformation. This will ensure that optimal cross - organisation collaboration and resource utilization is achieved as the new models are embedded into usual practice.
Workforce experience	• The support of the whole-system workforce to design and implement real-world new ways of working that enhances care delivery, will create a more desirable working environment working so improving the recruitment and retention ambitions of the local area. • Opportunity for unique cross-organisational working arrangements • Opportunity for personal development and attainment of recognised transferrable skills (professional development) for whole workforce.

Proposed work streams and summary impact

- The following table provides an overview of estimated reduction in activity, cost and net savings across key work streams
- The impact of transformation will be wider than just non-elective admissions such as
  - Impact on social care, which has not been quantified due to non-availability of baseline spend in domiciliary and residential care.
  - Improvement in efficiency across the system through reduction in duplication and better interface between frontline workers
- The investment costs do not include any additional project management costs. Delivery of projects will be done through system wide delivery teams and groups that will be supported by system wide PMO
- More details on individual work streams are in the individual business cases (PIDs)

		19/20 PYE				20/21 FYE				Total FY			
	Workstreams	Reduction in activity	Gross Saving	Investment	Net Saving	Reduction in activity	Gross Saving	Investment	Net Saving	Reduction in activity	Gross Saving	Investment	Net Saving
1	Place Based Care	184	£388,817	£222,751	£166,066	318	£678,247	£56,555	£621,692	502	£1,067,064	£279,306	£787,758
2	Falls Programme	176	£497,086	£200,284	£296,802	150	£496,646	£50,428	£446,218	326	£993,732	£250,711	£743,021
3	Home Is Best (HIB)	674	£1,582,300	£783,768	£798,532	796	£1,866,888	£817,215	£1,049,673	1470	£3,449,187	£1,600,983	£1,848,205
4	ED Front Door	370	£846,974	£293,968	£553,006	230	£524,640	£97,990	£426,650	599	£1,371,614	£391,958	£979,656
5	Integrated Nursing Home Service	210	£1,738,294	£896,214	£842,080	155	£442,891	£0	£442,891	365	£2,181,185	£896,214	£1,284,971
6	EOL	175	£610,169	£152,543	£457,626	400	£1,380,936	£345,233	£1,035,703	575	£1,991,104	£497,776	£1,493,328
	Total Older People	**1789**	**£5,663,639**	**£2,549,528**	**£3,114,112**	**2049**	**£5,390,248**	**£1,367,420**	**£4,022,828**	**3838**	**£11,053,887**	**£3,916,948**	**£7,136,940**

- **Key messages:**
  - Total estimated reduction in activity in year 1 is 1789 (5.8% of total NEL admissions for older people) with a further reduction by 2049 (6.7%) admissions in year 2. In summary, we aim to reduce NEL admissions for older people by approx. 12% in two years
  - Please note that the net reduction in activity will be influenced by demographic and non-demographic growth. Hence, the net residual impact on 2018/19 baseline will be 3.5% (please see next slide) against growth
  - The total investment in year 1 is £2.5m and year 2 is an additional £1.3m
  - The total net savings is £3m and £4m for year 1 and 2 respectively

Amanda's story – before and after

What are we trying to address; Amanda's Story

The following depicts a real journey of an older person living in Havering; names have been changed to protect the identity of the individual

Amanda:
- 84 years old
- No LTC
- Very active
- Walks daily
- Gait becoming laboured and unsteady
- Always lived alone
- Only family; niece & nephew, live 2 hrs+ away, visit rarely

2017

- Lots of friends & very active with local church
- Volunteers in a local school library; loves this job
- No previous history of falls

Aug 2017
DETERIORATION: Significant functional deterioration; Neighbours and people Amanda comes into contact with notice that she has started staggering and that her gait is very unsteady; unsure how to address this

If an intervention had taken place here; would Amanda have still fallen/deteriorated further?

Sept 2017
FALL
Amanda falls at home and breaks her ankle; on the floor for hours until manages to crawl to the phone; 999 called, LAS transfer to hospital, two month length of stay. No rehab during this time

Nov 2017
Discharged from Hospital to Care Home for Respite for 6 weeks, then discharged home with Care Package; no shopping or cleaning support set up; relies on good will of Neighbours. Balance worsening

Dec 2017
FALL; Carer can't gain access to property; calls Police. Break in & Amanda found on floor. Dial 999, LAS transfer to hospital. Week long stay, transferred home, Care Package re-starts, falls alarm set up

Number of smaller falls during this period managed by Carers & neighbours

Dec 2017
FALL: Amanda presses her alarm as she has fallen; alarm company ask neighbour to call 999. LAS transfer to A&E and Amanda is admitted. Week stay, then transferred for rehab bed, then home Jan

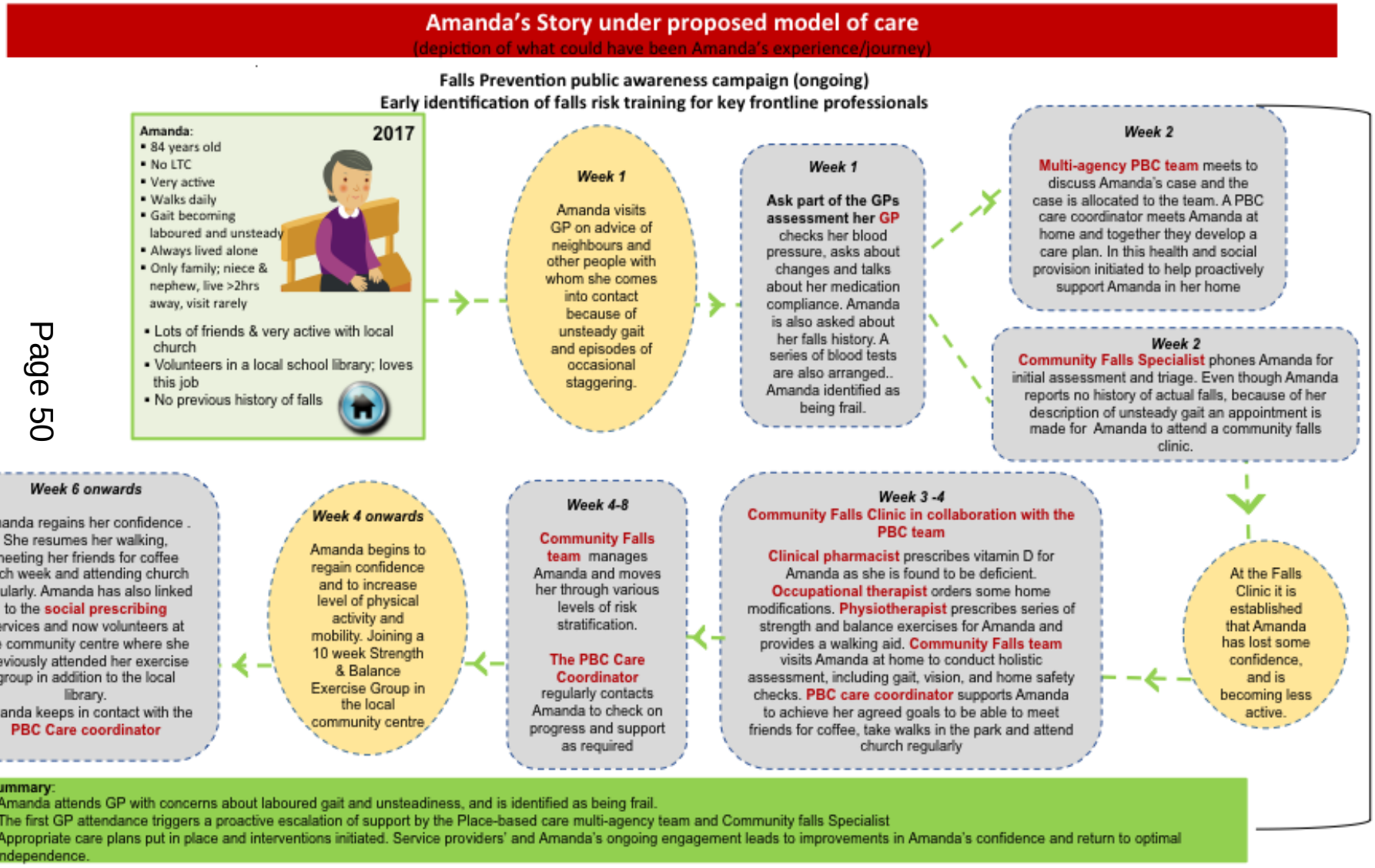
Number of smaller falls during this period managed by Carers & neighbours

Jan 2018
DETERIORATION: Amanda's mental health declines significantly, calls the Police claiming the Carers are moving people into her home. Number of falls and calls to neighbours during this period. Hallucinating

Feb 2018
Transfer to Care Home: Nephew comes to see Amanda and discusses her going to live in a Care Home; Amanda permanently moves to the Care Home she had previously refused when she had capacity

Summary:
- Rapid deterioration of previously very independent, active older lady
- Significant number of falls, LAS calls, calls to Police, A&E attendances, and lengthy acute admissions in a short period of time (5 months). The care received did not lessen this, and the eventual result is rapid mental health decline, coupled with an outcome – transfer to a Care Home – that was not what this lady wanted when she had full capacity.

Amanda's story – before and after



Falls Prevention Services; Place-Based Care; Healthy Well-Communities

Model of Care key outcomes – in development

Key Outcomes (Dashboard development in process)	Current baseline available Yes / No / partial
Increasing participation in community via social prescribing	Partial
Reduce 1st time falls and related injuries in all BHR adults (aged 65+) Reduce 1st time and recurrent falls in all BHR adults (aged 65+) in the community and care homes	Yes
Reducing social inequalities across BHR and reduced social isolation	Partial
Reduced non-elective admissions / attendances & Reduction in unplanned hospital admissions from community and care homes	Yes
Fewer ambulance conveyances to ED from community and care homes	Yes
Fewer admissions to long term care (care homes) and long term care packages reduced	Partial
Positive PREMs/PROMs	No
Increase proportion of local population involved in health and wellbeing activities that will reduce their risk of frailty (including falls or fractures)	Yes
Care homes: Patients have an excellent experience of care and support (CQC ratings; CMC; PPC)	Partial
Integrated care system - multiagency collaboration / partnership working inc: LA – BHRUT – community (NELFT) – Care Home Providers – Care Agencies – CVS	No
Shared care record accessible across partners	No
Increase CMC recorded and shared	Yes
Increase number of patients who die in their preferred place of care	Yes
Reduce EOL deaths in hospital	Yes

Key risks and how we will mitigate

No.	Risks	Mitigating actions	Status (RAG)
1	Partners will continue to operate in silos which will hinder system transformation.	Ensure strong leadership at all levels through the OPTB to advocate for change. Ensure the programme is patient centred and outcome focused. Develop the enablers that will support whole system working e.g. contracting, IT.	
2	Management of unintended consequences that may occur such as triggered demand in other services and impact on staffing levels	Identify potential areas for increased demand and monitor against baseline Utilisation of non-traditional and community assets to cater to demand Baseline current manpower in relevant service lines and ensure robust workforce development and recruitment to be integral to transformation	
3	Patients do not experience a better service and an improvement in patient outcomes cannot be demonstrated.	Regular patient engagement to review and evaluate services and identify areas for improvement.	
		Focal group and working groups to embed “10 Cs” in the delivery plans and monitor patient outcome measures in dashboard.	
		OPTB communication and engagement strategy to regularly communicate programme outcomes; develop case studies.	
4	The model of care does not address the needs of frail and older people and acute activity continues to increase.	Business cases developed to secure additional capacity in integrated out of hospital services.	
		Baseline of activity and capacity pre and post implementation to measure impact.	
		KPI/outcome dashboard monitored by OPTB	
		Ongoing review of pathways by Focal Group.	
5	The delivery of the programme does not happen at the pace required to achieve system savings.	Establish system delivery group to drive forward implementation	
		Support PDSA approach to testing change and enable "just do its".	

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HEALTH & WELLBEING BOARD

Subject Heading:	**Progress and update on the Havering Dementia Strategy**
Board Lead:	**Barbara Nicolls**
Report Author and contact details:	**Jenny Gray, Dementia Commissioner and Project Manager, Joint Commissioning Unit, London Borough of Havering**

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 purpose of this report is to provide an update on initiatives relating to dementia in Havering as requested by the Health and Well-being Board.

Included are dementia projects and programmes within the Council, the Havering Dementia Action Alliance, BHRUT Hospitals Trust, North East London Commissioning Support Unit

RECOMMENDATIONS

The Board members are asked to:-

- Acknowledge the value of the multiagency approach being taken to support people living with dementia and their carers in Havering and across the BHR footprint
- Discuss the information provided in the presentation and provide feedback or pose questions as appropriate.

REPORT DETAIL

The presentation outlines the work of the Havering Dementia Action Alliance, plans for Dementia Awareness week 2019 in Havering, initiatives proposed by both North East London Commissioning Support Unit in relation to the newly commissioned Havering Dementia Advisory service, plans for the introduction of Admiral Nurses and Community Dementia Nurses, and an update on projects within BHRUT and their new Dementia Strategy.

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Cleaner, Safer, Prouder *Together*

www.havering.gov.uk

Dementia update for Havering Health and Wellbeing Board 8th May 2019

Jenny Gray LBH JCU
Gary Etheridge, BHRUT

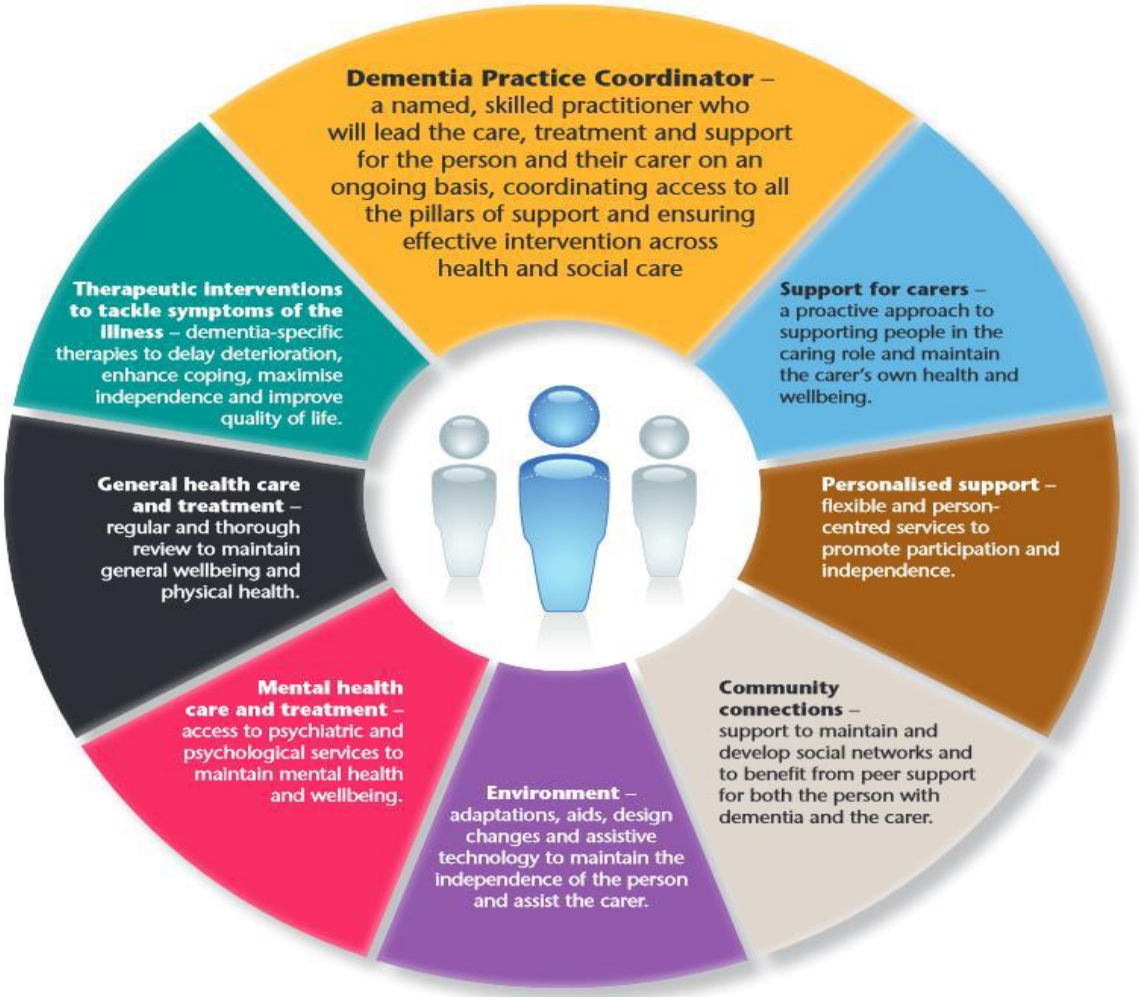
Areas covered in presentation:-

1. Present Havering Dementia Strategy 2017-2020

2. Dementia initiatives within:-
   - London Borough of Havering
   - BHRUT
   - Commissioning Support Unit

3. Next Steps

Current Havering Dementia Strategy 2017-2020



Havering Council Initiatives

- Dementia Champions established in Social Work Teams, Telecare, some Care Homes, The JAD Team at BHRUT, Social Work Teams, Sheltered Housing
- Dementia Friendly Environment checklist and recommendations completed on entire Havering sheltered housing stock
- Working with contractors on the re-design of the Solar, Serena and Sunrise Courts to try and "future-proof" new sheltered housing schemes
- Invited to highlight quality initiatives and service re-design within the JCU at The Kings Fund, and a Government Events Conference
- Working with BHR End of Life Group to raise profile of dementia in improved EOL experience for people living with dementia
- Supporting the Havering Dementia Carers Support Group to develop their organisation
- Meeting every newly-diagnosed person with dementia and their carers at the Memory Clinic to acquaint them with all the dementia-friendly activities available in Havering

Havering Dementia Action Alliance

- https://www.dementiaaction.org.uk/local_alliances/4789_havering_dementia_action_alliance

Currently 98 members including 2/3 of GP practices in Havering

- Recognised as an organisation breaking down barriers around dementia by Healthy London Partnerships

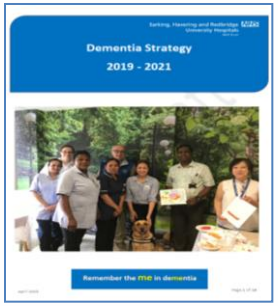
https://www.healthylondon.org/healthyldn-spotlight-on-the-havering-dementia-action-alliance/

- This year's Dementia Awareness week activities (20- 26th May 2019) include holding a Garden Party, launching Hornchurch as the first dementia-friendly High Street in Havering, supporting other partners to hold events

Barking, Havering and Redbridge NHS
University Hospitals
NHS Trust

BHRUT

- Dementia Steering Group re-invigorated, inaugural meeting held on February 2019
- Draft Dementia Policy developed
- Developed Dementia Audit Framework
- Dementia Workforce - reviewed; strengthened role of assistants. Business case approved to increase team and skill mix
- Dementia Strategy developed - to be launched at Trust Dementia Conference in May 2019

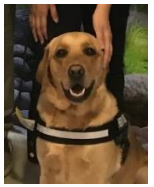


Remember the me in dementia

BHRUT

Barking, Havering and Redbridge University Hospitals NHS Trust

- Referral process introduced January 2019
- Initiatives - RITA, Dog Therapy, Tea parties (launched Trustwide in February 2019)
- Butterfly Scheme, John's Campaign and This is Me all re-launched
- Café Mornings to re-commence in May 2019



Remember the me in dementia

NELCSU

- Recommissioned Havering Dementia Advisory Service – including a "side by side" support service within the specification
- Working with BHR CCG to introduce Community Dementia Nurses

Next steps for Havering

Dementia Strategy

- Re-run Dementia Survey once the Dementia Advisory service has been embedded
- Use the survey results to inform the next Dementia Strategy
- Start the consultation process for the Strategy with people living with dementia and their carers
- Try to get specific representation on the next strategy consultation from the groups of people poorly represented:-
  LGBGTQ community, Travelling community, East African communities, South Asian communities
- Work with colleagues from NELFT, NELCSU, BHRUT to contribute to the Strategy and also to align and encompass their dementia work.

Other initiatives being explored

- Working with Direct Payments to expand their offer to give people living with dementia more choice and control over their care
- Incorporating a dementia offer into the Shared Lives scheme where people living with dementia can be offered respite care within a home setting rather than in residential care
- Investigating whether the Meeting Centres proposed by the University of Worcester can be developed in Havering to improve the Prevention offer

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HEALTH & WELLBEING BOARD

Subject Heading:	RTT Performance
Board Lead:	Steve Rubery, BHR CCG
Report Author and contact details:	Richard Pennington, BHRUT and Tracy Welsh, BHR CCGs

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
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- ☒ Theme 4: Quality of services and user experience

SUMMARY

At the meeting of the Health and Wellbeing Board on the 13 March 2019, requested that a report be presented on the progress of referral to treatment performance.

RECOMMENDATIONS

Members of the Health and Wellbeing Board are requested to note the contents of the presentation.

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REPORT DETAIL

The presentation provides a summary of Referral to Treatment performance for 2018/19 and the primary reasons for lower than planned performance and the Referral to Treatment plan for 2019/20.

RTT PERFORMANCE

Richard Pennington, Deputy Chief Operating Officer (Elective), BHRUT

Tracy Welsh, Director of Transformation and Delivery (Planned Care), BHR CCGs

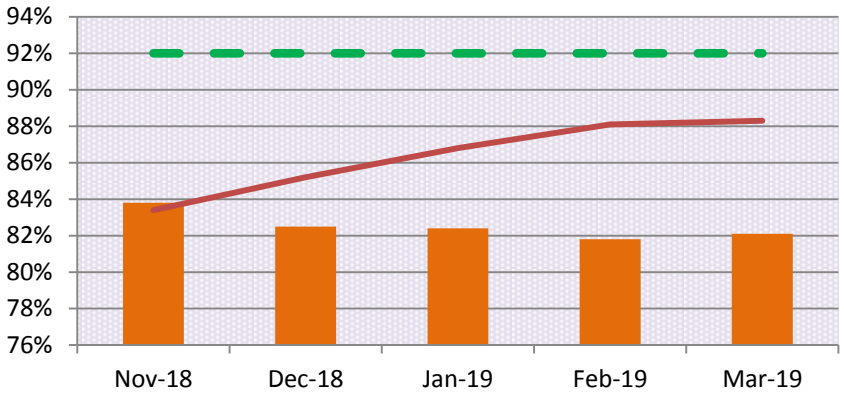
TAKING PRIDE IN OUR CARE

Barking, Havering and Redbridge University Hospitals NHS Trust

2018/19 RTT PERFORMANCE SUMMARY

- In October 2018 we agreed with commissioners that we would aim to deliver 88% RTT by March 2019
- Whilst we met that improvement trajectory in November, performance deteriorated from that point Our 52 week waiters also grew, with 14 patients waiting over 52 weeks in March 2019

2018/19 18 weeks performance and trajectory

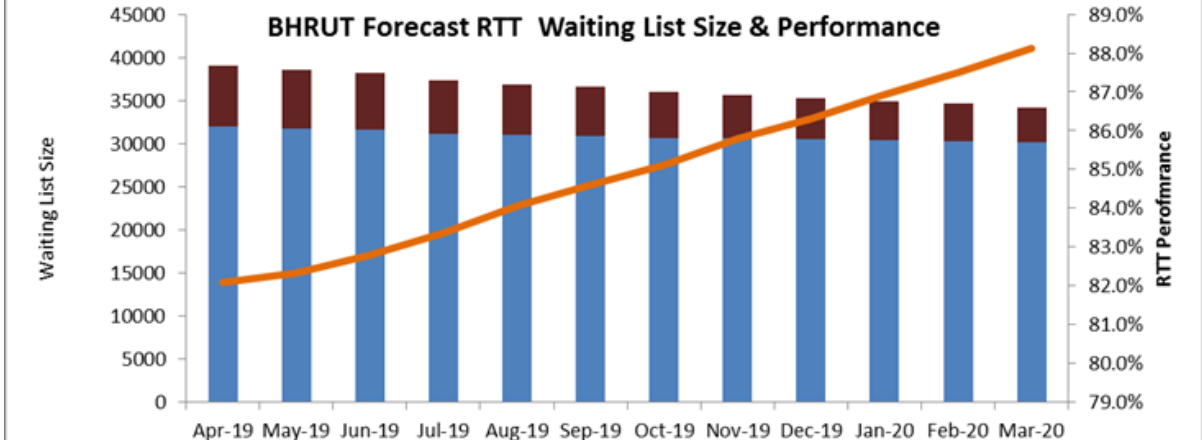


	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Actual / Forecast Validated	83.8%	82.5%	82.4%	81.8%	82.1%
National Target	92%	92%	92%	92%	92%
Trust Trajectory	83.4%	85.2%	86.8%	88.1%	88.3%

- The primary reasons for lower than planned performance were:
  - A greater than expected pressure over winter, affecting access to beds and needing to prioritise clinically urgent cases, which caused short notice cancellations
  - Capacity for diagnostics on patients pathways
  - Delays in commencing outsourcing for a number of specialties
  - Identification of Data Quality issues that we are in the process of investigating to ensure our data is as robust as possible

RTT 2019/20 PLAN

- The planning guidance from NHS England and NHS Improvement requires the Trust to reduce its overall waiting list or 'Patient Tracking List' (PTL)
- Our plan for 2019/20 is to reduce the size of our waiting list, such that at the end of March 2020 it is smaller than it was in March 2018
- Achieving this will also mean that 88% of our patients are waiting less than 18 weeks at the end of March 2020
- We also plan to have no patients waiting over 52 weeks



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Over 18 Weeks	6989	6817	6579	6214	5873	5626	5358	5063	4834	4564	4321	4060
Under 18 Weeks	32000	31779	31668	31146	30981	30925	30665	30582	30455	30372	30282	30093
Performance %	82.1%	82.3%	82.8%	83.4%	84.1%	84.6%	85.1%	85.8%	86.3%	86.9%	87.5%	88.1%

RTT 2019/20 PLAN

Our plan for 2019/20 combines:

1) Initiatives that will be led by the Trust and supported by our commissioners, to:
   a) **Increase the number of clinics, diagnostics tests and theatre sessions available for our patients** – this will combine investment in staff but also require the use of the independent sector where the Trust is unable to recruit suitable staff or has space constraints
   b) **Making better use of our outpatient clinic time**, through improved ways of working such as virtual clinics and enhanced triage of referrals
   c) **Focus on specialties which have 'long waiters'** (patients waiting more than 38 weeks for treatment)

2) Schemes that are being undertaken jointly with our commissioners that will provide alternative ways in which patients can access diagnosis and treatment. This supports the NEL programme to reduce outpatient demand by moving care "out of hospital" and closer to home, including:
   a) **Extending our 'Improving Referrals Together' initiative with GPs and hospital consultant working together to improve patient pathways**
   b) **Increasing the number of specialties for which patients can be seen in a community setting**. This means that a greater number of routine patients will be referred through 'Single Points of Access'
   c) **Increasing the use of 'Advice and Guidance' for GPs** to reduce unnecessary referrals to the Trust and improving the speed of diagnosis
   d) **Work on diagnostics** to procure community diagnostics capacity and also reduce the amount of duplicate testing