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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD AGENDA

1.00 pm	Wednesday 24 July 2019	Committee Room 3B, Town Hall

Members: 16, Quorum: 6

BOARD MEMBERS:

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

For information about the meeting please contact:
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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, ACTION LOG AND INDICATOR SET (Pages 1 - 24)

To approve as a correct record the minutes of the Committee held on 8 May 2019 and to authorise the Chairman to sign them.

5 DEVELOPMENT OF PRIMARY CARE NETWORKS IN HAVERING (Pages 25 - 40)

6 BHR CCGS' LONG TERM CONDITIONS STRATEGY (Pages 41 - 118)

7 PREVENTION OF OBESITY - ANNUAL UPDATE (Pages 119 - 146)

8 DATE OF NEXT MEETING

The next meeting is scheduled to be held on the 25th September 2019, commencing at 1.00pm.

Andrew Beesley
Head of Democratic Services

MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD
Town Hall
8 May 2019 (1.00 - 3.15 pm)

Present:

Elected Members: Councillors Jason Frost (Chairman), Robert Benham and Gillian Ford.

Officers of the Council: Barbara Nicholls, Director of Adult Services.

Havering Clinical Commissioning Group: Steve Rubery, Barking, Havering & Redbridge Clinical Clinical Commissioning Group.

Other Organisations: Anne-Marie Dean, Executive Chairman, Healthwatch Havering.

Also Present: Jenny Gray, Dementia Commissioner and Project Manager, Joint Commissioning Unit; Elaine Greenway, Public Health Consultant; Gerry Flanagan, Commissioning Programme Manager; Sharon Morrow, Barking, Havering & Redbridge Clinical Clinical Commissioning Group; Ali Omar, Head of Innovation and Improvements Children Services; Richard Pennington, Barking, Havering & Redbridge University Trust; Maurice Sanomi, Clinical Director, Clinical Commissioning Group; and Doug Tanner, Barking and Dagenham, Havering and Redbridge Clinical Commissioning Group.

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

11 **APOLOGIES FOR ABSENCE**

Apologies were received for the absence of Councillor Damian White, London Borough of Havering; Andrew Blake-Herbert, Chief Executive London Borough of Havering; Dr Atul Aggarwal, Chair, Havering Clinical Commissioning Group (Maurice Sanomi substituting); Ceri Jacob, Barking, Havering and Redbridge Clinical Commissioning Group; Jacqui Van Rossum, North East London Foundation Trust (NELFT); Chris Bown, Barking, Havering and Redbridge University Trust (Richard Pennington substituting); Mark Ansell, Director of Public Health, London Borough of Havering (Elaine Greenway substituting) and Tim Aldridge, Director of Children's Services, London Borough of Havering (Ali Omar substituting).

12 **DISCLOSURE OF INTERESTS**

There were no disclosures of interest.

13 MINUTES

The minutes of the meeting of the Board held on 13 March 2019 were agreed as a correct record and signed by the Chairman. The Chairman requested that the following actions from the previous meeting be included in the action log:

- Minute No. 5 (8), Minutes, Action Log and Indicator Set (Health Analytics) refers: That clarification be provided on whether data from the 21 Havering practices who had signed a data sharing agreement could now be assessed.

- Minute No. 6, Children and Adolescent Mental Health refers: That clarification be provided on which counselling services were currently available via traded services.

14 DRAFT JOINT HEALTH AND WELLBEING STRATEGY

The Board received a paper outlining the process followed to date to develop a new Havering Joint Health and Wellbeing Strategy.

A draft of the strategy reflecting the discussions of members during the two development sessions was prepared and shared with the Board for comment. Based on comments received, the draft strategy was viewed as being fundamentally sound. A further draft of the strategy was prepared to reflect further comments received and which provided further information about the priorities of the Integrated Care Partnership Board (ICPB) thereby making clear that mental health was a priority and that the Health and Wellbeing Board would lead in developing an effective, comprehensive multi-agency response to all health and housing related issues.

Members suggested some further changes to be made, including:

- Acknowledging formation of primary care networks.
- Referencing the transformation programme being taken forward.
- Describing what are anchor organisations.
- Highlighted the need for mental health to be referenced in respect of communities and places we live in.

During discussion, Members requested that the final document be circulated to the Board prior to consultation. It was suggested that by the Healthwatch representative that the document developed be an easy read version to meet the understanding of the target audience and requested to have sight of the final draft document prior to consultation.

RESOLVED: That

i) Members were content for the consultation to proceed.
ii) Authority be delegated to the Chair to approve an updated version of the draft strategy reflecting any amendments suggested, and to be used in the proposed consultation.

15 **JOINT HEALTH AND WELLBEING STRATEGY CONSULTATION**

The Board received a paper which set out the proposal for consultation on the draft Joint Health and Wellbeing Strategy.

During discussion, Members requested that the Local Authority's communication team be invited to consider and comment on the consultation questions.

Members suggested simplifying Q2 (to three options: yes, no, don't know) and reordering the sequence of questions (moving Q7 to below Q3)

RESOLVED: That

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

ii) The consultation to be hosted on the Council's consultation hub https://consultation.havering.gov.uk/ - where a dedicated section would be established for Health and Wellbeing Board that would deal with this and any future HWB consultation business.

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

iv) All Health and Wellbeing Board member agencies to 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).

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

vi) 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.

16 **BHR OLDER PEOPLE AND FRAILTY TRANSFORMATION PROGRAMME**

The Board received a presentation on the Older People and Frailty Transformation Programme. It was noted that the programme was established in June 2018 and aimed to co-ordinate transformational change across older people's services. The programme aimed to improve quality and patient outcomes and to ensure services were as efficient as possible and integrated around the patient.

The Board noted that Older People's health and social care had been identified as an area where cost savings could be made which would contribute towards the BHR recovery plan. The plan specifically emphasised that 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 Board noted the key objectives of the programme were:

- 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.

It was noted that a programme board was in place with clinical, professional and officer representation from Barking, Havering and Redbridge partner organisations. Some external support had been secured to support mobilisation of the programme and to establish the programme infrastructure to support delivery.

The Board was also informed that a strategic group of clinicians and professionals had put forward a new model of care, informed by wider patient and stakeholder engagement. A number of work streams had been established to take forward initiatives that would support the delivery of the new model of care and deliver improved quality and financial outcomes. Business cases for investment were being developed and the next stage of work would be to focus on a whole system delivery of the new model of care.

During discussion, the Healthwatch representative sought clarification on the commencement of the programme and suggested a phased approach. The Board agreed that there needed to be a sense of urgency in network development for the delivery of the programme. It was noted that network formation was scheduled for 1 July 2019.

The Board agreed to receive an update from the Chair of the Clinical Commissioning Group at the next meeting.

17 PROGRESS AND UPDATE ON THE HAVERING DEMENTIA STRATEGY

Further to a request, the Board received a report that provided an update on initiatives relating to dementia in Havering. The Dementia Strategy 2019-2021 was circulated to members at the meeting (appended to the minutes).

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

The Board noted the following initiatives that had been implemented in Havering:

- Dementia Champions established in Social Work Teams, Telecare, some Care Homes, the Joint Assessment and Discharge Team at Barking, Havering and Redbridge University Trust, Social Work Teams and Sheltered Housing.
- Dementia Friendly Environment checklist and recommendations completed on the entire Havering sheltered housing stock.
- Working with contractors on the re-design of the Solar, Serena and Sunrise Courts redevelopment in order to try and “future-proof” new sheltered housing schemes.
- Invited to highlight quality initiatives and service re-design within the Joint Commissioning Unit at The Kings Fund and a Government Events Conference.
- Working with Barking, Havering and Redbridge End of Life Group to raise profile of dementia in improved End of Life 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.

During discussion, Members requested for dementia services to be made available across the borough. It was suggested that the date and location

of the next Dementia conference be advertised widely including on Time FM radio.

The Board was informed that North East London Commissioning Support Unit was working with Barking, Havering and Redbridge Clinical Commissioning Group to enable them to recommission Dementia Advisory Service across the borough.

The Board commended the delivery of the Dementia Strategy and acknowledged the value of the multiagency approach being taken to support people living with dementia and their carers in Havering and across the Barking, Havering and Redbridge footprint.

18 UPDATE ON REFERRAL TO TREATMENT

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

The presentation provided 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.

The Board noted the following Referral to Treatment performance for 2018/19. In October 2018, the agreement with commissioners was to deliver 88% referral by March 2019. The summary outlined that whilst an improvement trajectory was achieved in November, performance had deteriorated from that point.

The primary reasons for lower than planned performance included:

- A greater than expected pressure over winter, affecting access to beds and a need 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 were in the process of being investigated to ensure data was as robust as possible.

The Board was informed that the planning guidance from NHS England and NHS Improvement required the Barking, Havering and Redbridge University Hospitals NHS Trust (the "Trust"), to reduce its overall waiting list or 'Patient Tracking List' (PTL).

The Trust plan for 2019/20 was to reduce the number of patients on the waiting list by end of March 2020 to a level below that recorded in March 2018. The Board was informed that achieving the reduction would also mean that 88% of the Trust patients were waiting less than 18 weeks at the end of March 2020.

The Board noted that the plan for 2019/20 included:

1. Initiatives that would be led by the Trust and supported by commissioners to:

   - Increase the number of clinics, diagnostics tests and theatre sessions available for patients. It was stated that this would require combined investment in staff and also the use of the independent sector where the Trust was unable to recruit suitable staff or have space constraints.

   - Making better use of outpatient clinic time, through improved ways of working such as virtual clinics and enhanced triage of referrals.

   - Focusing on specialties which have patients waiting more than 38 weeks for treatment.

2. Schemes that were being undertaken jointly with the Trust commissioners that would provide alternative ways in which patients can access diagnosis and treatment. These schemes support the NEL programme to reduce outpatient demand by moving care "out of hospital" and closer to home, including:

   - Extending the Trust 'Improving Referrals Together' initiative with GPs and hospital consultants working together to improve patient pathways.

   - Increasing the number of specialties for which patients can be seen in a community setting. This would entail a greater number of routine patients being referred through to 'Single Points of Access'.

   - Increasing the use of 'Advice and Guidance' for GPs to reduce unnecessary referrals to the Trust and improving the speed of diagnosis.

   - Working on diagnostics to procure community diagnostics capacity and also reduce the amount of duplicate testing.

19 **DATE OF NEXT MEETING**

The next meeting was scheduled for 1.00 pm, 24 July 2019 at Havering Town Hall.

Chairman

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

No.	Date Raised	Board Member Action Owner	Non-Board Member Action Owner	Action	Date for completion	RAG rating	Comments
5	13.03.19	Atul Aggarwal		Clarification to be provided on whether data from the 21 Havering practices who had signed a data sharing agreement could now be assessed.			
6	13.03.19	Steve Rubery/ Tim Aldridge	Clare Alp	Clarification to be provided on which counselling services were currently available via traded services.			
	08.05.19	Mark Ansell		Develop an easy read version of the strategy for public consultation and circulate to HWB members in advance of start of consultation.			
8	08.05.19	Atul Aggarwal		Regarding BHR Older People and Frailty transformation programme, an update to be provided from the Chair of the Clinical Commissioning Group at the next meeting regarding (a) commencement of the programme and (b) the development of local networks.			

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Barking, Havering and Redbridge University Hospitals NHS Trust

Dementia Strategy

2019 - 2021

Remember the me in dementia

Approved at the Dementia Steering Group in April 2019

CONTENTS

Foreword 3

Introduction 4

National Perspective 5

Current Position 6

Commitment 1: Patient Centred Care 7

Commitment 2: Education and Training 8

Commitment 3: Environment 9

Commitment 4: Communication 10

Commitment 5: Partnership working 11

Commitment 6: End of Life Care 12

Implementation of the Trust's Dementia Strategy 13

Conclusion 13

References 13

With thanks 13

FOREWORD

Barking, Havering & Redbridge University Hospitals NHS Trust is committed to improving the care for people living with dementia and their family/caregivers who access hospital services. (*A caregiver is recognised as an individual who provides help or support, physical or emotional, on a regular basis to a person living with dementia).*

It is high on our priorities to ensure that people living with dementia receive safe, equitable care and are treated with dignity and respect throughout their hospital journey.

This 3 year strategy has been developed through consultation with a wide range of stakeholders including clinical, non-clinical, carers, public and voluntary sector representatives. It recognises the work already undertaken by the Trust's Dementia Team and builds on those foundations to improve and develop our hospital services further.

The strategy identifies six commitments and formalises work already undertaken under the umbrella of dementia care and builds on projects, service improvements and process developments already achieved:

- Patient Centred Care
- Education and Training
- Environment
- Communication
- Partnership Working
- End of Life Care

We feel confident that the overall vision to achieve Dementia Friendly Hospital status and improve the care experience for our patients will be achieved through the continued hard work and commitment of Trust staff who will endeavour to ***Remember the Me*** in Dementia.

Kathryn Halford, OBE
Chief Nurse/Deputy Chief Executive
Executive Lead for Dementia

Gary Etheridge
Director of Nursing, Safeguarding & Harm Free Care
Strategic Lead for Dementia

INTRODUCTION

Dementia is a term used to describe a range of cognitive and behavioural symptoms that can include memory loss, problems with reasoning, communication and change in personality. These symptoms can result in a reduction in a person's ability to carry out daily activities, such as shopping, washing, dressing and cooking (NICE, 2018).

Dementia affects around 850,000 people across the UK with some areas having a greater number of people living with dementia than others. In areas with larger populations and older populations there will be a higher number of people living with dementia as age is the greatest risk factor (Alzheimer's Society, 2017).

The local demographics within the Barking, Havering and Redbridge tri-borough indicate that Havering has one of the highest proportions of older people in London and dementia is more prevalent in Havering (0.70%) than in London (0.49%) but similar to the England average (0.74%). Barking and Dagenham has one of the lowest proportions of people with dementia (0.36%) than any other area in the UK whilst Redbridge (0.53%) is closest to the London average. This data is based on GP registers and consideration has to be given that it is estimated that around half of people living with dementia are as yet undiagnosed (Dementia Statistics Hub, 2018).

The number of people with dementia in the UK is forecast to increase to over 1 million by 2025 and over 2 million by 2051 (Dementia UK, 2014).

People living with dementia often have other co-morbidities and therefore have complex needs. It is estimated that approximately 25% of beds in hospitals are occupied by people living with dementia. Their length of stay is often longer than for people without dementia and there can also be delays in supporting them to leave hospital (Dementia Statistics Hub, 2018).

TRUST DEMENTIA VISION

Our Trust vision is to provide person-centred care that preserves dignity and supports the person living with dementia, their family and caregivers.

We will be a Dementia Friendly Trust providing environments that promote a positive experience for the person living with dementia across our acute services.

The Trust's Dementia Vision was developed and agreed as part of the work undertaken by the Dementia Strategy development Focus Groups held in January and February 2019.

NATIONAL PERSPECTIVE

In recent years there have been a number of national documents that have been published which highlight the importance of dementia care and the need for increased awareness of health and social care professionals. The Trust's strategy has been informed by the following:

National Dementia Strategy - published by the Department of Health in 2009, it identifies improving dementia care and services as a key national priority. The strategy focused on raising awareness and understanding; early diagnosis and support and living well with dementia.

The Well Pathway for Dementia - designed by NHS England to assist Trusts in planning dementia care and services. The Well Pathway consists of Preventing Well, Diagnosing Well, Supporting Well, Living Well and Dying Well which supports the priorities of the National Dementia Strategy (2009).

Dementia Friendly Hospital Charter - launched in 2015 by the Dementia Action Alliance, the Charter outlines the high level principles that a dementia-friendly hospital should provide and was revised in 2018 to include a section on the important role of the hospital volunteer.

The Prime Minister's Challenge on Dementia 2020 - published in 2015 contains over 50 commitments that together aspire to make England the best country in the world for dementia care and support. It focuses on increasing research, improving care and raising public awareness about dementia.

The Dementia Statements - published in 2017, reflect what people with dementia and carers say are essential to their quality of life.

Dementia Assessment & Improvement Framework - developed in 2017, describes what 'outstanding' care looks like and consists of eight standards to achieve best practice.

10 year NHS Plan - developed by NHS England in 2018, the plan sets out a number of actions to improve detection and care for people with cardiovascular disease and respiratory disease, prevent diabetes and improve stroke services. The aim is to prevent up to 150,000 cases of heart attack, stroke and dementia over the next 10 years.

CURRENT POSITION

The Trust has a dedicated Dementia and Delirium Service which comprises of:

- Lead Nurse/Practitioner
- Clinical Nurse Specialist
- Dementia Nurse/Practitioner
- Nursing Associates
- Dementia and Delirium Assistants
- Dementia Administrator

The Named Nurse, Safeguarding Adults is the Operational Lead for the team who is managed by the Director of Nursing, Safeguarding and Harm Free Care.

The team works across both hospital sites to support the operational delivery of the national dementia agenda, working collaboratively with our tri-borough local authorities and the North East London Foundation Trust (NELFT) to achieve a positive journey for persons living with dementia, and support for their families and caregivers, both within our care settings and the local wider community.

The Trust is signed up to the National CQUIN for Dementia to identify new cases of Dementia in over 75s; the national target of 90% is currently being achieved.

The Trust has successfully implemented the following initiatives within the Care of the Elderly ward environments across both hospital sites with a view to embedding them Trustwide throughout 2019.

- **Butterfly Scheme** - this is a national initiative to improve patient safety and well-being in hospitals. The scheme teaches staff to offer a positive and appropriate response to people with Dementia and/or Delirium.

- **'This is me'** form - this provides information for health and social care professionals to build a better understanding of who the person really is. The form includes space to include details on the person's cultural and family background, events, people and places from their lives, preferences, routines and their personality.

- **Dementia & Delirium Care Plan** - this identifies the individual needs of the person and promotes person centred care.

- **'John's Campaign'** - this recognises the important role of those who care for people who are living with Dementia. The Campaign's purpose lies in the belief that carers should be welcomed and encouraged by staff. The Trust's Carer Policy and Carer Support Plan utilises the ethos of John's Campaign to support carers trust-wide.

- **Dementia Awareness training (Tier 1 & Tier 2)** - is essential training for all Trust staff. A plan is in place to launch Tier 3 training in spring 2019. A Dementia Training Strategy and Training Needs Analysis are currently being developed in line with the national Dementia Training Standards Framework (2018).

- **Holistic Therapies** - there is a range of innovative therapies including Pet Therapy, Twiddle Muffs, Fidget Blankets/Toys and Reminiscence Interactive Therapeutic Activities Screens that are available to provide distraction and comfort for a person living with dementia during their hospital stay.

COMMITMENT ONE:
PATIENT CENTRED CARE

We will deliver individualised care that supports the person living with dementia, their families and caregivers.

We will ensure that in all our care settings reasonable adjustments are made enabling appropriate care and support to be provided.

To achieve this commitment our priority will be to become a dementia friendly organisation.

We will deliver patient centred care by:

- Identifying and inviting persons living with dementia, their families and caregivers, to join our Trust's Dementia Steering Group

- Involving persons living with dementia, their families and caregivers in decision making from admittance to discharge

- Training Trust Volunteers to support nutrition and hydration for persons living with dementia who are in our care, alongside specialist input from Speech and Language Therapists and Dietitians

- Capturing the views of persons living with dementia, their families and caregivers to monitor service implementation and environmental modifications

- Working collaboratively with our facilities contractors to Introduce 'John's Campaign' Trustwide

- Re-launching the Butterfly scheme across our care settings

COMMITMENT TWO:
EDUCATION AND TRAINING

We will ensure that all of our staff have access to dementia awareness training which will be aligned to our Dementia Training Strategy.

By fulfilling this commitment we will be supporting the Prime Minister's Challenge which aims to achieve a dementia friendly community to ensure there is a societal understanding of the impact of dementia.

To achieve this commitment our priority will be to develop a skilled and effective workforce.

We will develop a skilled and effective workforce by:

- Providing simulation training for staff to enable them to experience living with dementia
- Facilitating peer observation on wards from each of our Divisions covering various aspects of care delivery
- Enhancing the skills and knowledge of our ward based Dementia Champions Trustwide
- Developing a Dementia Training Strategy and Training Needs Analysis to ensure our staff have the skills and knowledge appropriate to their role and responsibilities

COMMITMENT THREE:
ENVIRONMENT

We will ensure the care environment is comfortable and supportive, promoting patient safety and quality of life.

This commitment will embrace the five overarching principles that are identified to support a dementia friendly environment in Acute Trusts which are familiarity, legibility, meaningful activity, orientation and wayfinding. Of these principles, each has suggested elements that can support and encourage patients in a care environment.

A dementia friendly care environment will be promoted across our organisation by:

- Ensuring established initiatives are in place on our care of the elderly wards are introduced across all care settings within the Trust, for example picture toilet signage, easily visible large face clocks and non-reflective flooring
- Setting up a Task & Finish Group to drive forward identified improvement plans such as adapted cutlery, pictorial menus and noise reduction
- Participating in national audits relevant to dementia in order to benchmark against agreed minimal standards for a dementia friendly hospital environment
- Exploring the potential for designated quiet areas in our Emergency and Outpatient Departments to reduce anxiety for our patients living with dementia

Remember the me in dementia

COMMITMENT FOUR:
COMMUNICATION

We will work in partnership with families and caregivers to gather accurate information about the person living with dementia and their needs to develop positive relationships of care.

We will support our staff in communicating with patients living with dementia and their families and caregivers by:

- Re-launching the 'This is Me' form across all our care settings, and the introduction of the 'Life Collage' which offers a visual alternative to the 'This is Me' form promoting choice and appropriate reasonable adjustments for the person living with dementia, their families and caregivers

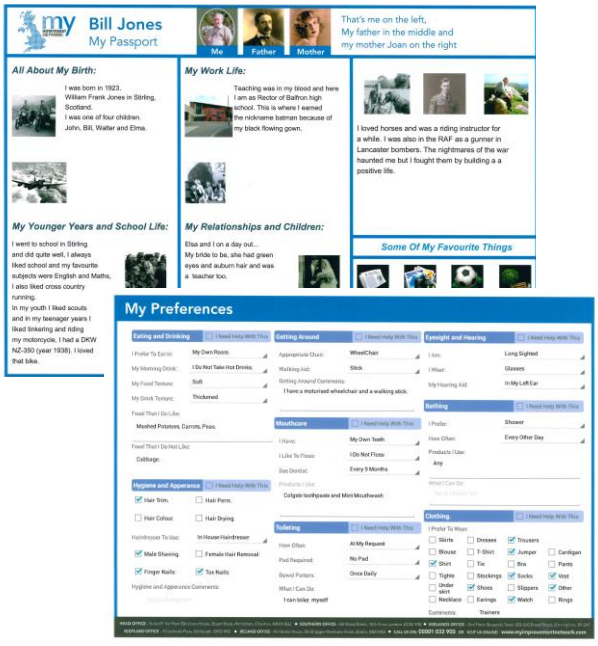
- Making the 'This is Me' form/Life Collage, where utilised, an integral part of the 'Red Bag' which accompanies persons living with dementia on their discharge back to their care home

- Utilising electronic alerts to ensure the journey for the person living with dementia is smooth and stress free throughout our Trust

- Ensuring that persons living with dementia are given all opportunities to communicate their wants and wishes and be involved in decision making via any means of communication possible. Where necessary it should be ensured that advice is sought from Speech and Language Therapists to provide specialist communication support/interventions

- Sourcing information from external agencies for persons living with dementia, their families and caregivers to assist informed decision making about current care needs and future planning

- Utilising the Carer Support Plan as an effective tool for communication between staff and carers who are staying on the ward to provide support for the person living with dementia



COMMITMENT FIVE:
PARTNERSHIP WORKING

We will work collaboratively with external organisations to provide individualised care for persons living with dementia ensuring support is available both for them as a patient and their families/caregivers.

We will promote partnership working by:

- Establishing a stronger relationship with the Alzheimer's Society in order to refer from hospital based services on to other available relevant services
- Re-establishing Dementia Café mornings with a view to joint hosting with the Alzheimer's Society
- Liaising with the Barking, Havering and Redbridge Clinical Commissioning Group with regards to the wider community training provision
- Exploring support forums for families and caregivers by way of external partners providing regular information events on Trust Premises and establish a Dementia Working Group
- Promoting awareness of the availability of Carer Assessments

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COMMITMENT SIX:
END OF LIFE CARE

We will promote a dignified and supportive environment for the person living with dementia, their families and caregivers, at the end of their life.

We will achieve dignified and supportive end of life care by:

- Promoting advanced care planning
- Ensuring our healthcare professionals have the right skills, knowledge and confidence to support open and honest conversations between persons living with dementia, their families and caregivers
- Providing regular staff opportunities to discuss end of life care with persons living with dementia, their families and caregivers
- Exploring with the tri-borough local authorities how we can work collaboratively to create the right place for persons with dementia to die that encompasses appropriate end of life care and support for their families and caregivers

IMPLEMENTING THE TRUST'S DEMENTIA STRATEGY

Each of the commitments will be individually owned and operationally progressed by Trust professionals who have experience and/or a special interest in that area. An overarching, detailed action plan will be aligned to the strategy identifying how these commitments will be achieved.

Delivery of this strategy will be overseen by the Dementia Steering Group, who will be responsible for monitoring the progress of the overall delivery of the identified actions. Progress will be reported to the Trust's Dementia Steering Group and the Trust's Safeguarding Strategic & Assurance Group bi-annually.

CONCLUSION

In summary, this Strategy provides a framework that will ensure a cohesive approach to the continued development of services that are relevant to and meet the individual needs of people with dementia when receiving care in the Trust's hospitals. Effectively implemented it will move the organisation closer to the achievement of its ultimate vision:

To provide person-centred care that preserves dignity and supports the person living with dementia, their family and caregivers.

We will be a Dementia Friendly Trust providing environments that promote a positive experience for the person living with dementia across our acute services.

REFERENCES

Dementia Action Alliance (2015), Dementia-Friendly Hospital Charter (Updated in 2018)
Dementia Statistics Hub (2018)
Department of Health (2017), Dementia Assessment & Improvement Framework
Department of Health (2009), National Dementia Strategy
Department of Health (2015), The Prime Minister's Challenge on Dementia 2020
NHS England (2009), The Well Pathway for Dementia
NHS England (2018), 10 Year NHS Plan
NICE (2018) Dementia: Assessment, Management and Support for People Living with Dementia and their Carers

WITH THANKS

The Director of Nursing, Safeguarding & Harm Free Care and the Dementia Team would like to thank everyone who has contributed to the development of this strategy.

With thanks to the Director of Nursing and Quality, Blackpool Teaching Hospitals NHS Foundation Trust for agreeing to share the powerful "*remember the me in dementia*" strap line.

Thank you to My Improvement Network for printing the strategy.

This document is available in alternative formats on request. Please contact:

The Chief Nurse's Office
Trust Headquarters
Queen's Hospital
Rom Valley Way
Romford
RM7 0AG

01708 435000

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Development of Primary Care Networks in Havering
Board Lead:	Dr Atul Aggarwal, Chair, Havering CCG
Report Author and contact details:	Sarah See, Director, Primary Care Transformation, Barking & Dagenham, Havering and Redbridge CCG

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

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

SUMMARY

The attached slides provide information regarding the development of Primary Care Networks across Havering.

RECOMMENDATIONS

The Board are asked to note and support the ongoing development Primary Care Networks, as part of the Barking & Dagenham, Havering and Redbridge (BH)R Integrated Care System.

Havering
LONDON BOROUGH

REPORT DETAIL

The NHS Long Term Plan and the GP Contract reforms set the direction of travel for primary care over the next five years. Essentially the ambition of the NHS is to dissolve the divide between primary care and community health services by delivering new service models in which patients receive more options, better support, and properly joined-up care at the right time delivering optimal care. The plan also recognises the need to redistribute funding flows and reform contracts to enable more robust care organisation structures.

One outcome will be the establishment of Primary Care Networks (PCNs) with general practice at the centre of these networks. Practices will come together serving populations that are geographically aligned, based around natural local communities, typically serving populations of 30,000+ . That is, PCNs should be small enough to maintain the traditional strength of general practice, but large enough to provide resilience and support the development of integrated teams.

As set out in 'Investment and evolution: a five-year framework for GP contract reform to implement The NHS Long Term Plan', all participating practices were required to sign a mandatory network agreement and submit a registration form to ensure that they meet the minimum national requirements and be eligible to claim financial entitlements under the PCN arrangements (such as workforce reimbursement and core funding) and any Directed Enhanced Services.

It can be confirmed that all the practices across Havering are aligned to a primary care network. The identified networks for each CCG are:

Havering – 4 PCNs:

- North Network – list size 82,231 (14 practices)
- South Network – list size 106,280 (17 practices)
- Marshall Network – list size 47,990 (4 practices)
- Havering Crest Network – list size 42,663 (8 practices)

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

Primary Care Network Development in Havering

Jordanna Hamberger – Primary Care Delivery Manager
Emily Plane – Head of Primary Care

24 July 2019

Why Primary Care Networks?

- PCNs are the key building block of the NHS Long Term Plan.

- ‘At scale’ general practice has been a policy priority for a number of years, alongside the aspiration to create more integrated health and care systems where services are aligned around the needs of local people.

General Practice is currently experiencing pressure in relation to:
- Workforce; recruitment and retention
- Workload; significant workload pressure
- Quality and variation
- Increasing demand in relation to leading change / transformation

- There are a number of benefits to primary care at scale, both to GPs (improved ability to recruit and retain staff, management of financial and estates pressures), and to the wider system / range of services (ability to more easily integrated primary care at scale with the wider health and care system).

- Whilst GP practices have been finding different ways of working together – eg in super-partnerships, federations, clusters and networks – the NHS long-term plan and the new GP contract (April 2019), puts a more formal structure around this way of working, without creating new statutory bodies

Primary Care Networks in Havering

- To serve populations of **30,000-50,000+**; formed around '**natural communities**' or '**defined populations**' based on GP registered lists

- **Small enough to provide personal care** - valued by both patients and GPs - but **large enough to enable deeper collaboration** between practices and others in the local health & social care system

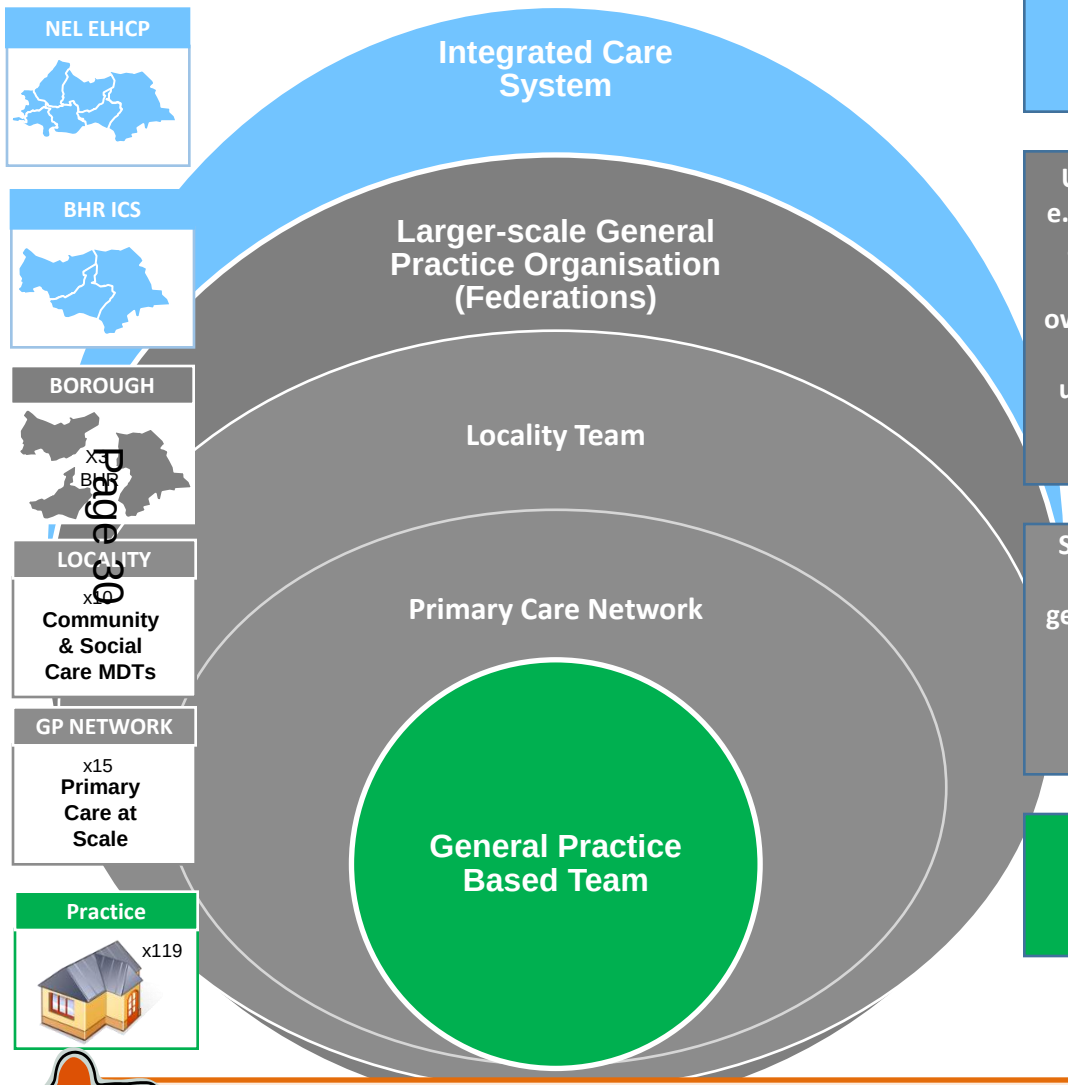
- Will provide a **platform for providers** of care **being sustainab**le into the longer term and are the **building blocks for an integrated care system** (ICS)

- Requires **100% geographical coverage**

- Every **ICS** will have a critical role in ensuring that **PCNs work in an integrated way** with other health & care community staff

There are now 15 Primary Care Networks across BHR, and three GP Federations:
- Barking & Dagenham – 6 PCNs
- Havering – 4 PCNs
- Redbridge – 5 PCNs

Primary Care Networks in context; where do the Federations and GP Networks sit



General practice as the foundation of a wider Integrated Care System, working in partnership with other health and care providers to collaboratively manage and provide integrated services to a defined population within a shared budget

Usually at a borough level and often a single formal organisation e.g. Federation, this is the platform to provide the scale to develop and train a broad workforce, create shared operational systems and quality improvement approaches including use of locally owned data, support the delivery of collective back office functions to reduce waste and enhance efficiency, develop integrated unscheduled and elective care services for the whole population, and provide professional leadership and the 'voice for general practice in the local health economy

Serving populations of 30,000 – 50,000, bringing together groups of practices and other community providers around a natural geography. Support multi disciplinary working to deliver joined up, local and holistic care for patients. Key scale to integrated community based services around patients' needs who require collaboration between service providers and long-term care coordination

General practice as the foundation of a wider Integrated Care System, working in partnership with other health and care providers to collaboratively manage and provide integrated services to a defined population within a shared budget

The **Primary Care Network** model is at the core of both the development of General Practice in its own right, and as the foundation of place-based, integrated care. The **GP Federations** are a key platform to expand on the benefits of PCNs and enable further commissioning and to achieve economies of scale at both a borough (single GP Federation) and multi borough (e.g. three BHR Federations working together) level

The BHR Integrated Care System – What are we trying to achieve

System challenges

Health and wellbeing challenges

Care and quality challenges

Funding and efficiency challenges

Corporate Objectives

- Securing financial recovery
- Development of an accountable care system
- Delivery of our CCG and system-wide transformation programmes for planned, urgent and emergency, complex and mental health care
- Continued implementation of our agreed Primary Care Transformation Strategy
- High quality safe and compassionate care from all commissioned services. - delivering better outcomes.

BHR CCGs; *High impact transformation areas targeted to address key challenges using principles of integrated care vision*

Prevention	Primary care	Planned care	Unplanned care
Moving care upstream to prevent deterioration, includes wider determinants of health. Focussed on prevention of disease and ill health	Develop primary care at scale including workforce and supporting delivery of more integrated care through GP Fed development	Care in right place, first time, reducing inappropriate activity, and improving effective decision making	Reducing inappropriate demand, admissions and ensuring appropriate length of stay (reducing delayed discharges)
Older people, frailty & end of life			
Children & Young People			
Long term conditions			
Mental health			
Medicines optimisation			
Maternity			
Cancer			

BHR Joint Commissioning Board; *Developing cross system strategic commissioning to deliver integrated care system vision*

- **Frailty**
- **To be scoped**
- **Diabetes & AF**

Key enablers including:

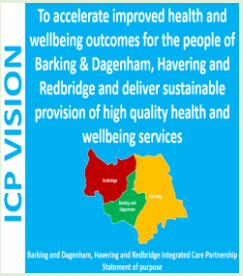
- Develop Joint Commissioning opportunities
- Population Health management
- New digital platform
- Robust workforce plan
- Robust comms and engagement
- Fit for purpose estates

Barking Riverside; place based care model

BHR Provider Alliance

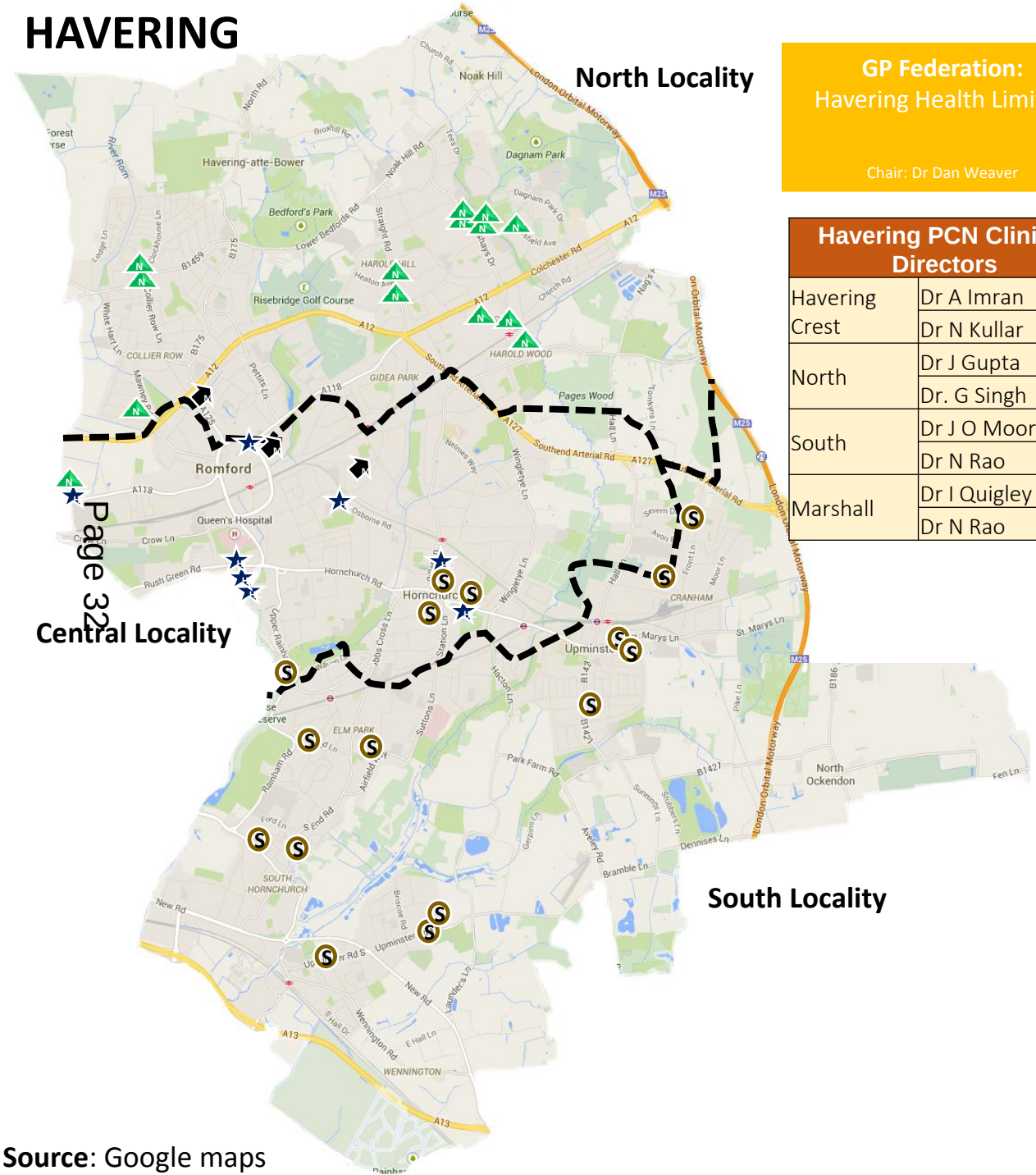
Development of Integrated Care System delivery model

Vision



New delivery model achieving improved health and wellbeing outcomes for local people

HAVERING



GP Federation:
Havering Health Limited

Chair: Dr Dan Weaver

Havering PCN Clinical Directors	
Havering Crest	Dr A Imran
	Dr N Kullar
North	Dr J Gupta
	Dr. G Singh
South	Dr J O Moore
	Dr N Rao
Marshall	Dr I Quigley
	Dr N Rao

Havering Crest Primary Care Network: 8 practices List size 42,663		
F82031	Rush Green Medical centre , Dr Samoni	4838
F82675	Billet Lane Surgery	3831
F82039	Dr Poolo	3502
F82638	Modern Medical Surgery	5830
F82011	St. Edwards Surgery (formally mawney medical)	10856
F82019	The Upstairs Surgery (Dr Imran)	6902
F82023	Dr Pervez High Street Surgery	3333
F82663	Dr Marks	3571
		42,663

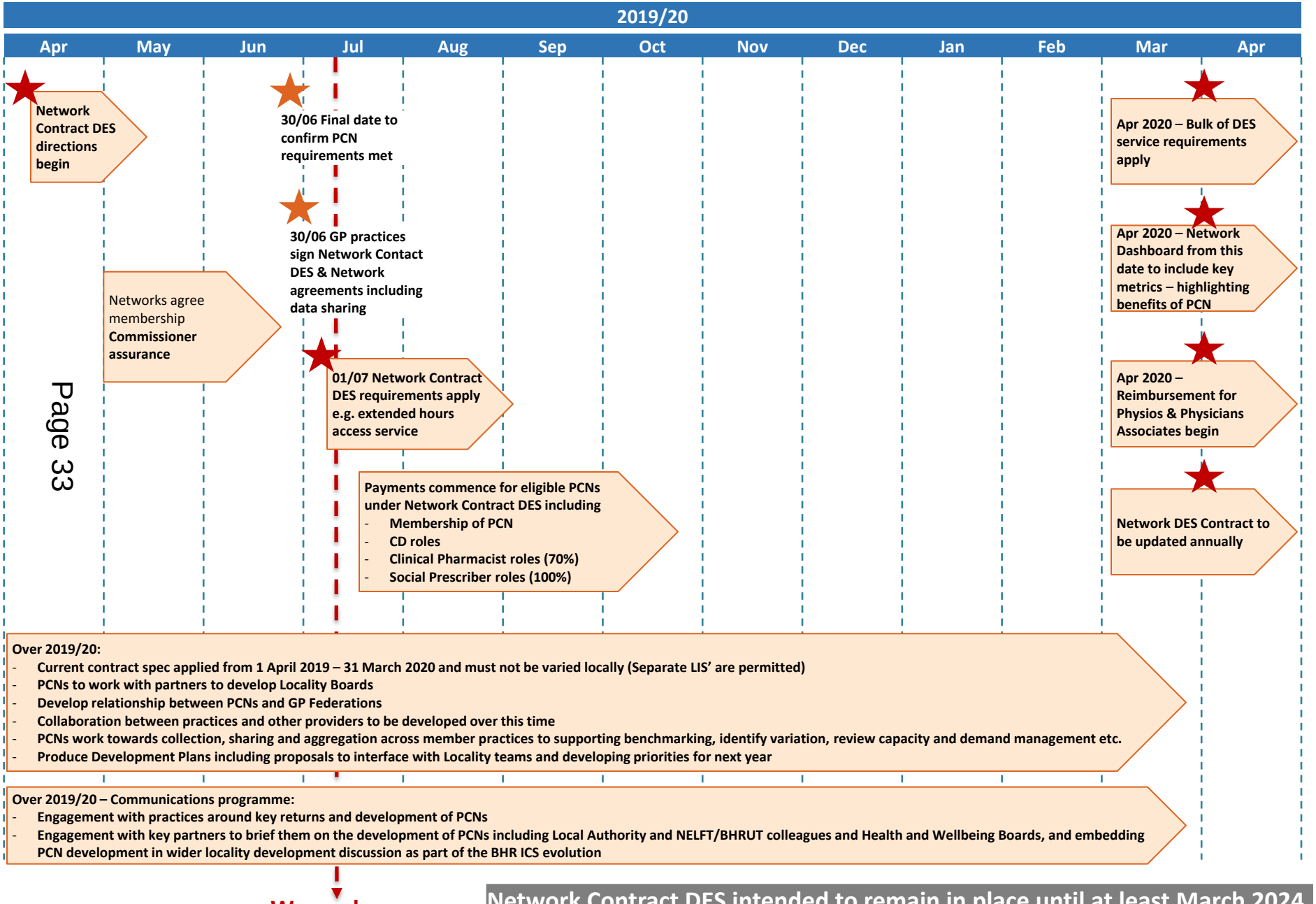
North Primary Care Network: 15 Practices List size 82,231		
F82671	Dr J Gupta & Dr Prasad Straight Rd Surgery	2762
F82007	Greenwood Surgery	11732
F82010	Petersfield Surgery	7428
F82045	Dr Choudhury	3335
F82610	Dr N Gupta	2969
F82014	Harold Hill H/C Dr Kucchai	7178
Y02973	Kings Park Surgery	7812
F82670	Harold Hill H/C Dr Jabbar	2660
Y00312	Robins Surgery	4729
F82016	Central Park	7457
F82030	Lynwood Medical Centre	12141
F82630	Chase Cross Surgery	5933
F82648	Ingrebourne Surgery	3007
F82686	Dr A Patel	3088
		82,231

South Primary Care Network: 17 Practices List size: 106,280		
F82008	Maylands Health Care	14549
F82624	Upminster Medical Centre (Dr O'Moore)	3798
F82614	South Hornchurch Clinic	3190
F82619	Harlow road Surgery	2001
F82002	Haiderian Medical Centre	6288
F82028	Wood Lane Surgery	8448
F82006	Dr Dhas and Humberston	11824
F82033	Dr V M Patel	3776
F82609	Dr P Patel	4522
F82055	Hornchurch Healthcare	6909
F82607	Spring Farm	5058
F82627	Dr Abdullah	5191
F82666	Dr Rahman and Tsoi	4264
F82674	Avon Rd Cranham H/C	5155
F82649	Berwick Surgery	4653
F82053	Upminster Medical Surgery Dr Baig	4230
F82022	Rosewood Surgery	12424
		106,280

Marshall Primary Care Networks: 3 Practices List size 47,990		
F82013	Western Road Surgery	17129
F82009	North Street Medical Centre	18457
F82021	The New Medical (Dr M Edison)	9747
F82639	Dr Joseph Surgery list has been taken on by North Street practice Romford	2657
		47,990

Source: Google maps

Key milestones



Funding to support Primary Care

Payment details and allocation	Amount	Allocations	Payment timings
1. Core PCN funding	£1.50 per registered patient per year (equating to £0.125 per patient per month)	CCG core programme allocations	▪ Monthly in arrears from July 2019 ▪ The first payment (to be made on or by end July 2019) will cover the period 1 April to 31 July. ▪ Subsequent payments will be made monthly in arrears.
2. Clinical Director contribution	£0.514 per registered patient to cover July 2019 to March 2020 (equating to £0.057 per patient per month)	PMC allocations	▪ Monthly in arrears from July 2019. ▪ First payment to be paid on or by end July 2019 and thereafter on or by the last day of each month.
3. Staff reimbursements ▪ Clinical pharmacists ▪ Social prescribing link workers	Actual costs to the maximum amounts per the Five-Year Framework Agreement	PMC allocations	▪ Reimbursement payable on or by the last day of the following month (for example, July 2019 payment to be made on or by end August 2019) ▪ Payable once staff are in post
4. Extended hours access	£1.099 per registered patient to cover period July 2019 to March 2020 (i.e. equating to £0.122 per patient per month) NB: This amount is pro-rata from £1.45 over 12 months	PMC allocations	▪ Monthly in arrears ▪ First payment made for July to be made by end of July 2019. ▪ Subsequent payments made on or by the end of the relevant months.
5. Network Participation payment	£1.761 per registered patient per year (i.e. equating to £0.147 per patient per month)	PMC allocations	▪ Monthly variation to Exeter as 12 equal payments

Funding to support Primary Care by PCN

PCN Network	Extended Hours	Clinical Director	Social Prescriber	Clinical Pharmacist	PCN Support (£1.50)	Practice Participation Payment	
Cranbrook	54,375.22	25,431.18	34,113.00	48,231	74,215.50	74,847.08	
Fairlop	68,207.24	31,900.38	34,113.00	48,231	93,094.50	100,575.09	
Loxford	68,013.81	31,809.92	34,113.00	48,231	92,830.50	94,411.03	
Seven Kings	80,534.72	37,665.92	34,113.00	48,231	109,920.00	111,302.90	
Wanstead & Woodford	88,501.37	41,391.91	34,113.00	48,231	120,793.50	127,316.39	
Redbridge Total	**£359,632.36**	**£168,199.30**	**£170,565.00**	**£241,153.50**	**£490,854.00**	**£508,452.49**	**£1,938,856.65**
East	43,885.27	20,525.05	34,113.00	48,231	59,898.00	63,515.47	
East One	40,953.14	19,153.70	34,113.00	48,231	55,896.00	63,165.74	
New West	34,427.27	16,101.56	34,113.00	48,231	46,989.00	49,684.49	
North	47,491.09	22,211.48	34,113.00	48,231	64,819.50	73,685.22	
North West	36,052.70	16,861.77	34,113.00	48,231	49,207.50	54,315.00	
West	47,585.60	22,255.69	34,113.00	48,231	64,948.50	69,479.92	
B&D Total	**£250,395.06**	**£117,109.25**	**£204,678.00**	**£289,384.20**	**£341,758.50**	**£373,845.84**	**£1,577,170.85**
Havering Crest	46,849.27	21,911.31	34,113.00	48,231	63,943.50	73,487.11	
Marshall	50,129.79	23,445.60	34,113.00	48,231	72,363.00	81,337.88	
North	91,430.21	42,761.72	34,113.00	48,231	124,791.00	143,958.31	
South	117,267.70	54,845.86	68,226.00	96,461	160,056.00	181,727.94	
Havering Total	**£305,676.96**	**£142,964.47**	**£170,565.00**	**£241,153.50**	**£421,153.50**	**£480,511.24**	**£1,762,024.67**

* Social Prescriber Based on Band 5 19/20 Salary (Note South Network has over 100k)

* Clinical Pharmacist based on 70% reimbursement (Note South Network has over 100k)

PCNs will begin to receive their ‘staff reimbursements’ once the new staff are in post – the figure noted is the maximum available based on the staff being in post from July 2019 – March 2020

Role of the PCN Clinical Director

- PCN required to appoint a named accountable Clinical Director; via a selection process, needs to be a practising clinician from within PCN member practices. Can be a job share
- Accountable to the PCN members – provide leadership for PCN strategic plans, work to improve quality & effectiveness of services
- Represents respective PCN's collective interests, and works collaboratively with other PCNs within the ICS/STP
- A role in shaping & supporting ICS/STP, ensuring full engagement of primary care in implementing local system plans
- Leading & supporting quality improvement and performance, and the professional lead for QOF Quality Improvement activity
- Strategic lead for workforce development, delivering on assessment of clinical skill mix & development of a PCN workforce strategy
- Support implementation of agreed service changes & pathways) to develop, support & delivery national local improvement programmes aligned to national priorities

What will PCNs doing this year?

Priorities for 2019/20 – 2020/21:

- Ongoing establishment of PCNs
- Work with the BHR Integrated Care Partnership and Haverin Federation to adopt a single system vision, set of values and goals
- Understand the needs of local neighbourhoods/localities to begin to inform current and future service planning further develop PCN Development Plans
- Development of relationship with Federations to support delivery of System Financial Recovery Plan through the Transformation Board Programmes with a focus on Long Term Conditions, Older People and Frailty and Outpatients
- Initiate recruitment of PCN workforce e.g. Social Prescribers and Clinical Pharmacists in 2019/20
- Establish Extended Hours DES across respective
- Begin to prepare for DES' from April 2020:
  - Structured medication reviews
  - Enhanced health in care homes
  - Anticipatory care with community services
  - Personalised care
  - Supporting early cancer diagnosis
- Consider how GP practices and individual GPs within the PCNs will receive key message and engage with PCN priority setting and development going forward

PCN focus from April 2020 / April 2021

DES: A 'DES', or Direct Enhanced Service is a primary medical service other than essential services, additional services or out-of-hours services.

DES	What is it?	Go Live date	New workforce roles in PCNs to support	Linked to Transformation Programme/s
Structured Medication Reviews	▪ aims to optimise use of medicines for some people (such as those who have LTCs or who take multiple medicines) ▪ can identify medicines that could be stopped or need a dosage change, or new medicines that are needed. ▪ can lead to a reduction in adverse events.	April 2020	▪ Clinical Pharmacist	▪ Medicines Optimisation ▪ LTCs ▪ Older People and Frailty ▪ Unplanned Care ▪ Planned Care
Enhanced health in care homes	▪ Access to consistent, named GP and wider primary care services ▪ Medicines review ▪ Hydration and nutrition support ▪ Access to our of hours / urgent care when needed	April 2020	▪ Clinical Pharmacist ▪ Community Paramedic	▪ Older People and Frailty ▪ Unplanned Care ▪ Medicines Optimisation
Anticipatory care with community services	▪ thinking ahead and understanding their health needs of individual people ▪ knowing how to use services better ▪ helps people make choices about their future care. Those with LTCs or chronic health problems can benefit from having an Anticipatory Care Plan.	April 2020	▪ Social Prescriber ▪ Clinical Pharmacist ▪ Physician Associate ▪ Community Paramedic ▪ PCN Physios	▪ LTCs ▪ Older People and Frailty ▪ Unplanned Care ▪ Planned Care ▪ Children &Young people ▪ Mental Health ▪ Cancer
Personalised care	▪ Care tailored to the needs of people and what matters to them ▪ Prevention embedded ▪ Personal Health budgets ▪ Shared decision making is key	April 2020	▪ Social Prescriber ▪ Clinical Pharmacist ▪ Physician Associate ▪ Community Paramedic ▪ PCN Physios	▪ LTCs ▪ Older People and Frailty ▪ Unplanned Care ▪ Planned Care ▪ Children &Young people ▪ Mental Health ▪ Cancer ▪ Maternity
Supporting early cancer diagnosis	▪ Supporting early identification and diagnosis of cancers in primary care to increase life expectancy	April 2020	▪ Physician Associate	▪ Cancer ▪ Unplanned Care ▪ Planned Care
CVD Prevention and diagnosis	▪ Identification of those at risk of developing CVD and embedding programmes of prevention to prevent onset of the disease ▪ Closing the prevalence gap	April 2021	▪ Social Prescriber ▪ Clinical Pharmacist ▪ Physician Associate	▪ Unplanned Care ▪ Planned Care ▪ LTCs
Inequalities	▪ Reducing inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities	April 2021	▪ Social Prescriber ▪ Clinical Pharmacist ▪ Physician Associate	▪ All Transformation Programmes

Key messages:

- Likely to be a marathon not a sprint
- Owned and led by primary care
- Needs to be meaningful to local communities and partners
- Should be the platform to build wider integration
- Must dock into wider ICS to get system benefits
- Must ensure remain focused on the end and the spirit of intent

Questions?

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	BHR CCGs' Long Term Conditions Strategy
Board Lead:	Tracy Welsh/Jeremy Kidd.
Report Author and contact details:	Jeremy Kidd, Deputy Director of Delivery (Planned Care) jeremy.kidd1@nhs.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

This paper sets out the work that is being undertaken on Long Term Conditions. BHR partners are working together to move forward our shared integration aspirations and address system wide issues. A number of clinically led transformation boards have been established to coordinate transformational change across the system that will drive down costs whilst improving both quality and outcomes. Long Term Conditions (LTCs) is one of the transformation boards. As Long Term Conditions have not previously constituted a defined area of work, a strategy document has been developed to understand the key challenges and develop a response to those challenges. (Our detailed LTC Strategy is set out as Appendix 1)

The key challenges are:

1. The gap in prevalence between national forecast levels and local levels of diagnosis

2. The level of activity on long term conditions in a non-elective care setting

A vision and plan to address these challenges has been developed and task and finish groups are in place, overseen by the LTC Transformation Board.

RECOMMENDATIONS

The HWBB is asked to note the report.

Havering
LONDON BOROUGH

REPORT DETAIL

1.0 Purpose of the Report

1.1 This purpose of this report is to present our Long Term Conditions (LTC) Strategy to the HWBB. The strategy document is attached as appendix 1.

2.0 Background/Introduction

2.1 BHR partners are working together to move forward their shared integration aspirations and address system wide issues. This is enacted formally through the BHR Integrated Care Partnership (ICP), which comprises clinical, democratic and officer leaders. The ICP vision is to accelerate improved health and wellbeing outcomes for the people of Barking & Dagenham, Havering and Redbridge and deliver sustainable high quality health and wellbeing services.

2.2 A number of clinically led transformation boards have been established to coordinate transformational change across the system that will improve both quality and outcomes whilst driving down costs. The LTC Transformation Programme was established in April 2019 to co-ordinate transformational change across the conditions that were agreed to be in the scope of the programme in order to improve quality, patient outcomes and to ensure services are as efficient as possible and integrated around the patient. The LTC Transformation Board is chaired by Dr Rami Hara who is BHR CCGs' Clinical Director GP lead for LTCs.

2.3 LTCs have not previously been treated as a defined group of conditions or as a single transformation area. As such it was agreed that an LTC Strategy would be developed to allow the partners to understand the issues and to develop an approach to address them.

2.4 The in scope conditions for the LTC Transformation Board are:

- Diabetes
- Atrial Fibrillation
- Chronic obstructive pulmonary disease (COPD)
- Coronary Heart Disease (CHD)
- Asthma
- Chronic Kidney Disease (CKD)
- Hypertension

3.0 How we have developed our strategy

3.1 The LTC Strategy was developed with the input of a range of organisations across the health and care economy including the CCGs, BHRUT, NELFT, Public Health (with the Director of Public Health for Redbridge leading on behalf of the three

boroughs), Care City and Redbridge CVS. The partners came together with the common recognition that no one partner in the health economy can address the strategic and practical challenges of LTCs alone, and that a joint coordinated approach will be required to effectively identify, treat and support patients with long term conditions in the most appropriate setting of care. In addition the partners acknowledge that as a consequence of an aging population, local demographic factors and lifestyle changes the challenge of LTCs is growing and that action to impact growth , improve health outcomes , and ensure the most efficient use of joint resources to address the challenges of LTCs under these circumstances is required.

3.2 During the development of the strategy, significant work was undertaken to understand the particular challenges faced as a result of these conditions in BHR. At its core, our long term conditions challenges can be articulated in two statements:

- Prevalence Gap – comparison of national data and Quality Outcomes Framework data recorded by GPs demonstrates that there is a difference between the numbers of patients diagnosed with LTCs when compared to national forecast data. Patients who are not diagnosed and are not aware that they have a condition will not be accessing the appropriate support and treatment and are therefore at risk of their condition deteriorating and/or of accessing treatment, non-electively as a result. In addition as a result of an aging population and changing lifestyles the prevalence of all in scope conditions is increasing.

- Settings of Care - Analysis was carried out focusing on cardiology and diabetes LTCs to understand the burden of cost as a result of LTCs. This demonstrated that a very high proportion of spend on LTCs is spent on non-elective care. While it is recognised that this may be in part due to the relatively higher cost of non-elective care (as opposed to elective treatment) it is indicative of the fact that we are seeing more patients being admitted to hospital as non-elective admissions, some of which may be avoidable.

3.3 A clear vision for LTCs has been developed in response to these challenges which includes the development of common/single pathways for patients with multiple LTCs, a renewed emphasis on empowering the patient to manage their own condition and improving diagnosis rates.

3.4 The programme of work set out in our LTC strategy is grouped into four thematic areas:

1. Early Identification
2. First Response
3. Managing Well
4. Patients with complex needs who may have more than 1 LTC

To deliver this vision, two task and finish groups and a number of sub-groups underneath them have been established, with participation from clinicians and officers from across the BHR system.

3.5 It is noted that the strategy represents the starting point for ongoing work on LTCs, which will be directed by the LTC Transformation Board.

3.6 We will engage with patients and carers when required to ensure that our work is based on feedback from the latter groups. We are in the process of completing a patient friendly version of our strategy which will outline in simple terms our offer to our local populations.

IMPLICATIONS AND RISKS

4.0 Resources/investment

There are no financial or resource implications arising from the report. However there will be financial implications from implementing the identified initiatives within the strategy, therefore individual business cases will be developed for each of the initiatives.

4.1 Risks

A risk register is included in the strategy document, Individual business cases will also include a project specific risk register. The strategic risks are outlined below:

- There is a risk that the proposed model of care/interventions across our LTC programme of work does not stem the flow of activity into secondary care and may actually increase activity. **Mitigation:** Development of clinical pathways and referral criteria, MDTs for more complex cases and encouraging patients to self-care
- As there are a number of detailed programmes of work emerging from the LTC strategy, there is a risk of insufficient capacity to deliver the work to timescales. **Mitigation**: Senior project manager now in post, task and finish groups established, project support now in place
- Detailed programmes of work emerging from the LTC strategy requires coordination between and across organisations. There is a risk to delivery to timescales as a result of the need to work across multiple partners. **Mitigation:** establishment of task and finish groups attended by all relevant organisations, with the Transformation Board providing oversight
- Detailed programmes of work emerging from the LTC strategy require significant financial investment which may not yield the expected returns (ROI**). Mitigation**: detailed financial modelling will be undertaken for most schemes. Where investment is needed, business

cases will be subject to due diligence as part of the approval processes.

4.2 Equalities

There are no equalities implications arising from this report. Individual business cases will be developed for each of the initiatives, which will include an Equability Impact Assessment

BACKGROUND PAPERS

1. LTC Strategy Document- Appendix 1

NHS
Barking and Dagenham, Havering and Redbridge
Clinical Commissioning Groups

Long Term Conditions Strategy

Scope

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

The conditions within the scope of this strategy are set out below. Local and national data demonstrates a growth in the prevalence of all of these conditions, and with it an increase in cost. A coordinated strategic approach is required to impact growth rates, improve care and deliver savings.

Diabetes – A lifelong condition that causes a person's blood sugar level to become too high. It's important for diabetes to be diagnosed as early as possible as it can get progressively worse if untreated. It can also lead to heart disease and stroke, nerve damage, vision loss and blindness and kidney problems.

Atrial Fibrillation - A heart condition that causes an irregular and often abnormally fast heart rate. Those with AF are at increased risk of having a stroke and in extreme cases, it can lead to heart failure.

Chronic obstructive pulmonary disease (COPD) – A group of lung conditions that cause breathing difficulties, typically affecting middle-aged / older adults who smoke. COPD is irreversible but can be managed to slow progression and control the symptoms.

Coronary Heart Disease (CHD) – A major cause of death when the heart's blood supply is blocked often due to a build up of fatty substances in the coronary arteries. This can be caused by hypertension, diabetes, high cholesterol and smoking.

Asthma – A common lung condition which causes breathing difficulties through inflammation of the breathing tubes that carry air in and out of the lungs. Whilst it can be kept under control, it's still a serious condition that can cause stress, anxiety, or lung infection.

Chronic Kidney Disease (CKD) – A condition often associated with getting older where kidneys do not function optimally. This is often caused by high blood pressure, diabetes, kidney infections, and long term / regular use of certain medicines

Hypertension – A condition which rarely has noticeable symptoms. But if untreated, it increases risk of serious problems such as heart disease, heart attack, kidney disease, or strokes.

Case for change

Prevalence Gap

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

There is a significant gap between the expected number diagnosed patients in the population compared to those patients actually identified with LTCs. There is a risk that patients are not diagnosed early, and do not access treatment earlier in the course of their condition resulting in avoidable unplanned care in the future. In addition as a result of an aging population and changing lifestyles the prevalence of all in scope conditions is increasing.

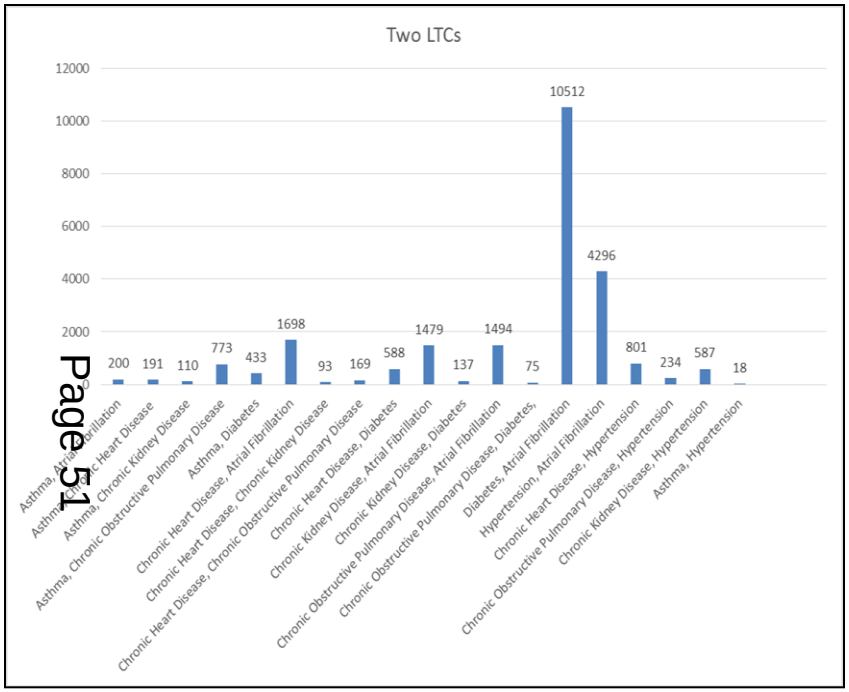
		Borough level prevalence gap		
LTC	Expected Prevalence in BHR	B&D CCG (pts)	Havering CCG (pts)	Redbridge CCG (pts)
Diabetes	14,019	624	5,983	7,412
AF	6,884	1,456	2,720	2,668
COPD	10,323	3,327	4,624	2,372
Asthma	36,556	9,567	13,055	13,934
CKD	23,028	4,367	10,063	8,598
Hypertension	68,206	14,350	27,470	26,386

- The overall population of BHR is 776,419, which has been used to calculate the figures shown in the table
- There is a risk of continued increase in diagnosis and patient gap if there is not imminent change

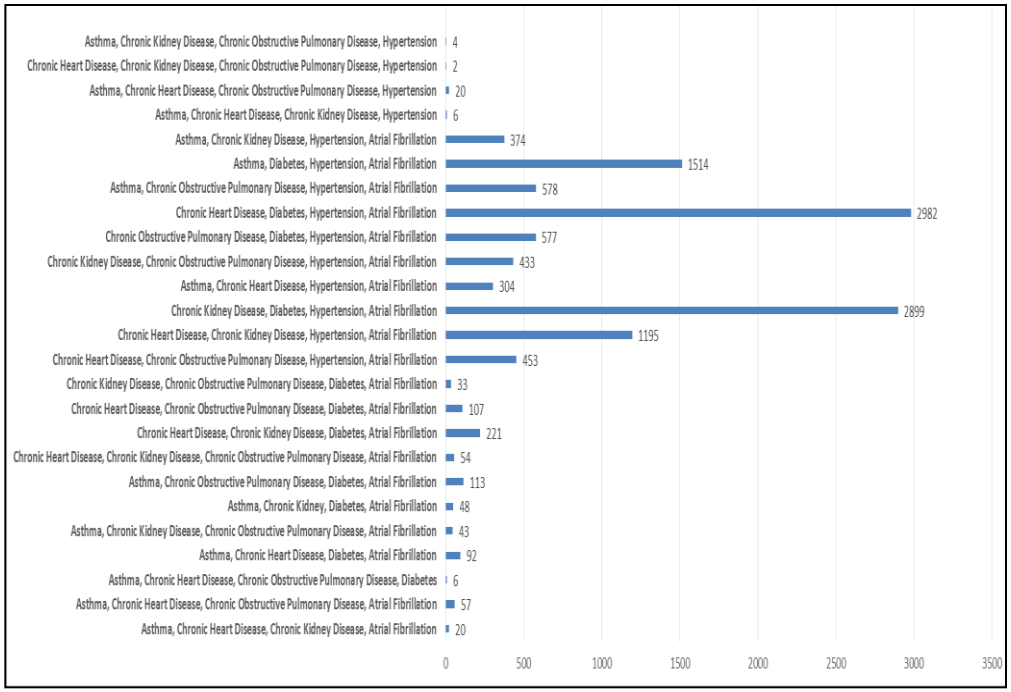
Multimorbidity

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

Patients with Two LTCs



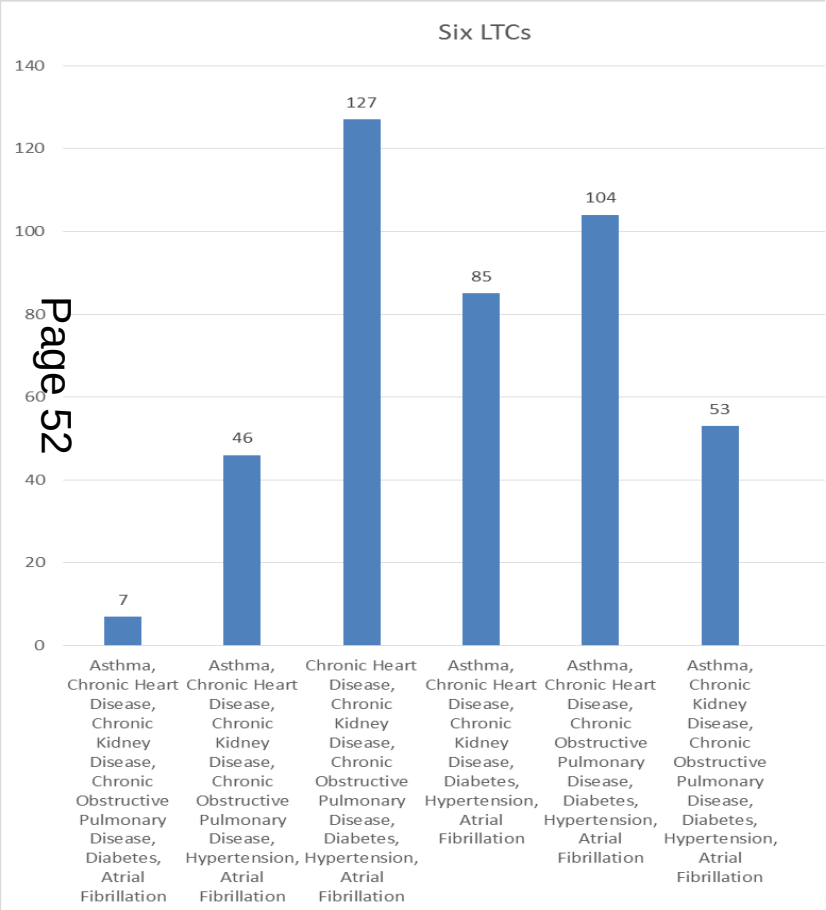
Patients with Four LTCs



- The most common combination affecting more than 10,000 patients is the combination of AF and Diabetes.
- The second highest combination is Hypertension and AF affecting 4,296 patients.
- CHD, CKD and COPD all contribute to the next three highest combinations

- More than 2,900 patients have a combination of CHD, Diabetes, Hypertension and AF
- Over 2,800 patients have a combination of CKD, Diabetes, Hypertension and AF
- COPD continues to be a condition affecting patients with Asthma

Patients with Six LTCs



- CHD, CKD, COPD, Diabetes, Hypertension and AF are the leading six combinations
- Asthma, CHD, COPD, Hypertension and AF is the second highest affecting patients.
- These are your complex, expensive cases for the health system

Whole System burden of LTCs

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

This analysis includes admissions for both planned (day cases and electives) and unplanned (non-elective) for age group 18+ in BHR CCGs. The analysis is based on SUS+ data and Long term conditions are based on HRG codes identified by clinical leads. The long term conditions shown in this analysis are related to cardiovascular and diabetes conditions only.

Highlights

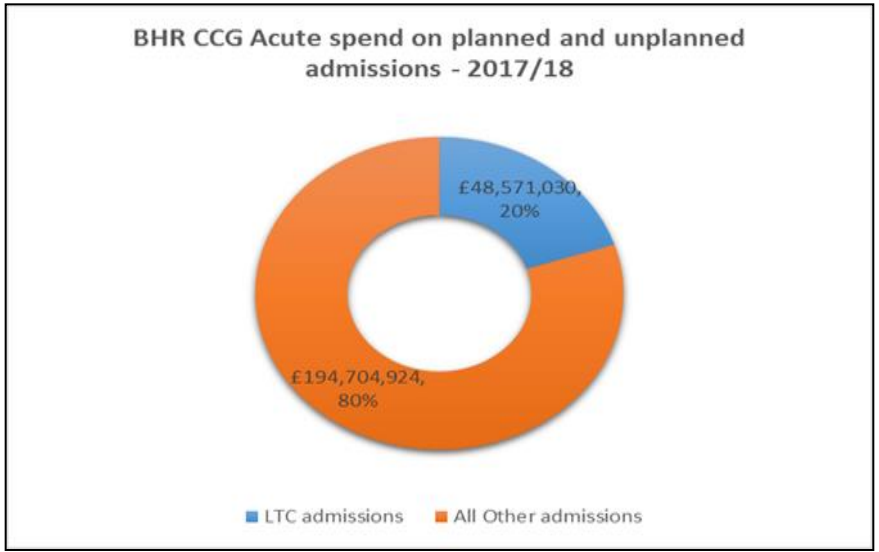
•BHR CCGs total spend for admissions both planned and unplanned in 2017/18 is £243m; of which £49m is related to admissions for long term conditions (LTC) (20%). Of the £49m spend for LTC

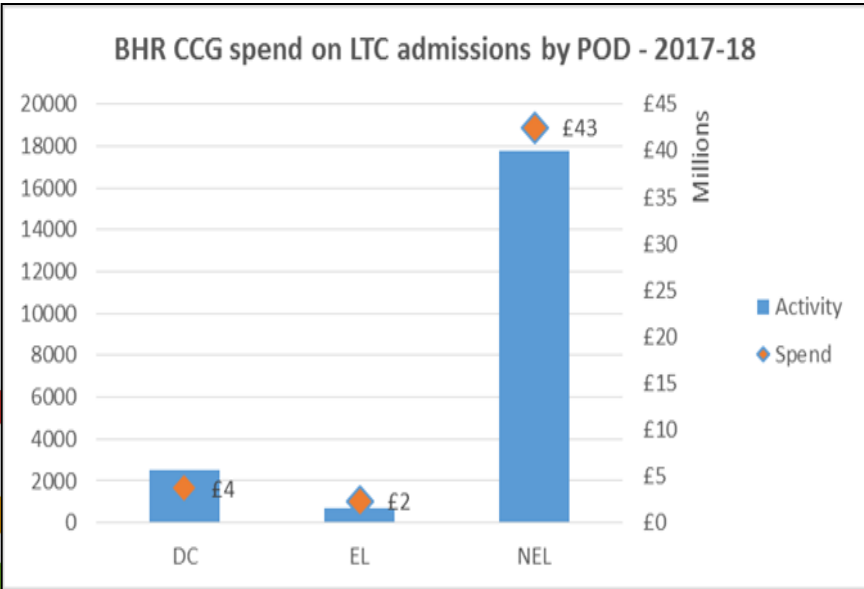
- 7.7% (4m) is attributed to day cases (DC),
- 4.8% (£2m) to elective admissions,
- 87.5% (£43m) is attributed to non-elective admissions.

Planned admissions: Day cases (DC) and Elective (EL) admissions

•Of the £4m spend in day cases, majority of the spend is around cardiac (78%), vascular procedures and disorders (8%), eyes and periorbital (6%).
•Of the £2m spend in elective admissions, majority of the spend is around vascular procedures and disorders (41%), cardiac (24%) hepatobiliary and pancreatic system (13%).

The charts on the right shows the percentage distribution of admissions related to LTC conditions and all other admissions by provider.



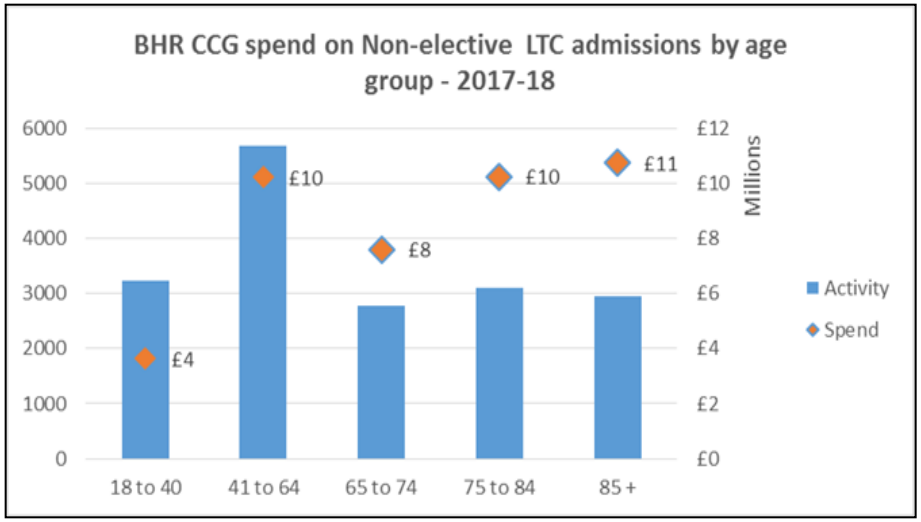


Whole System burden of LTCs

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

Non-elective admissions

- 67% (£29m) of the non-elective spend in 2017/18 are for admissions related to 65+ age category, of which nearly 50% are for the 75+ age group.
- 33% (£14m) of the non elective spend are for admissions for working age group (age group 18-64).
- There is an increasing trend in 17/18 and 18/19 (based on M6 forecast) toward non-elective admissions related to long term conditions across all age groups.



Non-elective admissions	Age_Categories	2015/16	2016/17	2017/18	2018/19 M6 FOT	movement from 15/16 to 16/17	movement from 16/17 to 17/18	movement from 17/18/to 18/19
No of admissions for LTC	18 to 40	1139	1098	1179	1216	-4%	7%	3%
	41 to 64	2751	2593	2827	2904	-6%	9%	3%
	65 to 74	1397	1467	1672	1844	5%	14%	10%
	75 to 84	1846	1876	2125	2402	2%	13%	13%
	85 +	1441	1639	2040	2090	14%	24.5%	2.5%
All other admissions	18 to 40	12902	12658	12774	13238	-2%	0.9%	3.6%
	41 to 64	13511	12790	13374	14316	-5%	4.6%	7.0%
	65 to 74	6505	6132	6517	6694	-6%	6.3%	2.7%
	75 to 84	8073	7738	8040	8390	-4%	3.9%	4.4%
	85 +	7859	7748	9120	9710	-1%	17.7%	6.5%

Conclusions

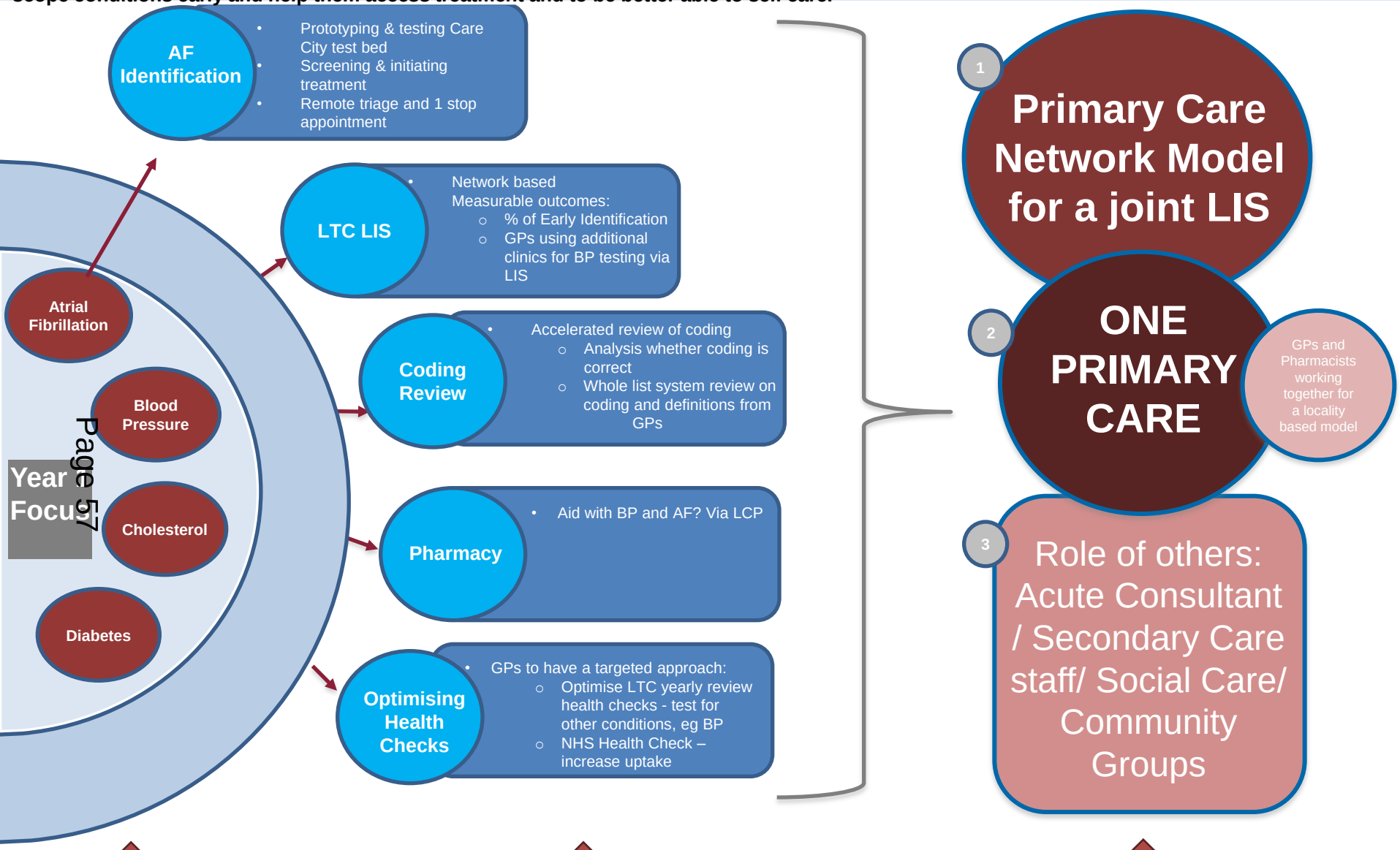
Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

1. Increasing prevalence is a growing challenge with more and more people having a condition and not being identified / managed at an earlier stage, leading to unplanned care and possible admission.
2. The need to shift care from NEL to elective, this focus on proactive care and patient empowerment will drive better outcomes and deliver financial savings across the system.
3. Year one focuses on Diabetes and Cardiology
4. Strategic focus at national level

Model of Care Overview

Early Identification

Early identification and proactive disease management are key to tackling high hospital admissions, this strategy aims to identify people with in scope conditions early and help them access treatment and to be better able to self care.



Year 1 focus on four key areas

Interventions that support Early Identification

How would we deliver

First Response

This element of the strategy deals with the first contact a health Profession has with a newly diagnosed patient. This is the first opportunity to provide support, enable self-care and provide management. The aim is to have a comprehensive set of tools and enablers we would provide to a person.

1. Identifying ability to self manage (levels of activation using self assessment questionnaire)

Options (TBC)
1. Patient Activation Measure (PAM) High/Medium/Low
2. Well-being Star

2. Care Planning

- Goals
- Plan
- Activate

- What is the outcome and process for the patient?
- Time to sit and co-develop care plan with patient.
- It could 20-30 minutes session or more.
- GP/Other trained professionals
- Utilising Network LIS
- What enabling support can be offered?

One Primary Care Network Model

Roles of others Acute Consultant / Secondary Care staff/ Social Care/ Community Groups

a Information — PAM H/M/L Patients
- Customise packs
- App website
- System Navigation
- DoS
- 3rd Sector (Communities)

b Expert Patients — PAM M/L Patients
- Phase 1: Generic + Diabetes
- Phase 2: Specific LTC
- Refresher Online / Face-to -face

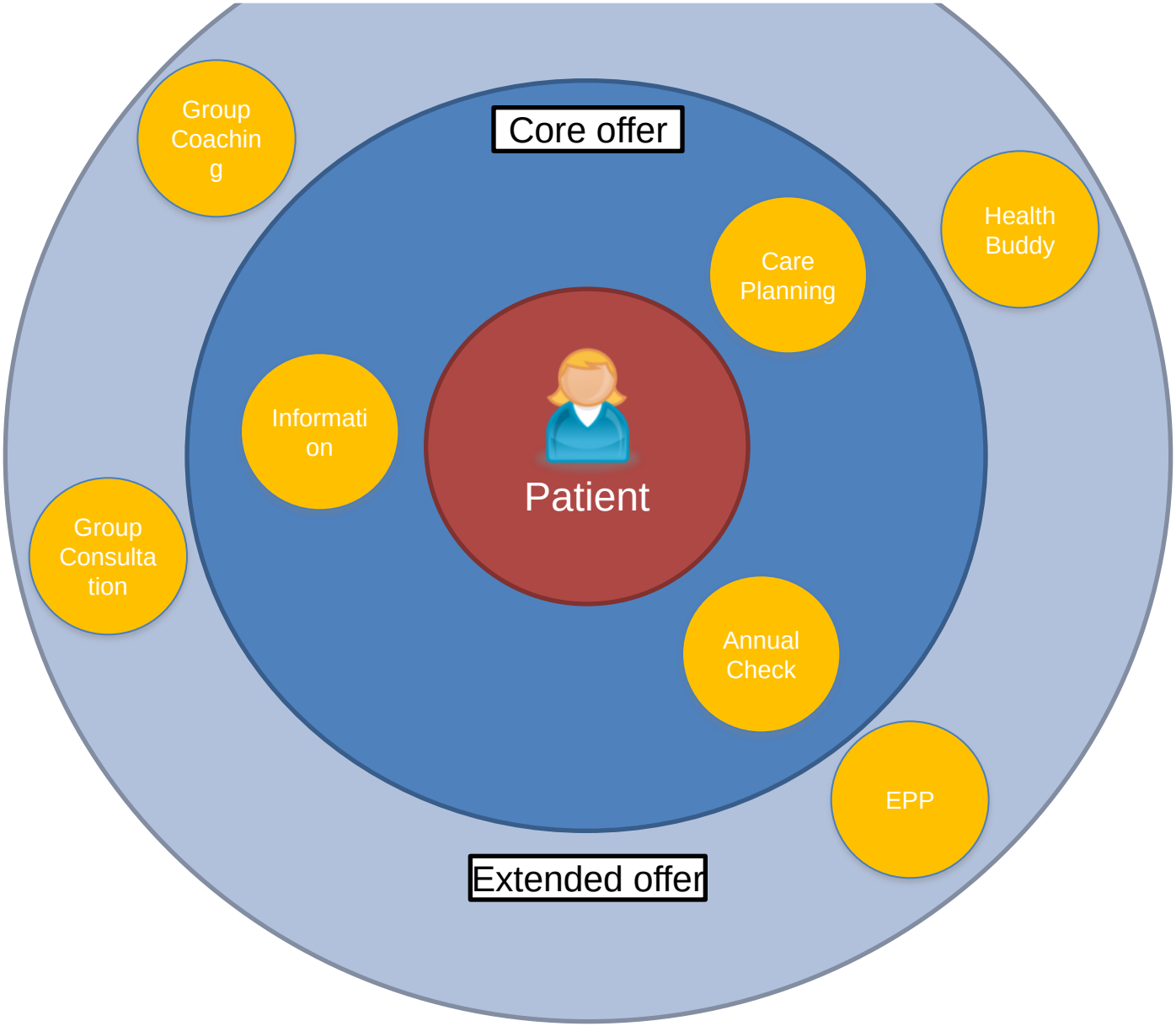
c Patient / Peer Buddy — PAM H/M/L Patients
- Clinical Whatsapp Group
- Forum

d Health Coaching — PAM L/M Patients
- CBT
- Coaching Conversations
- IAPT

e Regular Monitoring & Management — PAM H/M/L Patients
- Annual checks in General Practice
- QoF Monitoring

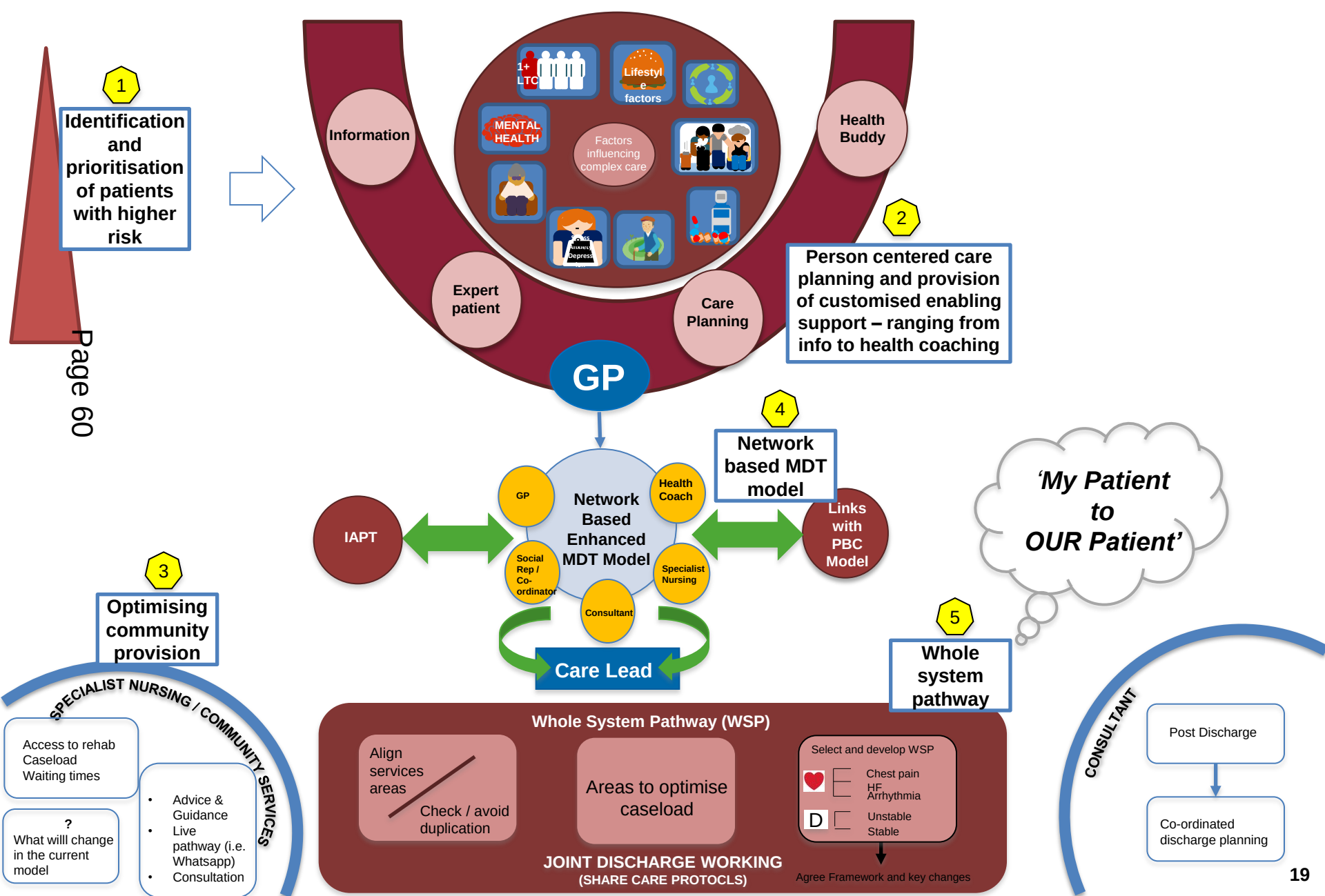
Managing Well

Focusing and retaining patients in this category for as long as possible is vitally important: to proactively manage the condition so it does not deteriorate, and to decrease probability of multiple LTCs occurring.



COMPLEX / UNSTABLE

Patients with complex care needs, with a combination of multiple chronic conditions, mental health issues, medication-related problems, and social vulnerability.



Questions?

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BHR whole system LTC strategy

1

Responding to the growing challenge of Long term conditions

March 2019
Not for further circulation

North-East London Local Pharmaceutical Committee
Supporting Pharmacists To Serve The Community Better

Barking, Havering and Redbridge University Hospitals NHS Trust

NELFT NHS
NHS Foundation Trust

London Borough of Redbridge

NHS
Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

	System leadership	Name	Organisation
1	SRO Leads	1. Jeremy Kidd 2. Tracy Welsh	BHR CCGs
2	Clinical SRO	1. Dr Ramneek Hara 2. Dr Shabana Ali 3. Dr Jyoti Sood	PELC
3	Consultants Clinical Leads	1. Devesh Sinha 2. Fahad Farooqi 3. Nick Lever 4. Nemanja Stojanovic 5. Afzal Sohaib 6. Olumide Adeotoye	BHRUT NELFT
4	Programme Lead Project Manager	1. Mina Epelle 2. Dee Patel	BHR CCGs BHR CCGs
5	Finance Leads	1. Nicola Spencer 2. Julia Summers 3. Andrew Ringshaw	BHR CCGs BHR CCGs NELFT
6	Public Health Lead	1. Gladys Xavier	London Borough of Redbridge

Contents

	Content	Page number
1	Executive Summary	4
2	Introduction (setting context)	5
3	Vision	10
4	Case for Change (‘The why’)	13
5	Model of Care (‘The what’)	22
6	Key interventions and phases of Implementation (‘The how’)	37
7	Key Enables	39
8	Cost Benefit Analysis	42
9	Key Risks	48
10	Conclusion	49
11	**Appendices** Activity and financial baseline Evidence Presentation LTC information source	53

Executive summary

This strategy was developed across the Barking and Dagenham, Havering and Redbridge (BHR) Health Economy with input from BHR Clinical Commissioning Groups (the CCGs), Barking and Dagenham, Havering and Redbridge University Trust (BHRUT), North East London Foundation (NELFT) Trust and the Public Health Teams from the three London Boroughs.

The partners came together with the common recognition that no one partner in the health economy can address the strategic and practical challenges of Long Conditions alone, and that a joint coordinated approach will be required to effectively identify, treat and support patients with long term conditions in the most appropriate setting of care. In addition the partners acknowledge that as a consequence of an aging population, local demographic factors and lifestyle changes the challenge of LTCs is growing and that action to impact growth and ensure the most efficient use of joint resources to address the challenges of LTCs under these circumstances is required.

Key challenges

Data analysis and clinical input demonstrates that at its core the long term conditions challenges can be articulated in two statements:

1. Prevalence Gap – comparison of national data and Quality Outcomes Framework data recorded by GPs demonstrates that there is a difference between the numbers of patients diagnosed with long term conditions when compared to national forecast data. Patients who are not diagnosed and are not aware that they have a condition will not be accessing the appropriate support and treatment and are therefore at risk of their condition deteriorating and/or of accessing treatment, non-electively as a result. In addition as a result of an aging population and changing lifestyles the prevalence of all in scope conditions is increasing.

1. Settings of Care - Analysis was carried out focusing on the cardiology LTCs and diabetes to understand the burden of cost as a result of LTCs. This analysis demonstrates that a very high proportion of spend on LTCs is spent on non-elective care. While it is recognised that this may be in part due to the relatively higher cost of non-elective care (as opposed to elective treatment) it is indicative of the fact that we are seeing more patients being admitted to Hospital as non- elective admissions, some of which may be avoidable.

A clear vision for LTCs has been developed in response to the above which includes the development of common/single pathways for patients with multiple LTCs, a renewed emphasis on empowering the patient to manage their own condition, improving diagnosis rates and developing a framework to enable measurement of progress in relation to the various programmes of work/projects that we will be delivering.

Executive summary Contd

Our multi-agency strategy has been developed to coincide with the commencement of our system wide LTC Transformation Board, therefore this strategy can be seen to represent a starting point for an ongoing programme of work, directed by the board. The proposed work set out in this strategy is grouped into four thematic areas:

1. Early Identification
2. First Response
3. Managing Well
4. Patients with complex needs who may have more than 1 LTC

Our LTC programme will oversee the work and measure its effectiveness i.e. through performance review of identified KPIs, Outcomes etc

How we will deliver out LTC programmes of work

We have established task and finish groups to develop the various schemes outlined within the strategy. The groups comprise of a range of clinicians and officers from across the health economy.

We will engage with patients and carers when required to ensure that our work is based on feedback from the latter groups..
We are in the process of developing a patient friendly version of our strategy which will outline in simple terms our offer to our local populations.

Introduction

Introduction

The purpose of the our strategy is to set out how we will support those within our population with Long Terms Conditions (LTC). Our three year strategy sets out our key areas of focus and how we will deliver them. In developing our strategy we have aligned our priorities with and embraced the principles underpinning the following national and local drivers;

1.NHS 10 year plan
2.NEL Sustainability Transformation Plan (STP)
3.Joint Strategic needs assessment (JSNA)
4.Health and Wellbeing Strategy.

Our approach focuses on a shift away from a reactive, disease-focused, fragmented model of care and service provision towards one that is more proactive, holistic and preventive with a commitment to working with and supporting people with long-term conditions to play a central role in managing their own care.
How we provide services in the future will continue to involve joining up services across health and social care ensuring that the services we provide are integrated, spanning across primary, community and secondary care delivered by MDT teams where necessary thus providing a co-ordinated and seamless journey through the system for patients.

We know that we need to continue to focus on primary prevention as this will be key to reducing the incidence of LTCs within the population before LTCs occurs. How we do this will involve for example developing a range of universal measures that reduce lifestyle risks or by targeting high risk groups /areas within our boroughs with a higher disease prevalence /risk indicators. We will work jointly with our Local Authority partners, third sector organisations and the community to support individuals who have no current health or care and support needs but may require support in the future.

We know that we need to continue to improve how we undertake early diagnosis and detection, provide timely treatment and on-going management and that this will be crucial to ensure that those with LTCs avoid un-necessary hospital admissions and or re-admissions and are able to manage well when faced with a crisis. We know as per the latter that having the correct packages of support and interventions in place is one of the ways that will help us both empower patients to be equal partners in the shaping their care as well as improve outcomes for this cohort of patients.

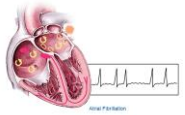
We know that mental health is equally important as physical health and well being and that people with LTC may need a range of support packages which address both in a holistic way. This is why we will continue to ensure that in implementing this strategy that we draw on work happening within our mental health transformation programme so our work is co-ordinated better for those with LTC.

We recognise that this strategy is just the start of our journey and we will continue to work with patients, carers and wider stakeholders to update, prioritise and deliver the various elements of our work.

Introduction – The LTC conditions that will be covered by our strategy (scope)

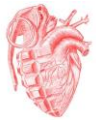
The conditions within the scope of this strategy are set out below. Local and national data demonstrates a growth in the prevalence of all of these conditions, and with it an increase in cost. A coordinated strategic approach is required to impact growth rates, improve care and deliver savings.

Diabetes – A lifelong condition that causes a person's blood sugar level to become too high. It's important for diabetes to be diagnosed as early as possible as it can get progressively worse if untreated. It can also lead to heart disease and stroke, nerve damage, vision loss and blindness and kidney problems.



Atrial Fibrillation - A heart condition that causes an irregular and often abnormally fast heart rate. Those with AF are at increased risk of having a stroke and in extreme cases, it can lead to heart failure.

Chronic obstructive pulmonary disease (COPD) – A group of lung conditions that cause breathing difficulties, typically affecting middle-aged / older adults who smoke. COPD is irreversible but can be managed to slow progression and control the symptoms.



Coronary Heart Disease (CHD) – A major cause of death when the heart's blood supply is blocked often due to a build up of fatty substances in the coronary arteries. This can be caused by hypertension, diabetes, high cholesterol and smoking.

Asthma – A common lung condition which causes breathing difficulties through inflammation of the breathing tubes that carry air in and out of the lungs. Whilst it can be kept under control, it's still a serious condition that can cause stress, anxiety, or lung infection.

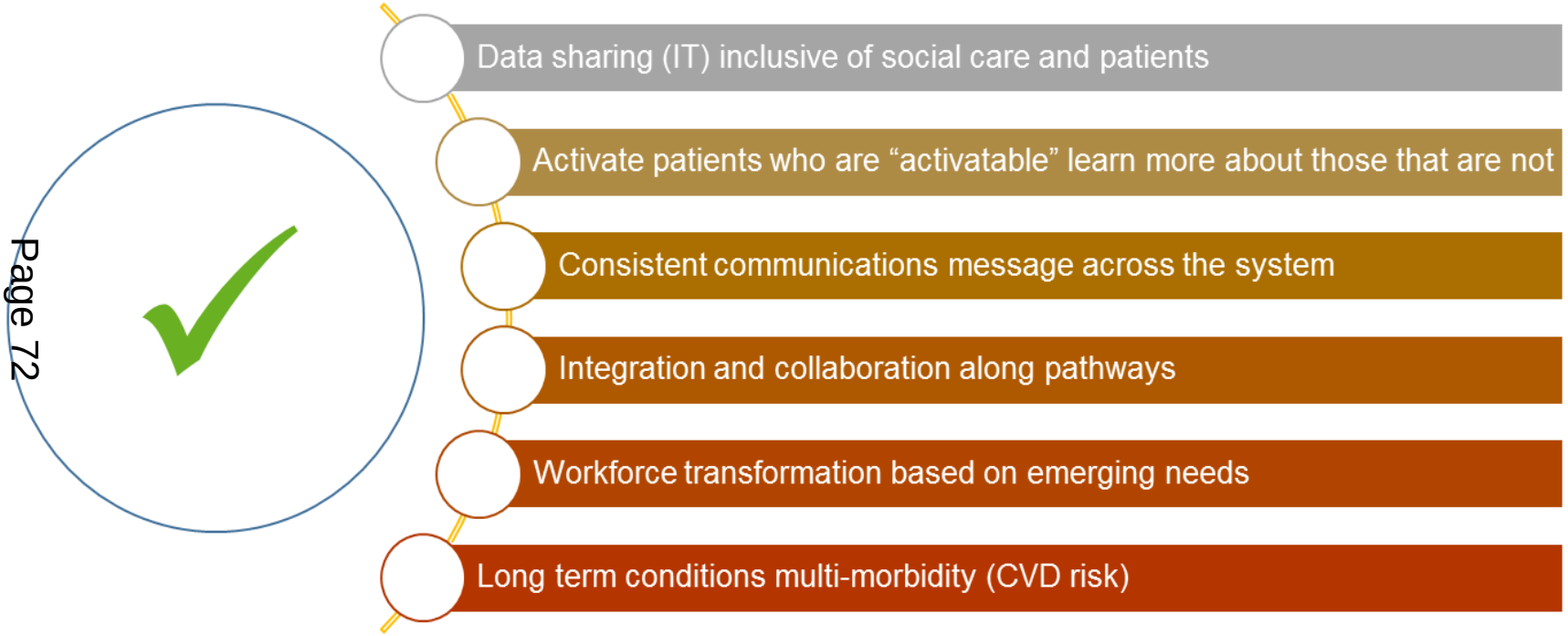
Chronic Kidney Disease (CKD) – A condition often associated with getting older where kidneys do not function optimally. This is often caused by high blood pressure, diabetes, kidney infections, and long term / regular use of certain medicines

Hypertension – A condition which rarely has noticeable symptoms. But if untreated, it increases risk of serious problems such as heart disease, heart attack, kidney disease, or strokes.

Vision

9

Vision – high level summary



Vision

How we will work to transform care for patients

- Enhancing integrated working across BHR which will help to facilitate a system wide approach from prevention and case finding through to education and care. This will include single pathways for the different “in scope” conditions.
- We will work on LTCs on a system wide basis, ensuring that pathways work for patients on an end to end basis
- Work will be clinically led, with input from partners from all parts of the commissioner/provider spectrum
- We will agree key metrics/outcome measures to measure impact/delivery
- We will involve patients in the development of initiatives

Deliver an LTC Model of Care that will

- Focus on prevention and aim to impact the forecast growth for the “in scope” conditions (see page 8)
- Improve diagnosis rates
- Improve patient education and awareness

What will be different for patients with long term conditions

- People in BHR will receive end to end care for their long term condition, this will include:
  - People at risk of developing a LTC will be informed early and patients will be provided with support to prevent the condition developing
  - Provision of education for patients at risk, on diagnosis and throughout their care
  - Patient care will be provided with care close to home and will, where possible, avoid multiple appointments for patients with more than one long term condition, improving patient access and clinical quality.
- Take a partnership approach between patient and clinician for all LTCs
- Support and information that enables patients to be equal partners in shaping their care with help from health and social care professionals
- Effective preventive care to reduce the risk of complications and other morbidity
- On-going monitoring of their condition to detect and respond to their health and social care challenges early in the course of their condition

How we have developed our strategy

12

How we have developed our strategy- An overview of our approach

BHR CCGs over the last couple of months have been working jointly with our partners across the health economy and with Local Authority colleagues and patients to look at how best we can continue to improve services for people within our local population with Long Term Conditions.

We have looked in depth at our population needs, disease profiles and trends, in order to understand what we need to address including where we are, what we need to do and how we need to get there. As part of this exercise we have sourced from elsewhere, clinical evidence and best practice of what works well and how we can apply this locally. We have identified a number of themes and areas of focus that we need to address in order to improve and better co-ordinate the services on offer for those with LTC. We will be undertaking further work with patients and carers to obtain their views.

Emerging from this work, has been the development of the following:

- Our vision for supporting people with long term conditions (LTC)
- The LTC conditions that we will focus on (the Scope),
- Our Case for Change-
- Our Model of Care, (drawing from evidence and best practice)
- A range of delivery focused areas for implementation (The How).
- We have established a multi–agency LTC Transformation Board to provide overall direction and oversight

How we have developed our strategy- An overview of our approach

Phase 1: Mobilisation

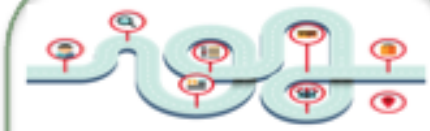
1.Overarching plan with timescales, outputs and roles / responsibilities

2. Define approach to engagement with stakeholders

3. Initial data analysis and interrogation

4. LTC workshop and formation of core 'steering' group(s)

Phase 2: Prioritisation and preparation



1. Map of 'what's happening' across system in areas of priority

2. Prep and coaching sessions with professional / clinical leads

3. Whole population analysis of data and outcomes

4. Collation of national / international good practices

5. Setting up groups at whole system governance pathway

Phase 3A: Development of LTC strategy

Co-production

Workshops and focus group sessions with Programme board, any reference or groups and wider stakeholder workshops

Development of LTC strategy

- *Our goals and outcomes*
- *Growing burden and case for change*
- *Define LTC framework*
- *Agree Priority areas*
- *How: Transformation approach*
- *Estimate whole system impact*
- *Engagement and development of system leadership*

Phase 3B: PID for individual projects

Project initiation document

(For eg: AF identification and management)

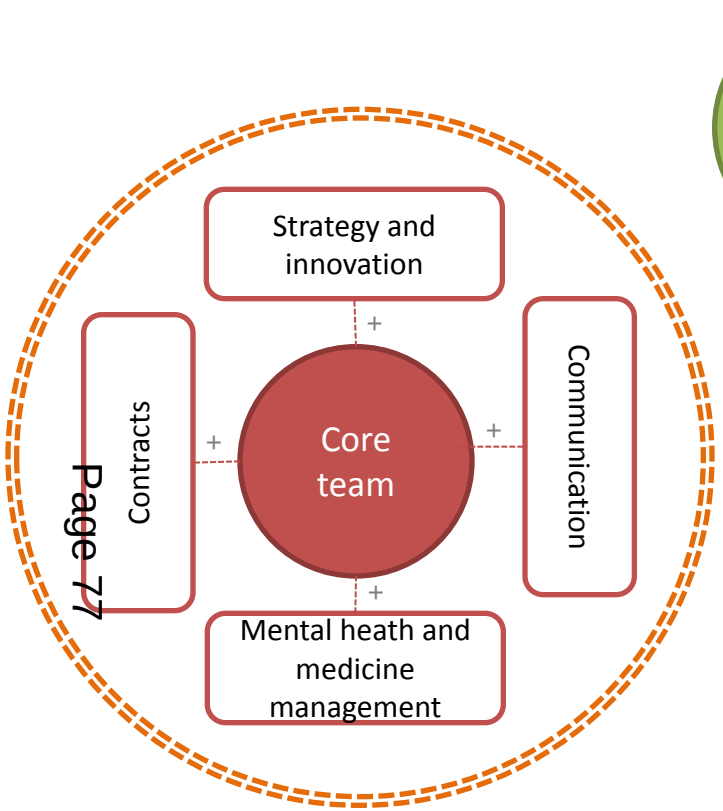
1. Define clear outcomes
2. As Is Map / Issues / gaps
3. **NEW MODEL OF CARE**

- *Key initiatives (what)*
- *Impact assumptions*
- *Delivery - who and how*
- *Achievement of outcomes*
- *'Just do it' initiatives*
- *Work plan for implementation*

Sept 2018 — *October 2018* — *November – April 2019*

Consistent engagement with stakeholders

How we have developed our strategy- Stakeholder map and engagement



Patient reference group

Clinical directors and IJEC

GP reference group

Heath / clinical care cabinet (Check)

LTC board

Organisation champions
BHRUT (2)
NELFT (1)
LA (1)
TBA

Keep engaged
- LPC
- Health watch

TBC
- A
- B
- C

Core team:
1.Clinical leads(s)
2.Project manager(s)
3.Primary care
4.Public health
5.BI
6.Finance
Meets weekly – TBC

Core plus
Provides support to core team
1. Strategy and innovation
2. Comms
3. MH and Med
4. Contracts
5. IT and IG

Core team to engage as required

Reference groups:
Provides advice / direction
1. Clinical directors / IJEC
2. GP reference group
3. Patient reference group
4. Health / CCC

Monthly discussion

LTC prog board:
Provides leadership and decision making
1. Member A
2. Member B
3. Member C
4. Member D
5. E

Monthly discussion

Case for change

Case for Change ('The why') 1

Long term conditions are a growing challenge for the NHS across the UK as a result of an aging population which increases demand for services, some of which require complex interventions. This trend is present in BHR where social economic factors such as the high levels of deprivation in some parts of the health economy and by demographic composition of the population means that some of the population are at greater risk of developing some conditions (diabetes in particular, which can lead to a number of other conditions and co-morbidities).

NHS 10 Year Plan, there is a focus on Long Term Conditions, which in summary covers the following:

- Funding for specific prevention programmes.
- Increased focus over the 5 years of 'shared responsibility for health' ramping up support for people to manage their own health.
- Pharmacists and nurses in Primary Care to case fund and treat people with high risk conditions including AF and CVD more widely. Pharmacists to undertake medicines reviews and help with training patients.
- Access to weight management services in primary care for T2 diabetics and those with hypertension.

In developing our strategy, we have sought to embrace the above themes. Our starting point has been to firstly understand our populations needs. Analysis carried out during the development of this strategy demonstrates three key points:

1. **Prevalence Gap** - There is a significant (detection gap) between the number of patients diagnosed with long term conditions across BHR and those people who have not been diagnosed. Patients who do not have a diagnosis will not be on the appropriate disease registers and will therefore not be receiving treatment, support and medication for their conditions. This increases the risk that their condition will worsen and that they may first present at A&E or admitted in hospital as a non elective (emergency admission).
2. **Co-morbidities** – There are significant number of patients diagnosed with multiple LTCs. We know that patients with four or more LTCs are likely to be complex and will require a greater level of clinical support and packages of care, i.e. Social Care input. As a result of our aging population this cohort is likely to continue to grow; therefore developing bespoke pathways and services is crucial to supporting this cohort in a cost effective way.
3. **NEL Activity** – Analysis demonstrates that a very high proportion of the spend on LTCs is on non elective admissions. While it is understood that non elective activity for patients with LTCs will in some cases be unavoidable the continuation of the level of spend when coupled with an aging population will lead to increase demand for services and subsequently an increase in how much we spend. So we know that, to deliver improved patient quality, reduce cost and deliver savings it is necessary to ensure that a greater proportion of activity is elective, or preventative.

Prevalence Gap

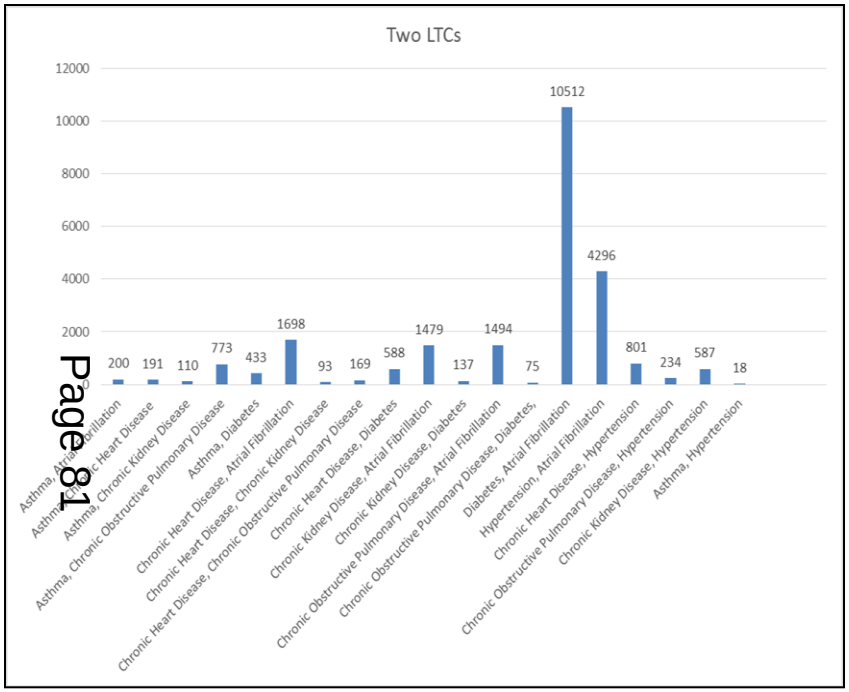
The figures in table 1 below demonstrations there is a significant gap between the expected number of diagnosed patients in the population compared to those patients actually identified with LTCs. There is a risk that patients are not diagnosed early, and do not access treatment earlier in the course of their condition resulting in avoidable unplanned admissions in the future. In addition as a result of an aging population and changing lifestyles the prevalence of all in scope conditions is increasing.

		Borough level patient gap breakdown		
LTC	Expected Prevalence in BHR	B&D CCG (pts)	Havering CCG (pts)	Redbridge CCG (pts)
Diabetes	14,019	624	5,983	7,412
AF	6,884	1,456	2,720	2,668
COPD	10,323	3,327	4,624	2,372
Asthma	36,556	9,567	13,055	13,934
CKD	23,028	4,367	10,063	8,598
Hypertension	68,206	14,350	27,470	26,386

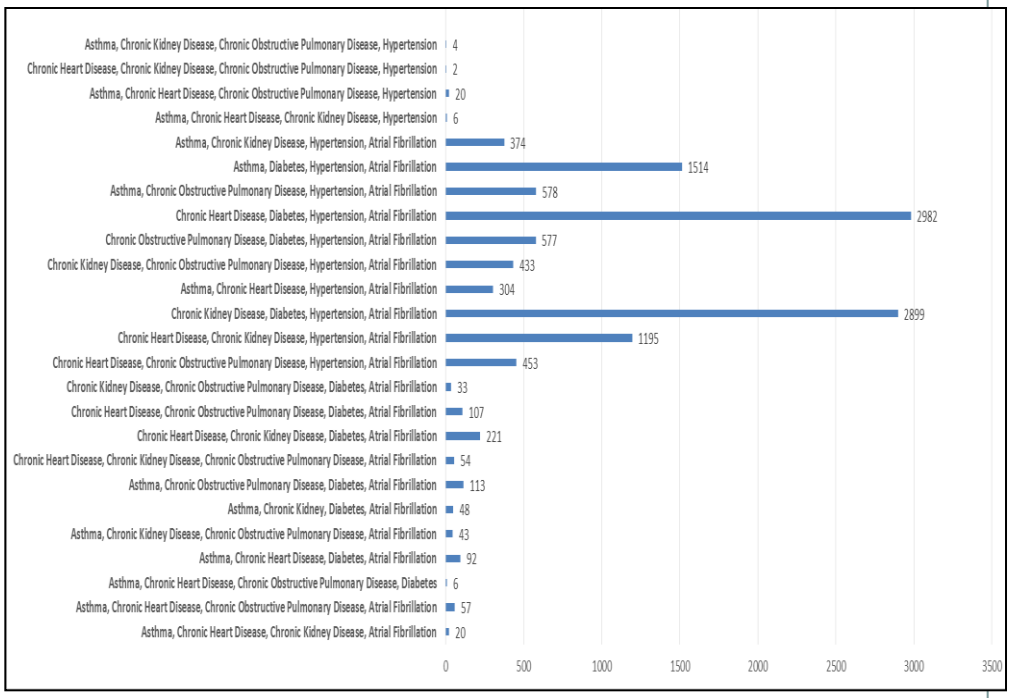
- The overall population of BHR is 776,419, which has been used to calculate the figures shown in the table
- There is a risk of continued increase in diagnosis and patient gap if there is not imminent change

Multimorbidity

Patients with Two LTCs



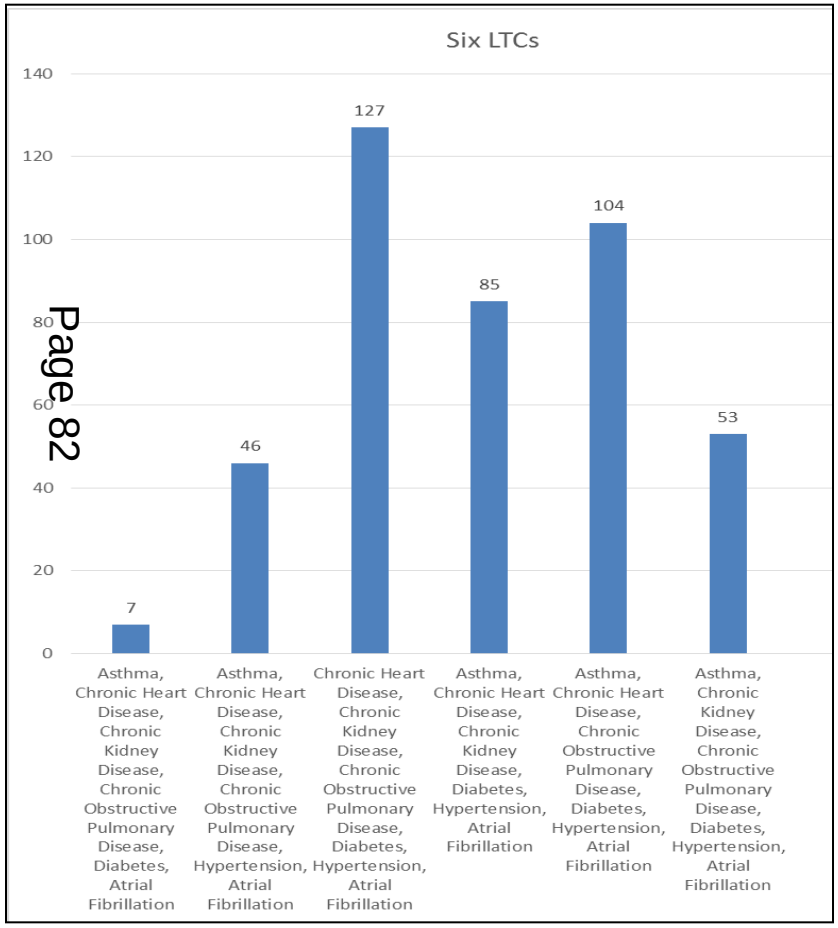
Patients with Four LTCs



- The most common combination affecting more than 10,000 patients is the combination of AF and Diabetes.
- The second highest combination is Hypertension and AF affecting 4,296 patients.
- CHD, CKD and COPD all contribute to the next three highest combinations

- More than 2,900 patients have a combination of CHD, Diabetes, Hypertension and AF
- Over 2,800 patients have a combination of CKD, Diabetes, Hypertension and AF
- COPD continues to be a condition affecting patients with Asthma

Patients with Six LTCs



- CHD, CKD, COPD, Diabetes, Hypertension and AF are the leading six combinations
- Asthma, CHD, COPD, Hypertension and AF is the second highest affecting patients.
- These are your complex, expensive cases for the health system

Whole System burden of LTCs

This analysis includes admissions for both planned (day cases and electives) and unplanned (non-elective) for age group 18+ in BHR CCGs. The analysis is based on SUS+ data and Long term conditions are based on HRG codes identified by clinical leads. The long term conditions shown in this analysis are related to cardiovascular and diabetes conditions only.

Highlights

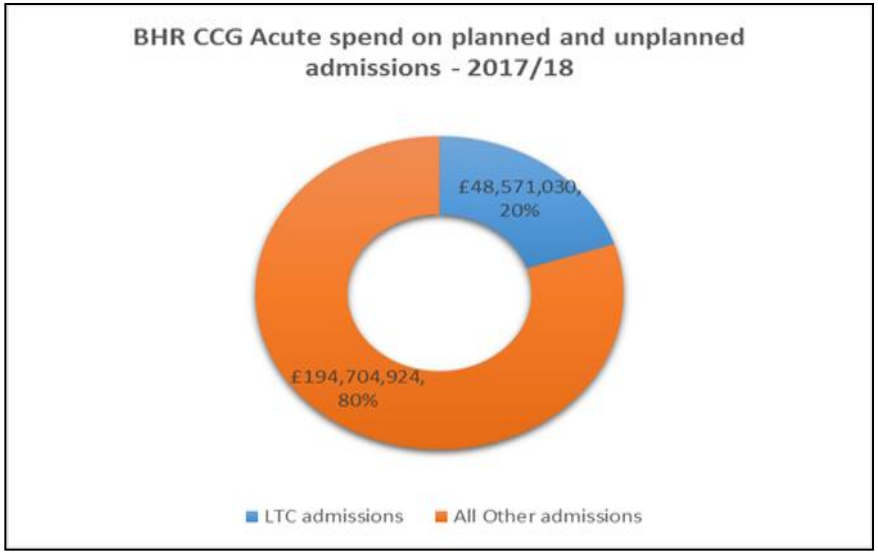
- BHR CCG total spend for admissions both planned and unplanned in 2017/18 is £243m; of which £49m is related to admissions for long term conditions (LTC) (20%). Of the £49m spend for LTC

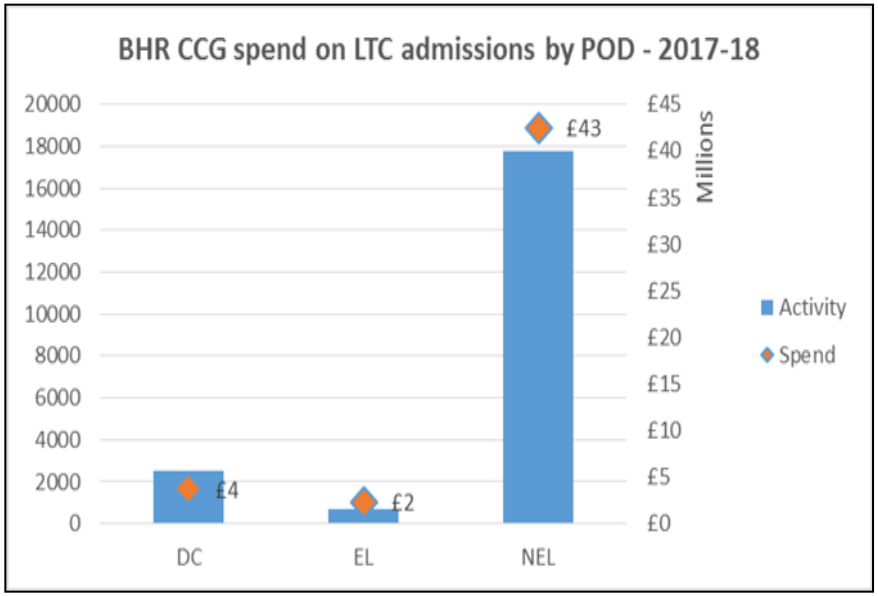
  - 7.7% (4m) is attributed to day cases (DC),
  - 4.8% (£2m) to elective admissions,
  - 87.5% (£43m) is attributed to non-elective admissions.

Planned admissions: Day cases (DC) and Elective (EL) admissions

- Of the £4m spend in day cases, majority of the spend is around cardiac (78%), vascular procedures and disorders (8%), eyes and periorbital (6%).
- Of the £2m spend in elective admissions, majority of the spend is around vascular procedures and disorders (41%), cardiac (24%) hepatobiliary and pancreatic system (13%).

The charts on the right shows the percentage distribution of admissions related to LTC conditions and all other admissions by provider.





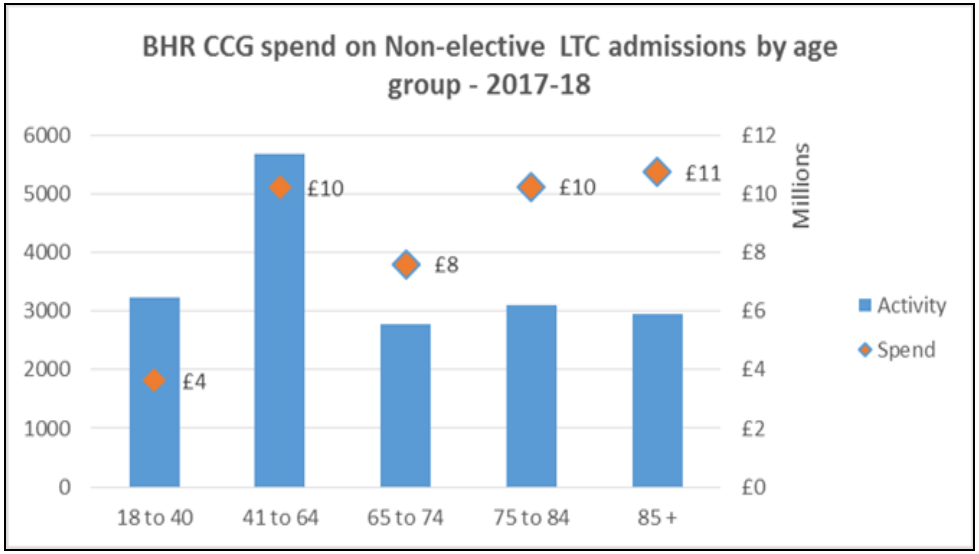
Whole System burden of LTCs

Non-elective admissions

- 67% (£29m) of the non-elective spend in 2017/18 are for admissions related to 65+ age category, of which nearly 50% are for the 75+ age group.

- 33% (£14m) of the non elective spend are for admissions for working age group (age group 18-64).

- There is an increasing trend in 17/18 and 18/19 (based on M6 forecast) toward non-elective admissions related to long term conditions across all age groups.



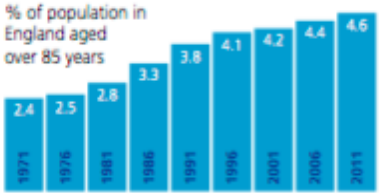
Non-elective admissions	Age_Categories	2015/16	2016/17	2017/18	2018/19 M6 FOT	movement from 15/16 to 16/17	movement from 16/17 to 17/18	movement from 17/18/to 18/19
No of admissions for LTC	18 to 40	1139	1098	1179	1216	-4%	7%	3%
	41 to 64	2751	2593	2827	2904	-6%	9%	3%
	65 to 74	1397	1467	1672	1844	5%	14%	10%
	75 to 84	1846	1876	2125	2402	2%	13%	13%
	85 +	1441	1639	2040	2090	14%	24.5%	2.5%
All other admissions	18 to 40	12902	12658	12774	13238	-2%	0.9%	3.6%
	41 to 64	13511	12790	13374	14316	-5%	4.6%	7.0%
	65 to 74	6505	6132	6517	6694	-6%	6.3%	2.7%
	75 to 84	8073	7738	8040	8390	-4%	3.9%	4.4%
	85 +	7859	7748	9120	9710	-1%	17.7%	6.5%

ENHANCING THE QUALITY OF LIFE FOR PEOPLE LIVING WITH LONG TERM CONDITIONS

NHS England

Long Term Conditions are those that cannot, at present, be cured, but people living with these conditions can be supported to maintain a good quality of life.

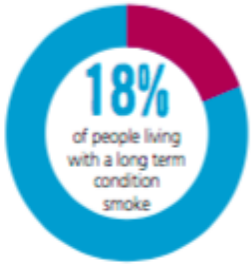
People aged over 85 years are more likely to be living with a long term condition including frailty.



People might be living with more than one long term condition. Of the people who report that they live with long term conditions;

24% have two long term conditions...

...and 20% live with three or more long term conditions.



People who smoke are more likely to have flare ups in their condition and more likely to be admitted to hospital.

Carers are a hugely important asset to the NHS as well as the people for whom they care.

80% of carers said that caring has had a negative impact on their health.

Carers may need support both in their caring role and in maintaining their own physical and mental health

However many conditions people are living with it is important that they feel supported to manage their overall health and wellbeing. They should have a care planning discussion recorded in a written care plan.

72% of people with long term conditions use their care plan to manage everyday health

5.4% of people with long term conditions have a written care plan

People living with a long term condition are less likely to be working than the general population.

72% of the general population are in work

59% of people with long term conditions are in work

35% of people with a mental health condition are in work

Over time the needs of people living with long term conditions may change. Planning ahead is key for people who are approaching the end of life and for those important to them.

People should have opportunities to discuss their wishes and preferences for now, and for the future, and to have these recorded in a personalised care plan.

People living with a long term condition are more likely to use health and care services. They account for:

50% of all GP appointments

64% of all hospital outpatient appointments

70% of all hospital bed days

70% of total health and social care spend

More information about enhancing the quality of life for people living with long term conditions can be found at: www.england.nhs.uk/house-of-care/

Model of care ('The what')

Page 86

Model of Care – guiding principles

1. Prime focus on Prevention – both primary and secondary
2. Person centered rather than disease centered. Recognising individual as the partner – not a patient
3. Galvanise communities as assets in jointly partnering in how care is delivered whilst activating people to self care and self manage.
4. Focus on multi-morbidity rather than an isolated single disease pathway
5. De-medicalisation of response –a more comprehensive and holistic response – with mental health as equally important as physical health.
6. Breakdown barriers and facilitate joint ownership across the system
7. Consistency of provision of health / care support services across BHR with variation triggered by need rather than historic commissioning decisions
8. Empower frontline staff to define and shape transformation and service delivery
9. Management of health inequalities ensuring services are responsive to local demographic and cultural variation
10. Improved care and experience for people (and their families) approaching end of life

Model of Care – key elements

The model of care encompasses the following key elements:

1. Primary prevention: Improvement in healthy lifestyles and reduction in risk factors through effective involvement in communities, third sector and schools.

2. Early / timely identification of people with long term conditions: This includes:

a) People with no known LTC diagnosed for the first time such as hypertension or diabetes
b) People with one or more LTC but not diagnosed with co-morbidities such as AF
c) People being managed for a condition but not coded as such – which means they are not being proactively monitored and managed
d) People who have not yet acquired a condition but are in stages preceding one such as pre-diabetes

3. Generating holistic 'First response' to people who are diagnosed with LTC

a) Understanding their health, psycho-social aspects and ability / willingness and to manage their condition (activation)
b) Generating a co-designed plan supported by coaching conversation (understanding drivers for change in the person and level of support they require to achieve their own goals)
c) Supporting people with appropriate information for them to manage their heath / well-being

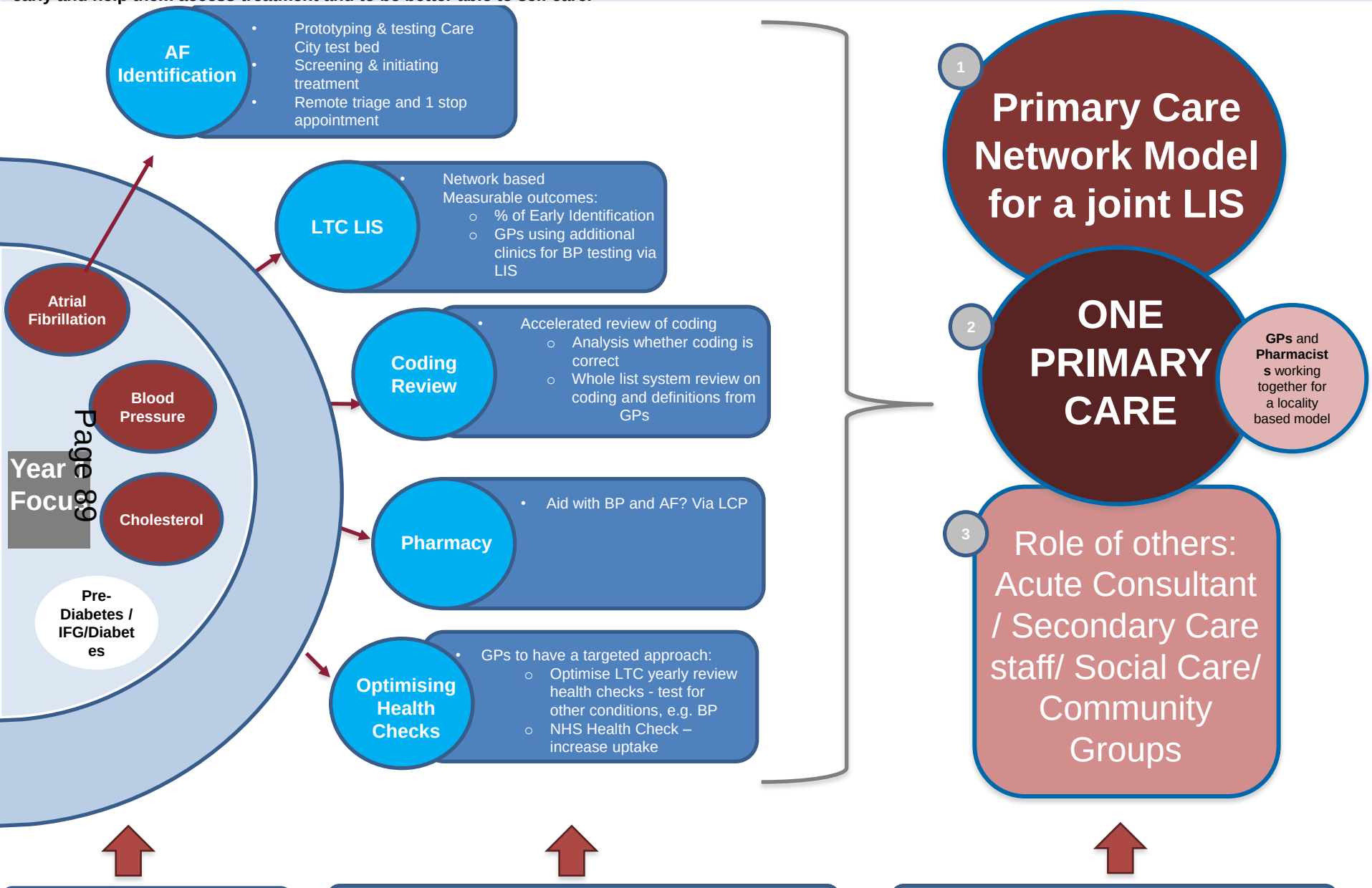
4. Secondary prevention: Optimise support to people who are managing well by provision of tools that are going to make them more resilient and independent.

5. Effective whole system integrated management of people who have multi-morbidity, complex and unstable: A range of measure and improvements in ways or working, relationships and system ownership. Key features include:

a) Optimising and ensuring consistency of community provision across BHR with effective pathways between primary, community and secondary care – ensuring apt involvement of the voluntary sector
b) Multidisciplinary working across the system – such as MDT support across the pathway.
c) Whole system pathways where there is agreement and clarity of roles, joint ownership and ensuring professionals work at the top of their license

Early Identification

Early identification and proactive disease management are key to tackling high hospital admissions, this strategy aims to identify people with in scope conditions early and help them access treatment and to be better able to self care.



Early / timely identification - key features

- Stakeholders from across the system agreed to focus on early / timely identification of Cardio-vascular and diabetes due to the significantly growing burden year on year and the potential opportunity for improvement. Year 1 focus will be timely identification of the following conditions:

    - (Atrial Fibrillation) AF
    - Hypertension
    - Diabetes

- The aim is to harness information, analytics and technology to support timely identification of people i.e opportunistic and targeted screening for those with undiagnosed LTCs i.e AF and Hypertension .The key change is that the responsibility of identifying people and treating them will not be limited to GPs but will expand to capitalise on the expertise on offer from community services and pharmacy
The opportunity for further identification (prevalence gap) has been summarised below:

	Condition	Prevalence gap (%)
1	Atrial fibrillation (AF)	0.82
2	Hypertension	7.40
3	Diabetes	1.76

Early / timely identification - key features

Our approach to early/timely identification of people will include the following areas:

A. Concerted approach to identification of AF:

- **Building on the care city innovation test pilot:**, we aim to prototype, refine and roll out this model fully in year 1.

- **Target screening for individuals who may be at risk:** In order to ensure greater return, that the approach will be targeted on individuals who are at risk. In order to do that, we will employ a risk stratification framework using existing primary care data either through raising queries in every GP practice (year 1) or using Data Discovery (Year 2 onwards).

- **'One primary care' approach:** Utilising GP practices and pharmacists alike in screening people at risk across the system in year 1. Further expansion of the contact base to areas like dentists, community nursing and other community / secondary resources in year 2 onwards

- **Harnessing technology and innovation:** Considering complexities related to AF identification, we will use technology such as Kadia mobile/ interfacing with IT software in GP practices and pharmacists.

- **Remote triage and one stop appointment (first response):** We will develop an integrated pathway for patients with AF including the establishment of a one-stop AF clinic (hub and spoke model) , with the necessary staff and diagnostics to confirm diagnosis and initiate anti-coagulation where appropriate. The clinic will offer an MDT approach including advice and guidance and will also expand from traditional medical assessment and management to ensuring holistic care planning and social prescribing
- Our LTC primary care LIS for LTC will support the identification and treatment of AF (treatment where practical) in primary care

B. Identification of other conditions such as diabetes (and pre-diabetes), hypertension and hypercholesterolemia:

- **Opportunistic stratified screening utilising points across the system (beyond just GP practices):**) will support identification of people who have an undiagnosed condition.

Early / timely identification - key features

- **Incentive framework for 'one primary care':** We will provide an incentive framework (LTC LIS) where GPs and pharmacists (year 1) can proactively case-find, treat where applicable , signpost people to (or provide) self care information, care planning and ongoing management (first response)

- **Screening in communities:** Provision of testing kits in communities such as mosques, temples, community groups and supermarkets to engage with people who are not known to or engaged with the healthcare system.

- **Screening is just the first step:** Screening with positive or negative results, both, should be accompanied with clear information on 'what to do next'. Social prescribers and links to local community groups will help improve lifestyle and meaningful social connectivity

C. Coding review:

Active search on GP systems: There are a number of people who have a condition and not being coded as such on the GP system. The aim is to proactively search GP systems (using pre-defined queries) to find cases.

- **In the short term:** Initially, this could be achieved by (1) provision of queries to practices who can run it themselves with remote telephone support, (2) visit by a IT or project team member who can run the queries in each practice in quarter 1 (2019/20). Going forward, data discovery or a central database can do the same take centrally on an annual basis.

- **In the longer term**, quarterly / bi-annually data reconciliation across the system to ensure people identified by other parts of the system such as A&E, community services and secondary care are on the LTC register in GP systems.

D. Optimising health check

- **Customised BHR health check:** Considering limitations with the current NHS health checks primarily health checks are not specifically targeted people with LTC and do not cover AF and respiratory conditions, we will embark on a customised health check across BHR (by invitation only) to case find people in these cohort .

- **Targeted approach:** These health checks will be focused on geographical hot spots across localities with high population risk factors thereby effectively targeting individuals who may be at higher risk. However, the same concept will apply to those accessing current NHS health checks who may have no LTC diagnosis.

First Response

This element of the strategy deals with the first contact a health Profession has with a newly diagnosed patient. This is the first opportunity to provide support, enable self-care and provide management. The aim is to have a comprehensive set of tools and enablers we would provide to a person.

1. Identifying ability to self manage (levels of activation using self assessment questionnaire)

Options (TBC)
1. Patient Activation Measure (PAM) High/Medium/Low
2. Well-being Star

2. Care Planning

- Goals
- Plan
- Activate

- What is the outcome and process for the patient?
- Time to sit and co-develop care plan with patient.
- It could 20-30 minutes session or more.
- GP/Other trained professionals
- Utilising Network LIS
- What enabling support can be offered?

One Primary Care Network Model

Roles of others Acute Consultant / Secondary Care staff/ Social Care/ Community Groups

a — PAM H/M/L Patients
- Information
  - Customise packs
  - App website
  - System Navigation
- DoS
- 3rd Sector (Communities)

b — PAM M/L Patients
- Expert Patients
  - **Phase 1**
    - Generic + Diabetes
  - **Phase 2**
    - Specific LTC
- Refresher Online / Face-to -face

c — PAM H/M/L Patients
- Patient / Peer Buddy
  - Clinical Whatsapp Group
  - Forum

d — PAM L/M Patients
- Health Coaching
  - CBT
  - Coaching Conversations
- IAPT

e — PAM H/M/L Patients
- Regular Monitoring & Management
  - Annual checks in General Practice
  - QoF Monitoring

First response - key features

Identification of conditions in people is only part of the process. Utilising this window of opportunity where we can make a positive impact on people's lifestyle and well-being is critical to long term success. It is acknowledged that support for patients diagnosed with an LTC needs to start early (right at the time of first response) and that they will be supported by health and social care professionals to express their own needs and decide on their own priorities through a process of information-sharing, shared decision-making and care planning.

Our approach to generating a consistent 'First response' that is consistent across the system and responsive to the needs and strengths of the individual includes the following key features:

A. Identifying ability to self manage / activation:

To ensure that appropriate support is provided to a patient it is necessary to first understand their level of activation, a method of ascertaining this will be agreed/developed. Multiple self instructed tools such as PAM can be used and customised response to people with high, medium and low levels of activation agreed.

B. Collaborative personalised care planning:

- **Collaborative personalised care planning:** Aims to ensure that individuals' values and concerns shape the way in which they are supported to live with and self-manage their long-term condition(s). Instead of focusing on a standard set of disease management processes, this approach encourages people with long-term conditions to work with clinicians/professionals to determine their specific needs and express informed preferences for treatment, lifestyle change and self-management support. Then, using a decision coaching process, they agree goals and action plans for implementing them, as well as a timetable for reviewing progress.

- **Patient brings personal asset and strengths:** The biggest change for clinicians involves recognising that the information about the lived experience and personal assets that the patient brings to the care planning process is as important as the clinical information in the medical record; processes will have to be in place to help the clinicians identify and include the patient's contribution.

First response - key features

- **Going beyond a medical consultation:** Care planning will not be the sole responsibility of the GP. It will be delivered using professionals such as HCA, health coaches, self care pharmacies who will provide time with people and develop from the medical management suggested by the GP/clinician and embark collaborative care planning

- **Network based delivery:** We will align planning delivery with Primary care networks to allow practices to work collaboratively and at scale. First response clinics (please note the term 'clinics' may change) will be located in each network and supported by appropriate professionals thus releasing pressure from GPs. Funding mechanism will include network LIS.

C. Individualised enabling response:

Patient / person is central to our entire response and the sole purpose is to enable the person, building on their own strengths. Depending on the their need and level of activation there are number of types of support that patients can access, as a minimum all patients should receive (in addition to their care plan) an information pack or guidance as to where they can receive information about their condition and an annual check up: this is in effect the core offer. In addition they can also access peer/buddies support, health coaching, social prescribing, as shown below:

Information

- Customised packs for each condition available
- Also available on App and website
- Personalised education for ethnic minorities

Expert patients

- Self-management course that supports people living with, or caring for someone with, one or more long-term health conditions

Patient buddy

- Use a buddy system to support patients who are newly diagnosed or require additional support
- Buddies can be expert patient themselves

Health coaching

- Evidence-based coaching conversation and strategies to actively and safely engage patients in health behaviour change – delivered at networks

Social prescribing

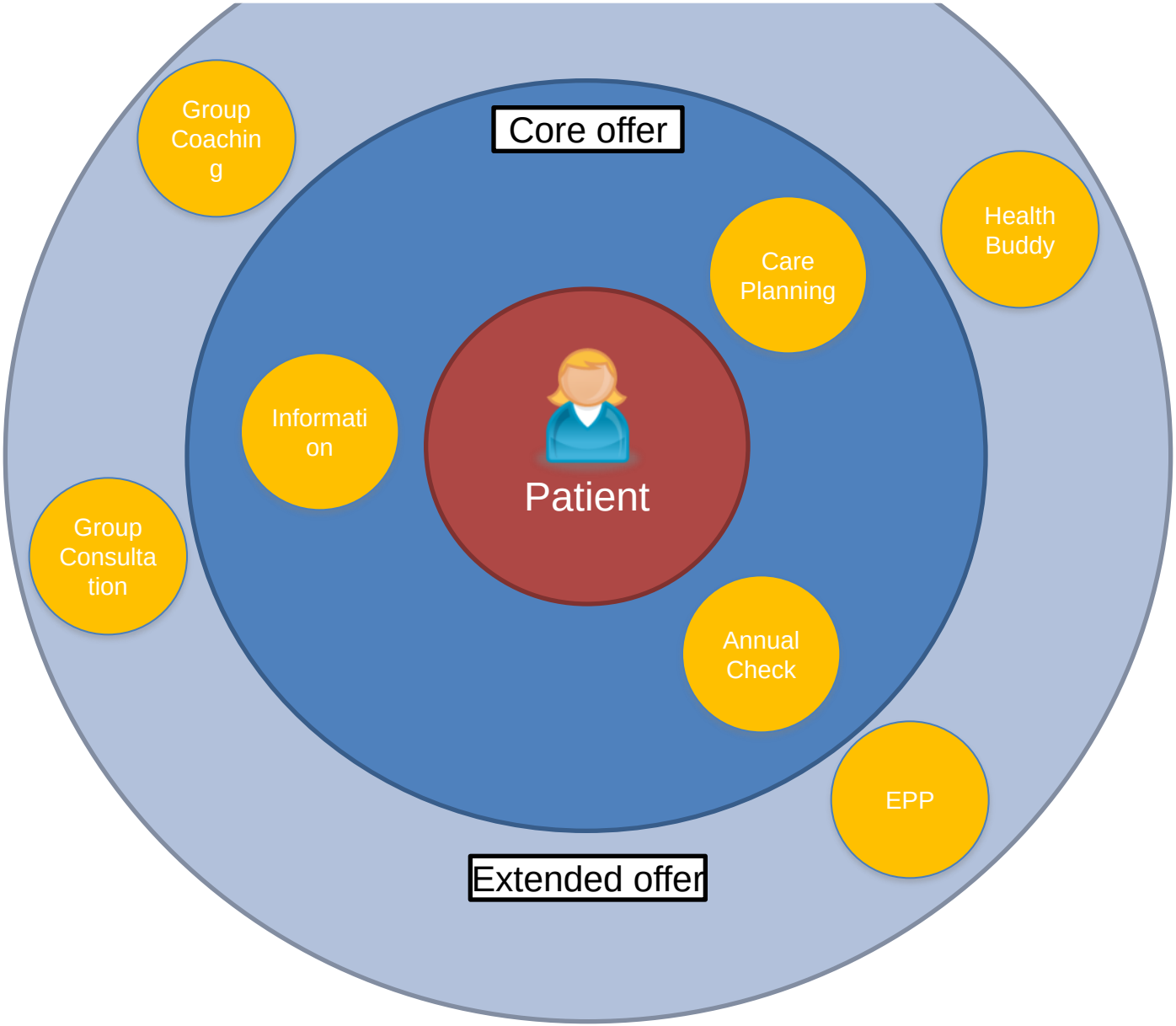
- Linking patients in primary care with sources of support within the community
- Social prescribers and social connectors at practice / network

Regular monitoring and management

- Enhanced target achievement of clinical markers at network level
- One primary care – role of pharmacies

Managing Well

Focusing and retaining patients in this category for as long as possible is vitally important: to proactively manage the condition so it does not deteriorate, and to decrease probability of multiple LTCs occurring.



Managing well - key features

- Patients who are effectively managing their condition may still require support to ensure that their management remains effective. Patients in this cohort will have access to all of the same support as patients in the newly diagnosed group (as set out in First Response), with all patient being provided with a jointly owned care plan, information about their condition and an annual check up.
- In addition these patients can access a wider range of services, in the same way that newly diagnosed patients can.

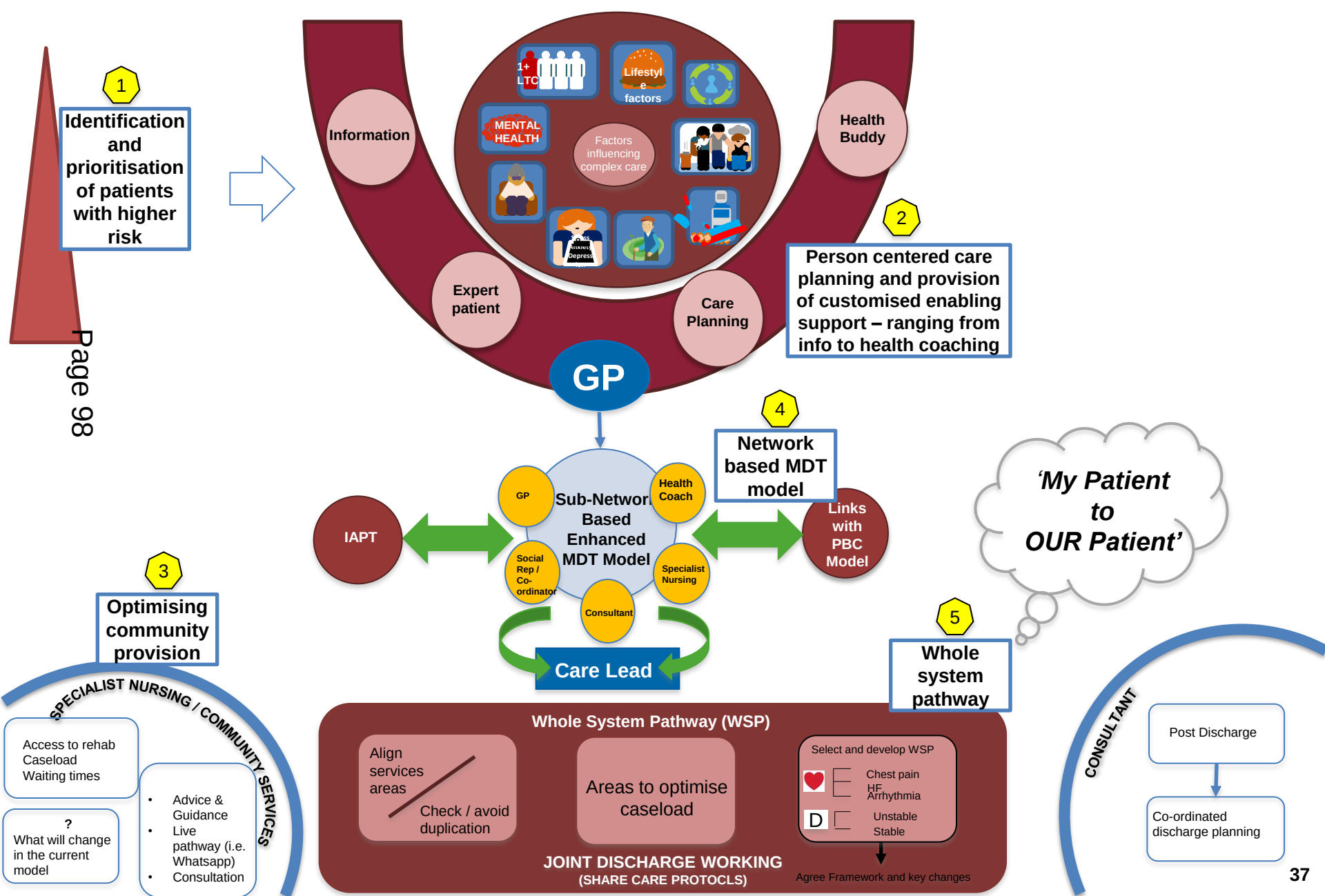
A. Clinical optimisation of markers at network level:

A key intervention, equally applicable to people who are complex / unstable is to aim for higher achievement of clinical markers i.e. improved glycemic control, sustained improvement in blood pressure readings etc. Achievement of these targets are already captured as part of QOF compliance. However, at a network or sub network level, practices can agree an enhanced or additional targets and a plan to achieve it in a collaborative way. Key aspects of this intervention include building up a sophisticated system of locally-tailored solutions, customising IT searches, register cleaning, patient recall tools, on-screen prompt, and support to poorly performing practices. A few have been elaborated below:

- **Target setting at network / sub network level:** Practice to agree enhanced or additional targets for areas such as cholesterol, BP, HbA1c
- **Agree a joint network plan for optimising clinical markers:** A key step is to understand current achievement and variation between practices. Practices should then work collaboratively to agree a plan which may include allocation of a joint resource (for eg; CVD nurse) to focus on identification, education of practice nurses and provision of clinical care to 'off target' patients
- **Optimising medication and improvement of lifestyle:** Optimising medication such as statins in line with NICE guidelines is just one example. This, coupled with interventions such as care planning, heath coaching and social prescribing will help attainment of better clinical outcomes
- **Data sharing, joint network dashboard and peer support:** Establish data sharing and development of dashboard that allows consistent monitoring of achievement, register management and on screen prompts for cases that require recall or follow up. Introduction of peer review where targets are not managed can be helpful
- **Collaborative working with local pharmacies:** especially to support monitoring of patients who may not engage or compliant. A joint approach between GPs and pharmacists to be agreed (for eg; readings to be taken at time of collection of medicines and use that contact to coach, activate and improve compliance)
- **Group consultations and coaching:** clinical consultations in a group setting complemented by group coaching supporting better self management, community cohesions and participation

COMPLEX / UNSTABLE

Patients with complex care needs, with a combination of multiple chronic conditions, mental health issues, medication-related problems, and social vulnerability.



Management of complex/unstable – key features

The impact of multi-morbidity is profound. People with several long-term conditions have markedly poorer quality of life, poorer clinical outcomes and longer hospital stays, and are cost intensive group of patients that the NHS has to look after. There is a need for a collaborative care model comprising multi-disciplinary case management, systematic follow-up, and working that is better integrated – for example between primary and secondary care professionals and equally, between mental and physical health professionals.

Management of complex / unstable will include the following key features:

A.'Population management' – identification and prioritisation of patients at risk:

- Proactively identifying individuals who are at risk of deterioration, with the intention of then developing interventions to help slow down the scale of deterioration and avoid the need for institutional care.

Use of locally agreed algorithms combined with clinical intelligence: use of local algorithms or off the shelf risk stratification tools to identify people who show manifestations of instability such as repeat GP, A&E attendance, NEL admissions, uncontrolled clinical markers with psycho-social factors that affect compliance and outcomes adversely. Validating data based searches and complementing it with local clinical / professional intelligence i.e. the knowledge of patients and their medical history will be key for effective management.

B. Collaborative personalised care planning:

- **Collaborative personalised care planning:** Aims to ensure that individuals' values and concerns shape the way in which they are supported to live with and self-manage their long-term condition(s). Instead of focusing on a standard set of disease management processes, this approach encourages people with long-term conditions to work with clinicians/professionals to determine their specific needs and express informed preferences for treatment, lifestyle change and self-management support. Then, using a decision coaching process, they agree goals and action plans for implementing them, as well as a timetable for reviewing progress.

C. Provide care closer to home – I.e. Providing IV Furosemide to patients in the community thereby avoiding unnecessary hospital attendances, admissions. or extended length of stay in hospitals for patients.

For more details , Please see section on First response as this offer will be available to enable management of those with complex needs

Management of complex/unstable – key features

C. Care-coordination/health coaching supported by personalised specialist support:

- **Range of support options for effective care-coordination:** Care planning will be actively supported by care co-ordination and proactive monitoring where needed. Care-coordination and personalised support will include care navigation to various enabling social groups, connectivity with other peers, one to one telephone / face to face follow up consultation to ensure optimal compliance and outcomes, CBT guided coaching conversations

- **Personalised specialist interventions:** Where required, a host of personalised specialist interventions need to be added to the support. A few examples below:
  - ‘Diet shape up’ with a dietician visit to home, assessing eating and lifestyle habits and making a plan for a step by step change
  - Use of personal trainers to help with initiate an exercise regime with intermittent follow up
  - Collaborating with community assets and private organisations as part of (public-private partnership) in delivering interventions

- **Network level delivery team:** Managing people with complex LTC will require more, probably much more than a GP appointment. The clinical advice will have to be supported by individuals such as HCA and health coaches who can closely work with local GPs at a network level. A team of network based health coaches / care lead (check name) will support GPs in that network in proactively managing people with complex / unstable LTC.

D. Network based MDT:

- **MDT at network / sub-network level:** A range of people will require multi-disciplinary input from a range of clinicians / professionals. We will deliver MDT meetings at a network or sub-network level. Patients will be prioritized by GPs supported by risk stratification and complemented by local intelligence, suggestions made by secondary care (LTC consultants) and community staff (such as specialist nursing teams). Patients being discharged from secondary care may benefit from continued MDT input in the community to avoid escalation and readmissions.

Management of complex/unstable – key features

E. Optimising community provision:

- **Consistency of provision across BHR:** There are variations across specialist nursing services across BHR such as eligibility of type of cases (AF vs CHD) and criteria of entry. A key aspect of LTC transformation will be to ensure consistency of service provision, entry criteria and clinical MDT support across all BHR unless guided specifically by local needs.

- **Single BHR team:** The teams across BHR are to merge as a singles team allowing more efficient service provision for example – utilisation of MDT for entire service instead of one area only and much greater coverage from nurse prescribers across the team. Further discussions to be held on potential for a single specialist nursing team covering acute and community together. It is key that the service ensures seamless discharge for patients (e.g. heart failure) where readmissions are deemed high.

- **Optimised service offer:** Multiple opportunities – for e.g.; to include cardiac rehabilitation directly from the community as against only after discharge from hospital. This could mark a significant move towards prevention. Other areas include comprehensive care planning with possibly initiation of medicines. Rationalisation of case load and appropriate risk management in the right place within the system will have to be done hand in hand to ensure appropriate level of case in service. This, alongside additional resources, will support increased capacity in the service. Review of current practices to ensure optimal NICE compliance.

- **Access to information:** Ensuring clinicians have access to records in primary and secondary care will aid efficient and safe service delivery.

F. Whole system pathway and joint clinics: Identification of key pathways such as heart failure and agreement on clinical pathway, roles and responsibility, seamless transition and handover, information sharing, points of opportunity to establish links with community assets. It is absolutely crucial that the whole system agrees to a single pathway rather than multiple organisational pathways. Complying to a mutually agreed pathway will directly impact on patient experience and outcomes, better efficiency and improved staff satisfaction. Joint clinics to be triggered in some areas to test the concept and establish a prototype and process that can be scaled up.

Key interventions and phases of Implementation ('The how')

Page 102

Key interventions and phases of Implementation ('The how') 1

Year 1

- Implement LTC Network LIS
- Reduce prevalence of AF through targeted and opportunistic screening
- Implement an integrated model of care for AF including establishing a 1 stop shop clinic for AF patients
- Begin to deliver our primary prevention strategy, focusing on Hypertension
- Increase the uptake of health checks
- Continue the provision of education and guidance for healthcare practitioners
- Optimising community services (enhancement and integration of community services). Focus on review of Cardiology, Respiratory and Diabetes services. –
- Whole system pathway development - integration between primary, community and secondary care).
- Provision of IV Furosemide in the community.
- Roll out of Health coaching and Group consultations
- Explore the best way to provide End of Life Care and Palliative Care to those with LTC.
- Undertake a detailed study and review of NEL admissions in order to inform the development of an MDT Model of Care for those with LTC.
- Establish a Performance Dashboard to enable effective performance management against plan, KPIs and outcomes
- Implement a scheme for the clinical optimisation of markers at network level for those patients that are unstable / complex to improve glycemic control/ BP readings, etc and agreeing local targets and a development plan to achieve these.
- Agree a phased target for improving access to those requiring IAPT and Mental Health (MH) services

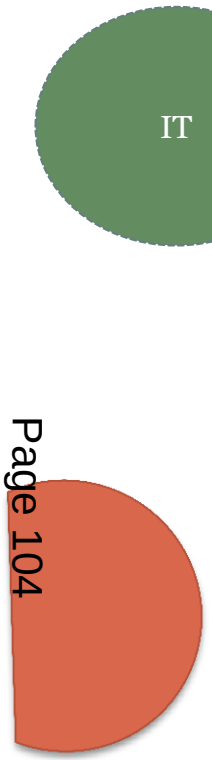
Year 2

- Select and evaluate service interventions implemented in year 1 to inform future planning and roll out. of schemes
- Implement our first response offer to support the delivery of our LTC model of care (see slide 34).
- Implement LTC MDT for the management of complex patients
- Extend MDT offer to other cohorts of patients with LTCs
- Continuation of target screening including the use of risk stratification tools,
- Continue the development of whole system pathways -Implement new models of care across BHR for Cardiology, Respiratory and Diabetes.
- Customise BHR health check to enable case finding, i.e. for AF, Hypertension and respiratory conditions.
- Develop an offer for End of Life and palliative care for those with LTC.
- Extend scheme for clinical optimisation across community provision and services.
- Embed access to IAPT Services for those with LTC.

Year 3

- Select and evaluate service interventions implemented in year 2 to inform future planning and roll out. of schemes
- Further extend MDT to other cohorts of patients with LTC
- Select new priority area to focus on as part of Primary prevention strategy
- Expand areas of focus as part of optimising community services work stream

Key enablers



- Information Governance i.e. Data sharing between GPs and Pharmacies
- System interoperability, for example between and across Provider systems
- Information hosting (coding review)
- Single Point of Access
- Use of technology to deliver innovation and promote new models of care – Virtual MDT Clinics for those with Multiple LTCs
- Improved access to shared diagnostics

- Ensuring estate(s) are fit for purpose
- Locality based networks – does not have to be physical location, services can be provided virtually. i.e. via different use of technology

- Community social marketing
- Working with patients and careers in delivering out LTC strategy
- Educate and provide patients and service users with the tools to self manage and encourage patient activation

- Multi-disciplinary teams
- Role of care Navigators
- Training and development for health care professionals
- Role of the third sector
- Recruitment and retention
- Ensuring there is a mixed skill set of staff delivering the LTC Model of Care, i.e. Health Coach

Task and finish group - 1

1. **Early ID and First response**

- Early identification, first response and clinical optimisation, AF and Hypertension, – LTC Network LIS
- Optimising health checks
- One primary care (effective use of community pharmacies working in collaboration with primary care for identification and management of patients)
- Health coaching
- Group consultations and coaching
- Self management and social prescribing (developing and promoting tools such as app, dos, info packs, patient/peer buddies and social prescribers(ing) initiatives

Self management tools

Network LIS

Health coaching

Potential sub groups

Task and finish group 2

2. Complex case management, optimising community services and whole system pathways

- Optimising community services (enhancement and integration of community services)
- Whole systems clinical pathway development (includes integration between primary, community and secondary care as the first port of call with joint ownership of patients)
- Management of complex patients – Locality model

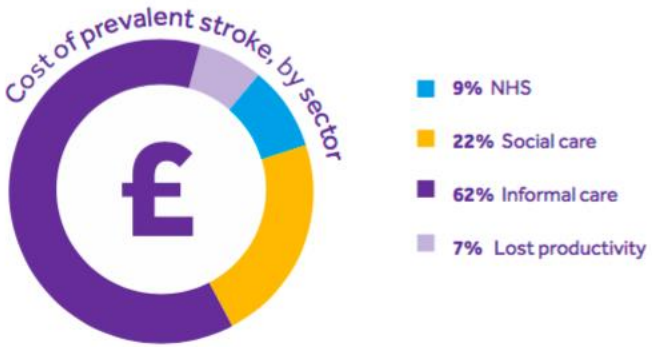
Cost benefit analysis

Current spend on LTC

- The total burden of LTCs traverses health and care boundaries and can impact significantly on a person's psycho-social wellbeing if not managed. People with Long term conditions account for about 50% of all GP appointments, 64% of all out patient appointment and 70% of all in-patient bed days (*source: DH, 2012)*

- Treatment and care for people with long term conditions is estimated to take up around £7 in every £10 of total health and social care expenditure *(source: Kings fund, time to think differently)*

- LTC burden goes well beyond health care spend, for e.g.; analysis produced by Stroke association shows significant burden on social, informal care and lost productivity *(as shown in diagram)*



For the purpose of local BHR strategy, we have tried to estimate direct impact from LTCs in hospital admissions, out-patient attendances, community services, social care costs and GP attendances (the latter three categories do not have a direct way to measure impact at present and would require whole system data capture to enable that). Work is in progress in form of data discovery that will provide more information on whole system costs.

- Our approach to estimating baseline costs and impact in secondary care included the following key steps:

Step 1: Selection of HRGs that are directly related to LTC (CVS and Diabetes)

Step 2: Refine HRG list with cross-validation from clinical leads

Step 3: Estimation of impact in year 1 and 2

Step 4: Quantum of savings if LTCs properly managed across the system

- Please note that the quantum of savings generated is an estimate (Base case scenario and best case scenario and will need to be refined further as part of individual project (PID) development.

Current spend on LTC – In-patient admissions

The analysis shown in the following slides represents a review of admissions both planned (day cases and electives) and unplanned (non-elective) for age group 18+ in BHR CCGs. The analysis is based on SUS+ data and Long term conditions are based on HRG codes identified by Clinical leads. The long term conditions shown in this analysis are related to Cardiovascular and diabetes conditions only. This report provides a high level summary to instigate further discussion and agreement of priority areas, before we embark on further investigation and deep dive analysis.

Key messages:

• BHR CCG total spend for admissions both planned and unplanned in 2017/18 is £243m ; of which £49m is related to admissions for long term conditions (LTC) (20%). Of the £49m spend for LTC

- 7.7%(2m) is attributed to day cases (DC)
- 4.8% (£4m) to elective admissions
- 87.5% (£43m) is attributed to non-elective admissions.

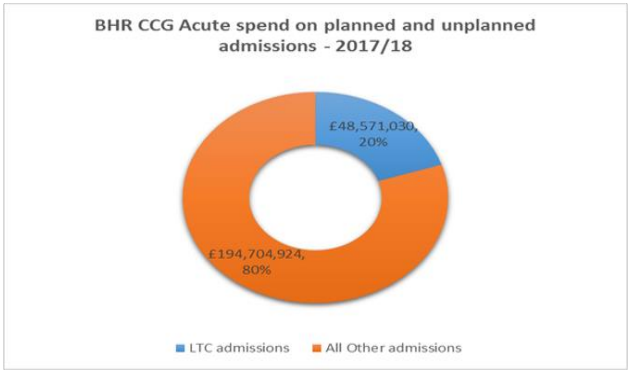
Non-elective admissions

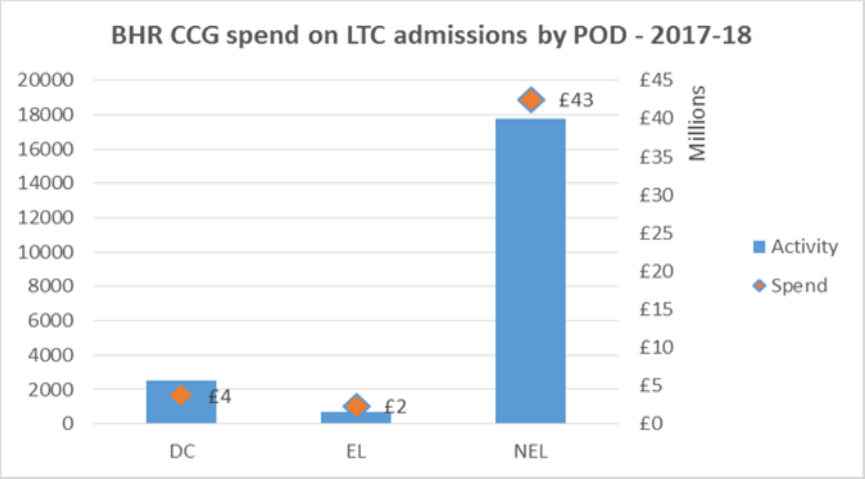
• 67% (£29m) of the non-elective spend in 2017/18 are for admissions related to 65+ age category, of which nearly 50% are for 75+ age group.

• 33% (£14m) of the non elective spend are for admissions for working age group (age group 18-64).

• Increase in trend in 17/18 and 18/19 (based on M6 forecast) for non-elective admissions related to long term conditions across all age groups.

For more details, please refer to the appendix. Please also note that the baseline data will need to be updated to reflect activity in 2018/19





Impact – quantum of savings – non elective admissions

- Two scenarios were created (scenario 1 – base case, scenario 2 – best case) in consultation with clinical leads
- Scenario 1 and 2 assume a reduction in admissions for specific HRGS between 7.5% to 35% in 2 years.
- Conditions such as stroke, heart failure, angina and diabetes with hypoglycemic disorders were deemed to have greater impact than others such as chronic kidney disease.
- Admissions such as cardiac arrest, primary pulmonary hypertension were deemed to have no impact in 2 years - although there was an expectation to see a sustained reduction in most HRGs in a longer period
- The table summarises potential quantum of savings in 2 years. For more details of individual HRGs, please refer to appendix and associated worksheets

Scenario 1			Year 1			Year 2		
	Total activity (NEL)	Total spend (NEL)	% impact	Activity reduction	Reduction in spend	% impact	Activity reduction	Reduction in spend
HRGs with high impact in 2 years	3823	£ 8,653,961	7.5%	287	£ 649,047	12.5%	478	£ 1,081,745
HRGs with medium impact in 2 years	4530	£ 4,015,909	3.5%	159	£ 140,557	6.5%	294	£ 261,034
HRGs with no impact in 2 years	8354	£ 22,231,797	0%	0	£ -	0%	0	£ -
Stroke	1057	£ 7,604,580	8%	88	£ 633,715	17%	176	£ 1,267,430
Total	**17764**	**£ 42,506,247**		**533**	**£ 1,423,319**		**948**	**£ 2,610,209**

Scenario 2			Year 1			Year 2		
	Total activity (NEL)	Total spend (NEL)	% impact	Activity reduction	Reduction in spend	% impact	Activity reduction	Reduction in spend
HRGs with definitive impact in 2 years	2211	£ 5,052,429	15%	332	£ 757,864	20.0%	442	£ 1,010,486
HRGs with medium impact in 2 years	1733	£ 3,955,286	7.5%	130	£ 296,646	12.5%	217	£ 494,411
HRGs with low impact in 2 years	5264	£ 5,705,536	2.5%	132	£ 142,638	5%	263	£ 285,277
HRGs with no impact in 2 years	7499	£ 20,188,416	0%	0	£ -	0%	0	£ -
Stroke	1057	£ 7,604,580	8%	88	£ 633,715.00	17%	176	£ 1,267,430
Total	**17764**	**£ 42,506,247**		**681**	**£ 1,830,864**		**1098**	**£ 3,057,603**

- Please note that these figures are estimates only and will need to be refined further during development of individual project initiation documents.
- Figures used are 2017/18 and will require to be updated by latest figures and prices for 2018/19
- Investments need to be considered on impact on savings and to assess/check potential overlaps with other existing 19/20 QIPP schemes

Impact – quantum of savings – other areas

- Other areas of impact will include:
  - Improvement in productivity in specialist nursing services
  - Reduction in costs of rehabilitation such as stroke and cardiac
  - Reduction in repeat attendances within primary care for people with LTCs
  - Reduction in social care costs and long term residential care
  - Wider economic benefits

Impact on quality outcomes

2

	Area		Potential impact
	Access		
	Efficiency		
	Clinical effectiveness		
	Patient / person experience		
	Staff experience		
	Equality		
	Other		

Dashboard to be developed post LTC board discussions

Key risks – Task Groups will continue to identify and address more operational risks working with Joint CCGS NELFT/BHRUT PMOs to oversee- escalating to LTC board as required.

Risk	Mitigation	RAG
There is a risk that the proposed model of care/interventions across our LTC programme of work does not stem the flow of activity into secondary care and may actually increase activity i.e. screening may led to the detection / identification of more people with LTCs which may require more complex cases needing referral into secondary care.	Development of clinical pathways and referral criteria, MDTs for more complex cases and encouraging patients to self-care/self – management should help mitigate this risk.	
As there are a number of detailed programmes of work emerging from the LTC strategy, there is a risk of insufficient capacity to deliver the work to timescales.	An LTC Senior Programme Manager is now in post since 19th March 2019. A number of T&F Groups have been established to drive project implementation. New Project Support Officer (2.5 days) is now in post since 3rd May 2019. Capacity issues to be reviewed as is required.	
Detailed programmes of work emerging from the LTC strategy requires coordination between and across organisations. There is a risk to delivery to timescales as a result of the need to work across multiple partners.	Our LTC Strategy has been developed jointly with partners with a series of workshops held over the last 5 months LTC Board and Task-Groups established and well attended by all partners. These provide a forum for joint working which enables co-planning, delivery and reaching joint resolution on issues.	
Detailed programmes of work emerging from the LTC strategy require significant financial investment which may not yield the expected returns (ROI).	Our approach is to capacity build where possible, reconfigure models of care and service delivery routes using technology and innovation where identified Detailed financial modelling will be undertaken for most schemes Where investment is needed, business cases will be subject to due diligence as part of PID approval processes.	

Appendix

Page 114

Potential impact analysis – summary table

- Two scenarios were created (scenario 1 – base case, scenario 2 – best case) in consultation with clinical leads
- Scenario 1 and 2 assume a reduction in admissions for specific HRGS between 7.5% to 35% in 2 years.
- The table summarises potential quantum of savings in 2 years. For more details of individual HRGs
- Figures used are 2017/18 and will require to be updated by latest figures and costs 2018/19

Scenario 1			Year 1			Year 2			Year 1 & 2 - Total		
	Total activity (NEL)	Total spend (NEL)	% impact	Activity reduction	Reduction in spend	% impact	Activity reduction	Reduction in spend	% impact	Activity reduction	Reduction in spend
HRGs with high impact in 2 years	3904	£ 8,755,289	7.5%	293	£ 656,647	12.5%	488	£ 1,094,411	20.0%	781	£ 1,751,058
HRGs with medium impact in 2 years	4700	£ 4,161,236	3.5%	165	£ 145,643	6.5%	306	£ 270,480	10.0%	470	£ 416,124
HRGs with no impact in 2 years	11287	£ 27,970,526	0%	0	£ -	0%	0	£ -	0.0%	0	£ -
Stroke	1065	£ 7,683,979	8%	89	£ 640,332	17%	178	£ 1,280,663	25.0%	266	£ 1,920,995
Total	**20956**	**£ 48,571,030**		**546**	**£ 1,442,622**		**971**	**£ 2,645,555**		**1517**	**£ 4,088,176**

Impact assumptions	Range	Average
High	20%	20%
Medium	10%	10%

Scenario 2			Year 1			Year 2			Year 1 & 2 - Total		
	Total activity (NEL)	Total spend (NEL)	% impact	Activity reduction	Reduction in spend	% impact	Activity reduction	Reduction in spend	% impact	Activity reduction	Reduction in spend
HRGs with definitive impact in 2 years	2262	£ 5,125,997	15%	339	£ 768,900	20.0%	452	£ 1,025,199	35.0%	792	£ 1,794,099
HRGs with medium impact in 2 years	1775	£ 4,024,967	7.5%	133	£ 301,873	12.5%	222	£ 503,121	20.0%	355	£ 804,993
HRGs with low impact in 2 years	5517	£ 6,108,308	2.5%	138	£ 152,708	5%	276	£ 305,415	7.5%	414	£ 458,123
HRGs with no impact in 2 years	10337	£ 25,627,779	0%	0	£ -	0%	0	£ -	0.0%	0	£ -
Stroke	1065	£ 7,683,979	8%	89	£ 640,331.58	17%	178	£ 1,280,663	25.0%	266	£ 1,920,995
Total	**20956**	**£ 48,571,030**		**699**	**£ 1,863,811**		**1128**	**£ 3,114,399**		**1827**	**£ 4,978,210**

Impact assumptions	Range	Average
High	30 - 40%	35%
Medium	20%	20%
Low	5 - 10%	7.50%

Potential impact analysis - HRG list

- The table shows list of HRGs with potential high, medium, low and no impact in two years

Additional information for scenario 2 - HRGs list		
Areas of high impact	1	Heart failure
	2	Hypertension
	3	Angina
	4	Diabetes with Hypoglycaemic Disorders
Areas of medium impact	1	Pulmonary Oedema
	2	MI
	3	Fluid or Electrolyte Disorder
	4	Syncope or Collapse, with CC Score 0-3
	5	Chronic Kidney Disease
Areas of low impact	1	Arrhythmia or Conduction Disorder
	2	Unspecified Chest Pain
	3	General Renal Disorders with Interventions
	4	Single, Amputation Stump or Partial Foot Amputation Procedure, for Diabetes/AD
Areas of no impact	1	Cerebral Degenerations or Miscellaneous Disorders of Nervous System
	2	Muscular, Balance, Cranial or Peripheral Nerve Disorders, Epilepsy or Head Injury
	3	Headache, Migraine or Cerebrospinal Fluid Leak
	4	Intracranial Procedures, 19 years and over
	5	Vitreous Retinal Procedures
	6	Pulmonary Embolus
	7	Cardiac Arrest
	8	Syncope or Collapse, with CC Score of more than 3
	9	Other Acquired Cardiac Conditions
	10	Primary Pulmonary Hypertension
	11	Complex Coronary Artery Bypass Graft
	12	Implantation of Cardioverter Defibrillator
	13	Implantation of Biventricular Pacemaker
	14	Implantation of Dual-Chamber Pacemaker
	15	Percutaneous Transluminal Repair of Acquired Defect of Heart
	16	Percutaneous Transluminal Coronary Angioplasty
	17	Cardiac Catheterisation
	18	Complex Echocardiogram
	19	Hepatobiliary or Pancreatic Procedures
	20	Liver Failure Disorders
	21	Non-Malignant, Hepatobiliary or Pancreatic Disorders
	22	Diabetes with Lower Limb Complications
	23	Acute Kidney Injury with Interventions
	24	Urinary Incontinence or Other Urinary Problems
	25	Ureteric or Bladder Disorders
	26	Percutaneous Transluminal Embolisation of Intracranial or Extracranial Aneurysm
	27	Multiple Open Procedures on Blood Vessels of Lower Limbs
	28	Single Open Procedure on Blood Vessel of Lower Limb
	29	Amputation of Multiple Limbs
	30	Amputation of Single Limb
	31	Peripheral Vascular Disorders
	32	Deep Vein Thrombosis
	33	Percutaneous Transluminal Angioplasty of Single Blood Vessel
	34	Other

Evidence Presentation LTC – information source

What works?

1. Health Coaching - Health Coaching quality framework from Health Education England: https://www.hee.nhs.uk/sites/default/files/documents/Health%20coaching%20quality%20framework.pdf
Why health coaching is beneficial to patients and the NHS: http://www.betterconversation.co.uk/images/Better_Conversation_Chapter1.pdf
Panagioti M, Skevington SM, Hann M, Howells K, Blakemore A, Reeves D, and Bower P(2018). Effect of health literacy on the quality of life of older patients with long-term conditions: a large cohort study in UK general practice. Quality of Life Research 27(5), pp. 1257–1268.
Blackmore A, Hann M, Howells K, Panagioti M, Sidaway M, Reeves D and Bower P (2016). Patient activation in older people with long-term conditions and multimorbidity: correlates and change in a cohort study in the United Kingdom. BMC Health Services Research 16(1), pp.

2. Quality and Outcomes Frameworks QoF - Forbes LJL (2017).The role of the Quality and Outcomes Framework in the care of long-term conditions: a systematic review. British Journal of General Practice 2017;67(664):510-

3. Self-management support interventions with certain component – 1. McBain H, Shipley M, Newman S (2015). The impact of self-monitoring in chronic illness on healthcare utilisation : a systematic review of reviews. 2. Panagioti M, Richardson G, Murray E (2014). Reducing care utilisation through self-management interventions (RECURSIVE) : a systematic review and meta-analysis.

4. Incentivisation - Bilger M, Shah M, Tan NC, Howard KL, Xu HY, Lamoureux EL and Finkelstein EA (2017). Trial to Incentivise Adherence for Diabetes (TRIAD): study protocol for a randomised controlled trial. Trials 18(1):551

5. Telehealth - Hanlon P, Daines L, Campbell C, McKinstry B, Weller D, and Pinnock H (2017). Telehealth Interventions to Support Self-Management of Long-Term Conditions: A Systematic Metareview of Diabetes, Heart Failure, Asthma, Chronic Obstructive Pulmonary Disease, and Cancer. Journal of Medical Internet Research 19(5): e172.

Evidence Presentation LTC – information source

6. Cognitive and behavioural therapies especially improving access to psychological therapies (IAPT) interventions -

1. McCrae N; Correa A; Chan T; Jones S; and de Lusignan S (2015). Long-term conditions and medically-unexplained symptoms: feasibility of cognitive behavioural interventions within the improving access to Psychological Therapies Programme. Journal of Mental Health 24(6), pp. 379-384. (6p). 2
2. . Anderson N and Ozakinci G (2018). Effectiveness of psychological interventions to improve quality of life in people with long-term conditions: rapid systematic review of randomised controlled trials. BMC Psychology 6(1), pp. 1-17

7. Collaboration (people 'working in partnership') in design and participation - Gilbert M, Staley C, Lydall-Smith S and Castle D. J. (2008). Use of Collaboration to Improve Outcomes in Chronic Disease. Disease Management & Health Outcomes 16(6), p381-390. 10p. 4 Charts.

8. Social interventions which link patients from health services to community-based sources of support - Mossabir R; Morris, R; Kennedy A; Blickem C; Rogers A (2015). A scoping review to understand the effectiveness of linking schemes from healthcare providers to community resources to improve the health and well-being of people with long-term conditions. Journal of Health and Social Care in the Community 23(5), pp. 467-484. (18p)

9. Proactive nurse telephone support services and home visits - Davis et al (2015). A Model for Effective and Efficient Hospice Care: Proactive Telephone-Based Enhancement of Life Through Excellent Caring, "TeleCaring" in Advanced Illness. Journal of Pain and Symptom Management 50(3), pp. 414-418

University of Birmingham (2009). Services for long term conditions: evidence for transforming community services. Birmingham: University Press

Health Care Professionals and Systems - Buja, A., Toffanin, R., Claus, M., Ricciardi, W., Damiani, G., Baldo, V., & Ebell, M. H. (2018). Developing a new clinical governance framework for chronic diseases in primary care: An umbrella review. BMJ Open, 8(7) doi:http://dx.doi.org/10.1136/bmjopen-2017-020626

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Havering Obesity Prevention Strategy – Annual Update 2018/19
Board Lead:	Mark Ansell, Director of Public Health
Report Author and contact details:	Claire Alp, Senior Public Health Specialist Claire.Alp@havering.gov.uk 01708 431818

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

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

SUMMARY

Havering's Prevention of Obesity Strategy 2016-19[1] and associated action plan was published in April 2016.

The strategy set out our approach towards preventing obesity in Havering, and encouraging our local population to be more active and eat more healthily. This was presented as three interlinked work streams to: -

- Shape the environment to promote healthy eating and physical activity;
- Support a culture that sees physical activity and healthy eating as the norm;
- Prompt individuals to change, primarily through self-help.

The action plan detailed how we would use existing assets and new opportunities to progress these workstreams, and the Health and Wellbeing Board agreed that an Obesity Prevention Working Group should be formed to periodically refresh and oversee delivery of this rolling annual action plan.

[1] London Borough of Havering. (2016). Havering Prevention of Obesity Strategy 2016-19.

Havering
LONDON BOROUGH

The purpose of this paper is to:-

- Update the Health and Wellbeing Board on progress made with implementation of the 2018/19 action plan. Notable highlights during 2018/19 include;
    - Local Implementation Plan 3 submitted incorporating healthy streets approach
    - Health In All Policies approach progressed
    - Embedding of the Healthy Early Years London awards programme
    - Expansion of Infant Feeding Cafés and Starting Solid Foods workshops
    - Ongoing success of the Veggie Run app and brand
    - Partnership approach to rollout of Healthy Pupils Capital Fund
    - Co-delivery of a joint Sugar Smart and Water Refill campaign
    - Piloting of an adult tier 2 weight management programme
    - Launch of the Havering Breastfeeding Welcome Scheme.
- Inform the Health and Wellbeing Board of local trends in prevalence of obesity, physical activity and healthy eating. Headline information includes:
    - Prevalence of excess weight remains broadly stable amongst 4-5 year olds but continues to increase amongst 10-11 year olds and adults. Prevalence in Havering is significantly worse than London for 4-5 year olds and adults.
    - Only 13.8% of young people and 65.8% of adults in Havering achieve the recommended levels of physical activity.
    - Half of young people aged 15 (49.2%) and adults (44.7%) in Havering eat the recommended five portions of fruit and vegetables per day.
- Highlight new national and regional publications, campaigns and funding programmes launched in the past year that support or guide our local efforts to prevent obesity;
- Outline plans to refresh Havering's Prevention of Obesity Strategy.
- Request the board's approval of the rolling action plan, refreshed for 2019/20;

RECOMMENDATIONS

The Board is asked to: -

- Review progress made with the action plan during 2018/19;
- Discuss the refreshed action plan for 2019/20 and suggest any amendments and additions;
- Subject to there being general agreement with the approach taken to date, and that any changes suggested by members are made, agree that the Chair of the Health and Wellbeing Board can approve the 2019/20 action plan without further reference to the Board;
- Approve our proposed approach to refresh the Havering Prevention of Obesity Strategy.
- Agree that the next update should be provided at the July 2020 meeting of the Health and Wellbeing Board.

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REPORT DETAIL

1.0 Update on progress made with implementation of the action plan and future planning

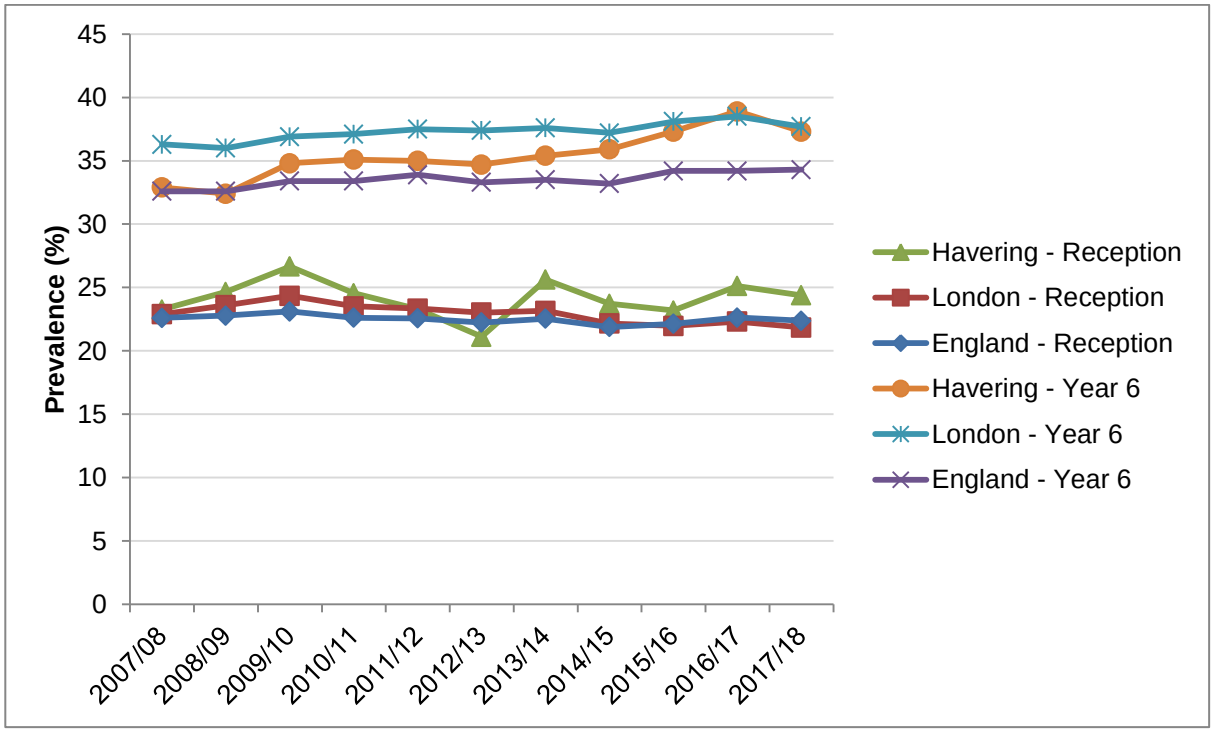
The Obesity Prevention Working Group, led by the LBH Public Health Service and with stakeholders from across the Council and external organisations takes responsibility for delivery of the action plan.

The action plan is provided as Appendix 1. RAG ratings and progress notes have been provided against 2018/19 actions, whilst new actions to be progressed during 2019/20 are indicated in blue in the RAG column.

2.0 Update on local trends in prevalence of obesity, physical activity and healthy eating

2.1 The prevalence of obesity in Havering

Figure 1. Prevalence of Excess Weight (Overweight and Obesity) in Reception and Year 6, Havering London and England, 2007/08 – 2017/18



- National Child Measurement Programme (NCMP) data shows that in 2017/18 prevalence of excess weight (overweight and obesity combined) amongst Reception children (4-5 year olds) in Havering was 24.4%. Trend data shows that prevalence has remained broadly stable since 2007/08. In 2017/18,

prevalence in Havering was significantly worse than England (22.4%) and London (21.8%).[2]

- NCMP data shows that in 2017/18 prevalence of excess weight amongst Year 6 children (10-11 year olds) in Havering was 37.3%. There has been an overall increase in prevalence in this age group since 2011/12, in line with the national trend. In 2017/18, prevalence in Havering was significantly worse than the England average (34.3%) but similar to the London average (37.7%).[2]
- Prevalence of excess weight amongst adults in Havering, drawn from self-reported height and weight measurements in the Sport England 'Active Lives' survey, was 71.2% in 2017/18. The survey methodology changed in 2016 and thus trend data is not yet available. In 2017/18, prevalence in Havering was significantly worse than both England (62.0%) and London (55.9%).[3]

2.2 Physical activity amongst adults and children in Havering

- In 2015, only 13.8% of Havering young people (aged 15) surveyed in the What About YOUth? survey reported that they had participated in the recommended minimum of 1 hour of moderate/ vigorous physical activity every day in the past 7 days, similar to London (11.8%) and England (13.9%). 74.1% reported they had a mean daily sedentary time in the last week of over 7 hours per day, significantly worse than across London (69.8%) and England (70.1%). This survey has only been carried out once so trend data is not available.[2]
- In Havering in 2017/18, 65.8% of adults surveyed in Sport England's Active Lives survey reported that they achieve recommended levels of physical activity (150 minutes per week according to the Chief Medical Officer's guidance). The survey methodology changed in 2016 and thus trend data is not available. Compared to regional and national averages in 2017/18, Havering is similar to London (66.4%) and England (66.3%).[3]
- The London Travel Demand Survey shows that on average from 2015/16 to 2017/18, 43% of journeys in Havering were made by active, efficient and sustainable modes of travel (walking, cycling and public transport). This ranks Havering 17th worst amongst the 19 outer London boroughs, ranging from 66% in Brent to 41% in Bexley and Hillingdon.[4]

2.3 Healthy eating amongst adults and children in Havering

- In 2015, 49.2% of Havering young people (aged 15) surveyed in the What About YOUth? survey reported that they achieve the recommended consumption of fruit and vegetables (5 portions per day). This survey has only been carried out once so trend data is not available. Prevalence in Havering is significantly worse than the London (56.2%) and England (52.4%) averages.[2]
- In Havering in 2017/18, 44.7% of adults surveyed in the Sport England Active Lives survey reported that they achieve the recommended consumption of fruit and vegetables (5 portions) on a 'usual day'. The survey methodology changed in 2016 and thus trend data is not available. This is significantly worse than the London (54.1%) and England (54.8%) averages.[3]

[2] Public Health England (2018) NCMP and Child Obesity Profile
[3] Public Health England (2018) Public Health Outcomes Framework
[4] Transport for London (2018) Travel in London: Report 11 Data

3.0 Highlights of 2018/19 work to prevent obesity

During the past year, members of Havering's Obesity Prevention Working Group have continued to make collective progress in their efforts to create an environment and culture in Havering that encourages and enables healthy eating and physical activity.

Building on projects and programmes described in the 2017/18 annual report, new and piloted interventions have been embedded during 2018/19 and a number of new programmes introduced. Highlights from actions carried out in the past year include:

3.1 Local Implementation Plan 3 submitted incorporating Healthy Streets Approach

The Healthy Streets approach provides a long-term vision to encourage more people to walk and cycle, by making streets healthier, safer and more welcoming. It seeks to ensure that noise, air pollution, accessibility and lack of seating and shelter are not barriers that prevent people – particularly our most vulnerable people – from getting out and about. In Havering we are implementing this approach through our Local Implementation Plan.

The importance of active travel is demonstrated by the fact that, by mode of travel, the amount of time spent being physically active during an average journey is less than one minute when travelling by car, compared to 8-15 minutes by public transport, 17 minutes on foot and 22 minutes by bicycle. The low level of physical activity participated in by children and adults in Havering (outlined above in Section 2.2) could be significantly increased if they were to walk or cycle as part of trips they already make. Schemes within the LIP3 submission aim to encourage this and have been designed with the Healthy Streets Approach in mind. Examples include:

- Implementation of pedestrian refuges on Squirrels Heath Road and Shepherds Hill which make roads easier to cross, encourage pedestrians from all walks of life and create a more relaxing and safe environment.
- Delivery of air quality initiatives across Havering which will achieve the clean air indicator of the Healthy Streets Approach and also create a more pleasant walking and cycling experience. The Miles the Mole campaign continues to be delivered alongside Air Quality Performance in Education theatre workshops and wider smarter travel work in schools.

Further proposals included in the LIP3 aim to assist in the prevention of obesity through increasing active travel. These include:

- Investment in Bikeability (cycle training programme) which provides skills and confidence for adults and children;
- School and Workplace Travel Planning
- Improved pedestrian access through alleyways
- Review of access arrangements into parks and open spaces
- A1306 Beam Parkway Major Scheme – Transformational scheme along the A1306 creating a Linear Park including pedestrian and cycle links and play areas.
- Greening the Romford Ring Road

3.2 Health in all Policies Approach progressed

Local authorities have a duty to improve health. Taking a 'Health in all Policies' approach ensures this duty is carried out systematically. In 2017/18 a combined Equality and Health Impact Assessment was piloted successfully. In 2018/19, next steps have been to incorporate consideration of health and wellbeing implications into the executive decision-making process.

Every decision the council makes, whether regarding a policy, strategy or delivery of a programme or initiative, has the potential to impact on people who live in, work in and visit Havering. Incorporating a 'Health in all Policies' approach into the decision-making process helps to ensure that positive impacts are recognised or potentially enhanced, and negative impacts are mitigated for or as a minimum shown to have been considered.

Obesity is a prime example of a health challenge that is impacted by multiple interacting factors that include wider social, cultural, environmental and economic impacts as well as individual lifestyle factors. By considering the impact a decision may have on factors such as an individual's behaviour and lifestyle or access to green space, and wider determinants such as quality of housing, access to services and amenities, and opportunities for social interaction, impacts on people being able to eat healthily and be physically active will be accounted for.

The Council's new Key Decisions template, which will include consideration of health and wellbeing implications and risks is due for publication in September 2019.

3.3 Embedding the Healthy Early Years London awards programme

HEYL provides a series of awards (first steps, bronze, silver and gold) through which early years providers develop a whole setting approach to supporting and improving the health of children in their care. The awards framework includes a number of steps to increase healthy eating and physical activity. Following a successful pilot phase, the Healthy Early Years London (HEYL) awards programme has been rolled out across the borough since June 2018.

At the conclusion of the pilot, three settings in Havering had achieved 'first steps', three had achieved the bronze award and two the silver. By the end of March 2019, this had increased to 41 registered settings, 20 of which had achieved First Steps, seven the Bronze Award and six the Silver Award.

In March 2019 the Deputy Mayor of London, Joanne McCartney, visited Havering to learn more about the approach taken by two of our childcare providers (Little Adventurers nursery and Little Poppets Childcare) in achieving their bronze and silver awards. Actions taken specific to obesity prevention by these settings included children growing their own fruit and vegetables which they then use to produce healthy snacks and menus.

3.4 Expansion of Infant Feeding Cafés and Starting Solid Foods workshops

Promoting breastfeeding and responsive bottle feeding, and the healthy and timely introduction of solid foods, are fundamental to our efforts to tackle obesity from the earliest possible opportunity in a child's life. In the past year, Infant Feeding Café provision has increased from two to three children's centres, with a fourth venue being considered in the Harold Hill area. Starting Solid Foods workshops have increased from one session per month in one centre, to three sessions per month across two centres with an additional session in a third centre being considered.

An evaluation of the first year demonstrated increases in knowledge and confidence of parents in introducing solid foods. Knowledge questions were scored out of 10, with the average increase being 2 points. 72.7% of parents reported increased confidence levels, and the remaining 27.3% reported that their confidence level remained the same. The validity of these findings will be increased in 2018/19 once more workshops have been held and accompanying pre- and post-workshop questionnaires gathered. The evaluation was also useful in highlighting aspects of the workshop that could be emphasised or strengthened and which were particularly welcomed or valued. Facilitator and delegate views are regularly discussed, and content and materials updated via Infant Feeding Steering Group meetings.

3.5 Partnership approach to rollout of Healthy Pupils Capital Fund

In May 2018, the Government made £100m of revenue generated from the Soft Drinks Industry Levy available to schools through the Healthy Pupils Capital Fund. The funding was for capital projects to support children's and young people's physical and mental health by improving and increasing availability to facilities for physical activity, healthy eating, mental health and wellbeing and medical conditions.

39 infant, junior or primary schools in Havering received funding via the local authority (academies received the funding direct). 33 of these schools used the funding to support physical activity and 9 schools used the funding to support healthy eating – note that some schools use the funding for more than one project and some projects (e.g. food-growing) cover both physical activity and healthy eating. Physical activity projects included playground resurfacing and markings, sport and play equipment, marking out routes for the Daily Mile and scooter parking/ storage. Healthy eating projects included water fountains, dining furniture and development of food growing areas.

OneSource Education Asset Management provided a list of schools and projects to Public Health and support was then offered to schools through the Health and Wellbeing in Schools service to add value to their projects. For example, schools that purchased water fountains were put in touch with the Waste and Recycling Team to link with the water refill scheme, and those that purchased gardening equipment were signposted to resources for food growing in schools.

3.6 Ongoing development of the Veggie Run app and brand

Veggie Run is a game app and brand developed by HES Catering Services that encourages children to make healthy choices and promotes uptake of school meals.

During the game, players aim to collect healthy foods and coins and dodge unhealthy foods. Health-based questions each time a child opens the app support learning. The app has been widely promoted across the borough, and prizes are offered to individuals and schools accumulating the most points. Partnerships have been formed with organisations and companies such as Everyone Active, Stubbers Adventure Centre, West Ham United Football Club and Quorn, to offer prizes that promote physical activity.

The branding and characters associated with the game are used on school menus and Veggie Run branding has been introduced around some canteen serving areas. Branded water bottles and character badges have also been promoted. 76% of primary schools in Havering endorse the app, and it has been downloaded over 23,000 times.

Significantly, school meal uptake in Havering increased by 300,000 meals between April 2018 and April 2019, and is thought to be largely attributable to Veggie Run. Research has shown that only 1.6% of packed lunches meet the school food standards (that all HES Catering primary school meals adhere to), so decreasing packed lunch and increasing school meal consumption is predicted to have a positive impact.

3.7 Delivery of a joint Sugar Smart and Water Refill campaign

Havering Council's Waste & Recycling Team and Public Health Service co-delivered a joint campaign during Recycle Week in September 2018 to raise awareness of the health and environmental benefits of swapping sugary drinks and plastic bottles for tap water and reusable bottles.

Free reusable water bottles and leaflets were distributed at events across Havering to promote the mutually beneficial campaign aims of reducing single use plastics and waste, whilst encouraging people to use free water refill stations around the borough and reduce sugary drink consumption.

Key to the campaign was making tap water more easily accessible, and local businesses and organisations around the borough were encouraged to register their venues as refill stations the Refill website to help make the healthier choice the easier choice.

3.8 Piloting of an adult tier 2 weight management programme

In 2017, Everyone Active, Havering Council's leisure provider, took over responsibility for delivering the Physical Activity Referral Scheme (PARS) from the Council. PARS is a 12-week gym-based programme that supports adults with a variety of long term conditions, who are referred by their GP, to increase their physical activity levels safely and effectively. Discounted membership is offered at the end of the programme. This year, Everyone Active built on this by working in partnership with their sister company Everyone Health to pilot a 12 week Tier 2 Weight Management Programme at Hornchurch Sports Centre. The programme incorporated nutrition education along with an exercise class tailored to achieving weight loss. This innovative community-based Tier 2 Weight Management programme attracted 11 participants of which 10 completed the programme. Nine participants lost weight with seven of these achieving the target

weight loss of 3-5%. The majority also reported improved self-esteem and eating habits. By locating a weight management programme at Everyone Active sites, the intention is to establish a routine of regular physical activity which helps to encourage longer-term participation.

Everyone Active is investigating funding options to enable it to build on the success of the pilot by continuing delivery of the programme at Hornchurch Sports Centre and expanding to other centres in Havering.

3.9 Launch of the Havering Breastfeeding Welcome Scheme

The aim of the Breastfeeding Welcome scheme is to make it easy for mums to find welcoming and supportive places to breastfeed and to recognise businesses and organisations for promoting and supporting breastfeeding.

Registered venues pledge to ensure the venue is promoted as being breastfeeding friendly, and that staff and volunteers are aware that mothers have a legal right to breastfeed in public and will support them if challenged by a customer or member of the public.

The scheme was soft-launched to Council and NHS premises in June 2018, and publicly launched to other community venues including cafés and restaurants in August 2018. Promotion took place via a press release, social media, Living magazine, a stand in the Liberty shopping centre during World Breastfeeding Awareness week, and an interview on Time FM.

Registration has also been written into the Healthy Early Years London bronze award framework in Havering.

By the end of March 2019, 29 venues had registered with the scheme. This includes all libraries and children's centres in Havering. The focus in 2019/20 will be on increasing the number of cafés and restaurants registered.

4.0 National and regional publications, campaigns and funding programmes

4.1 Childhood Obesity: A plan for action – Chapter 2 (HM Government, June 2018)

Since publication of the cross-Government 'Obesity: A plan for action – Chapter 2'[5] in June 2018 a number of actions have progressed at national level, including public consultations on restricting promotions of food and drink that is high in fat, sugar and salt and on updating the government buying standards for food and catering services, and launching the Childhood Obesity Trailblazer Programme (see section 4.2). The national plan for action aims to halve childhood obesity by 2030 and significantly reduce the gap in obesity between children from the most and least deprived areas by 2030. This

[5] HM Government (2018) Childhood Obesity: A Plan for Action, Chapter 2.

ambition has been reiterated in the vision document 'Prevention is better than cure' published in November 2018 and the NHS Long Term Plan published in January 2019.

Local authorities are strongly encouraged to take bold action including using planning powers to limit over-concentration of fast food takeaways, particularly around schools, as per National Planning Practice Guidance updated in 2017. In Havering this will be fulfilled though a combination of limiting overconcentration any of one type of use set out in our Local Plan, and preventing new outlets opening within 400m of schools in the London Plan.

The role of the public sector in leading by example is highlighted, and support will be provided for local authorities, schools and hospitals to adopt the Government Buying Standards for Food and Catering Services once consultation on strengthening the nutrition standards within these is complete. This consultation was launched by the Department of Health and Social Care in May 2019.

4.2 Childhood Obesity Trailblazer Programme

In November 2018, the Local Government Association launched the Childhood Obesity Trailblazer Programme (COTP) funded by the Department of Health and Social Care. Havering was one of 102 local authorities to submit a Phase 1 funding application, and one of 13 to be awarded £10,000 to undertake a 12-week discovery phase and develop a Phase 2 bid. If successful, a further £100,000 will be awarded per year for three years. At the time of writing the outcome of this bid is not known.

The COTP is focused on supporting innovation, harnessing the potential of local levers to address barriers to health eating and physical activity, and sharing learning. Examples include reducing children's exposure to advertising of products high in fat, sugar and salt; redressing the local high street food and drink offer so that healthier choices can become the default option; increasing options for physical activity locally; linking local services that provide prevention and intervention weight management support.

As in other areas, the local food and drink offer in Havering contributes to an obesogenic environment which heavily influences consumption behaviours. In 2018, Rainham Village high street was ranked the tenth most unhealthy in London. The discovery phase enabled us to work with residents, schools and food businesses in the Rainham Village area, mapping how children young people and families interact with their local food and drink environment, assessing what needs are driving this, and developing solutions to break these behaviour cycles. This phase revealed the following insights:

- Convenience and affordability are key influences on family food choices, even if parents' intention is to choose healthy options. There is opportunity to improve access to healthy, affordable and convenient meals.
- Independent business owners are highly risk averse and concerned about maintaining customers in a competitive, homogenous market
- The power of customer demand is crucial for motivating local food businesses to change their offer

- Typical council levers associated with shaping the food environment such as planning controls and business rate or licensing incentives did not have the propensity to restructure 'unhealthy high streets' in this instance so alternatives needed to be sought.

Our discovery phase revealed that the most compelling lever available to us was to extend the reach of the school catering service and use this to influence shopping, cooking and eating habits. Making use of our existing food procurement power through the Procurement Across London (PAL) group we proposed to:

- Design a viable option which could substitute the current 'every day' unhealthy convenience meal with a healthier product
- Use PAL buying power to ensure this is truly affordable for low-income families with children, using a cost-neutral business model so savings are passed on to parents
- Shift the local market in a healthier direction, encouraging businesses to sign up to the Healthier Catering Commitment
- Use social value funds from joint venture regeneration projects to support businesses to diversify their offer

Our application proposed using these assets and resources to explore how to meet parents' desire for healthy, convenient and affordable meals, and how to support businesses to take risks to improve their products. In doing so we hope to expose consumer demand for healthier products, and encourage Rainham's highly competitive market to shift toward healthier products in response.

We are due to be informed of the outcome of our Phase 2 funding application in June 2019.

4.3 Regional Strategies

Obesity prevention cuts across multiple regional policies and strategies including the London Plan[6], Transport Strategy[7], Food Strategy[8], Health Inequalities Strategy[9] and Strategy for Sport and Physical Activity[10].

The Healthy Streets Approach developed as part of the Transport Strategy is outlined in section 3.1.1 of this document.

The Food Strategy highlights the social, cultural and economic contribution food makes to London. Whilst acknowledging the positive and prosperous aspects of this, it also describes the challenges faced in creating equitable access to healthy food and the need for sustainable production, supply and consumption. It promotes good food across

[6] Mayor of London. (2016). The London Plan
[7] Mayor of London. (2018). Mayor's Transport Strategy 2018
[8] Mayor of London (2018). The London Food Strategy: Healthy and Sustainable Food for London
[9] Mayor of London . (2018). The London Health Inequalities Strategy
[10] Mayor of London. (2018). Sport for all of us: The Mayor's Strategy for Sport and Physical Activity

six domains, all of which contain links to actions that are in the gift of local authorities to support prevention of obesity:

- **Good food at home, and reducing food insecurity** – healthy eating is enabled through having the skills and access to fresh ingredients to cook at home
- **Good food economy, shopping and eating out** – opportunities for affordable, convenient, healthy ingredients and meals outside the home
- **Good food in community settings and public institutions** – schools, hospitals and other public settings provide healthy options
- **Good food for pregnancy and childhood** – healthy eating is promoted and supported in pregnancy, as are breastfeeding, starting solid foods and healthy eating in the early years and childhood.
- **Good food growing, community gardens and urban farming** – opportunities to grow food support healthy eating by connecting people with where their food comes from and increasing access to fruit and vegetables, and can increase physical activity levels.
- **Good food for the environment** – many synergies between healthy eating and the environment exist, for example breastfeeding benefits the health of mothers and babies, and benefits the environment by reducing the waste created as a result of infant formula milk production and packaging.

The Health Inequalities Strategy recognises the association between obesity and deprivation, noting the benefits of intervening early to address this. It outlines the greater presence of fast food outlets in deprived areas, the importance of free school meals in ensuring access to healthy food, and the need to ensure universal access to green space and safe, active and sustainable modes of travel.

A London Child Obesity Taskforce has been convened to coordinate opportunities for obesity prevention across these strategies and accelerate action on obesity across the city. The introduction of the Healthy Streets Approach, use of planning controls to prevent new hot takeaways opening within 400m of schools, and a ban on advertising of foods high in fat, sugar and salt across the Transport for London estate, evidence commitment and progress made to date.

5.0 Havering Prevention of Obesity Strategy

During 2018/19 Havering's Prevention of Obesity Strategy 2016-19 will be updated. Evidence in the JSNA and the direction of the Strategy remain relevant, so the intention is not to produce a new strategy but refresh the existing one to reflect the latest policy described in section 4. We will continue to produce an action plan that will be updated and reported on to the Health and Wellbeing Board on an annual basis.

Havering
LONDON BOROUGH

IMPLICATIONS AND RISKS

Financial implications and risks:

Any significant decisions arising from the ongoing implementation of this strategy action plan have or will be subject to normal governance processes within the relevant organisation.

There are no significant implications arising from adoption of this action plan.

Legal implications and risks:

Any significant decisions arising from the ongoing implementation of this strategy action plan have or will be subject to normal governance processes within the relevant organisation.

Human Resources implications and risks:

Any significant decisions arising from the ongoing implementation of this strategy action plan have or will be subject to normal governance processes within the relevant organisation.

Equalities implications and risks:

Any significant decisions arising from the ongoing implementation of this strategy action plan have or will be subject to normal governance processes within the relevant organisation.

BACKGROUND PAPERS

None.

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Havering Prevention of Obesity Strategy - Action Plan 2018/19 and 2019/20

Contents

Shaping the Environment
Supporting a Healthy Culture
Prompting Individuals

Key for RAG Rating columns

Action completed in 2018/19. Will not continue to be carried out/ monitored in 2019/20.
Action completed in 2018/19. Will continue to be carried out/ monitored in 2019/20.
Action in progress. Will continue to be carried out/ monitored in 2019/20.
Action halted or cancelled. Will not continue to be carried out/ monitored in 2019/20.
New action for 2019/20.

Key for other items

Brackets around officer names indicates officer is no longer responsible. New lead officer is named.

BHRUT	Barking, Havering and Redbridge University Hospital Trust
BPWG	Bedfords Park Walled Garden
C4L	Change4Life
CCG	Clinical Commissioning Group
CS	Children's Services
CSU	Commissioning Support Unit
CYP	Children and young people
DfT	Department for Transport
ED	Economic Development
FSM	Free School Meal
HAC	Havering Adult College
HCS	Havering Catering Services
HEYL	Healthy Early Years London
HIA	Health Impact Assessment
HSC	Havering Sports Collective
HV	Health Visitor
HWiSS	Health and Wellbeing in Schools Service
JCU	Joint Commissioning Unit
L&A	Learning and Achievement
LAC	Looked After Children
LBH	London Borough of Havering
LDP	Local Development Plan
LIP	Local Implementation Plan
MECC	Making Every Contact Count
NELFT	North East London Foundation Trust
NHS	National Health Service
PARS	Physical Activity Referral Scheme
PHS	Public Health Service
RS	Regulatory Services
STARS	Sustainable Travel: Active, Responsible, Safe
STP	Sustainability and Transformation Plan
SUD	Safer Urban Driving
TfL	Transport for London

Shaping the environment to promote healthy eating and physical activity									
Strategy objective *What we are trying to achieve*	**Action No.**	**Project/ Action** *What we will do to achieve it*	**Outcome** *How we will know we've achieved it*	**Resources** *What we need to be able to achieve it*	**Timescale**	**Lead officer**	**Impact on other services and organisations**	**Progress** *RAG*	*Notes*
Ensure Council decisions are consistent with efforts to increase levels of healthy eating and physical activity	**1.1**	Make use of resources on a healthy food environment and up-to-date guidance and training provided for planning inspectors when published		Officer time	Dependent on central government introduction as indicated in Childhood Obesity: A Plan for Action, Chapter 2	Claire Alp *Public Health*			Planning team aware of Health and Wellbeing section of Planning Practice Guidance. Local Plan includes oversaturation policy which will apply to hot food takeaways. Health in All Policies approach being embedded across the Council (see action 1.3).
	1.2	Incorporate consideration of health and wellbeing implications and risks into the new Key Decisions template	Key Decisions template includes section on Health and Wellbeing implications and risks.	Officer time	By September 2019	Louise Dibsdall *Public Health*	Provides framework to help ensure health and wellbeing is taken into account during decision making by all Council services		
Continue programme of work to create healthy streets and places	**1.3**	Continue to improve the street scene and local High Street offer	Planned improvements in street scene and the local high street offer are completed. More people accessing local centres on foot or bike. (reliant on DfT/ TfL data for monitoring) Reduction in road accidents (reported annually)	LIP/ Major Scheme funding LBH capital budget contribution for regeneration works Officer time	LIP funding awarded annually following a three year delivery plan Major Scheme funding for 5 year plan from 2016/17 (2 years of design, 3 years of build)	Chris Barter *Regeneration* Chris Smart *Regeneration*	Positive impact on local businesses Positive impact on transport network through new rail station		Beam Parkway continues to progress. Procurement is launching soon and contractor is due to be appointed by November 2019. Project will start in May 2020 with completion due by April 2021.
	1.4	Deliver Liveable Neighbourhoods Approach throughout regeneration work.	Schemes are funded through Liveable Neighbourhoods scheme to reduce car trips and improve neighbourhoods for walking, cycling and public transport.	Liveable Neighbourhoods scheme funding		Chris Smart *Regeneration*			
	1.5	Provide Public Health input into Romford and Rainham Masterplans	TBC as plans develop	Social Value Fund and additional funding as Masterplans progress		Nikita Sinclair *Public Health* Louise Dibsdall *Public Health*			
	1.6	Implement Childhood Obesity Trailblazer Programme proposals - in full if funding bid successful or scaled/ tailored appropriately if not	TBC as plans develop	TBC		Nikita Sinclair *Public Health*			
	1.7	Submit funding bid to GLA for installation and maintenance of public water fountains.	Bid successful and water fountains installed.	GLA funded scheme	April 2019	Natalie Naor *Waste & Recycling* Claire Alp *Public Health*			Bid submitted December 2018 for funding for water fountains to be located in Romford town centre, Rainham Village, Hilldene Shops, Upminster Park and Raphael's Park. Decision delayed due to water provider in Havering being Essex and Suffolk Water and not Thames Water (who had partnered with the GLA to offer the funding).

Shaping the environment to promote healthy eating and physical activity									
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	1.8	Develop Council-wide advertising policy jointly with Newham	Advertising policy developed and approved	Staff time	End of March 2020	Nikita Sinclair *Public Health* *One Source Procurement*	Impact on advertising revenue to be explored		
Continue to improve the public transport offer	**1.9**	Public transport to improve as a result of Romford, Gidea Park and Harold Wood Stations Crossrail investment	Planned improvements in public transport infrastructure are completed.	TfL funding	Ongoing - Crossrail works in place by 2019	Chris Smart *Regeneration*	Positive impact on local businesses, commuters and environment		Works to Romford Station and Gidea Park are complete. Works to Harold Wood Station are due to complete by April 2020.
	1.10	Develop transport and smarter travel work in ine with the Mayor of London's new 'Healthy Streets' vision and Transport Strategy	Programmes align	TBC	TBC	Daniel Douglas *Development & Transport Planning*			The LIP3 includes the 2019/20 LIP Programme. Included within this are a number of schemes that support Healthy Streets including identifiyng sustainable access routes into key town centres in the borough such as Upminster, Rainham and Harold Wood. The 2019/20 LIP Programme will be monitored on a monthly basis to ensure that schemes being delivered are working towards delivering the Healthy Streets targets set out within the LIP.
Maintain and improve access to high quality green space	**1.11**	Transition from SkyRide events to led cycle rides delivered through Havering's cycle hubs.	Local residents participate			Martin Day *Development & Transport Planning*			5 cycling hubs will operate through the summer holidays with led rides taking place at one of them (Ingrebourne Valley Visitor Centre) this year.
Improve the 'cyclability' of Havering	**1.12**	Cycle to Work scheme assists employees to purchase bikes to commute to work	Havering Council staff sign up to Cycle to Work scheme	Officer time	Report annually	Martin Day *Development & Transport Planning*			Was offered throughout 2018/19 and will continue into 2019/20.
Further improve schools as 'healthy' environments	**1.13**	Support schools to develop and update travel plans and continue to achieve STARS accreditation	Increased number of children, parents and staff travelling safely and actively. Monitoring integrated into programme including modal shift.	Officer time via TfL/ LIP funding	Report annually	Jay Amin *Development & Transport Planning*			Remains at 34 Gold schools (3rd highest in London). Campion School received School of Excellence award (1 of 20 across London). Anticipated decrease in engagement in STARS in 2019/20 due to impact of external influences on school capacity participate. TfL revisiting criteria.
	1.14	Continue to ensure meals meet school food standards in primary schools and work to implement standards in secondary schools	More CYP eating healthily, including disadvantaged CYP. Measure school meal take up in schools with menus that meet school food standards	Officer time HCS marketing	Report annually	Dennis Brewin *HES Catering* Claire Alp *Public Health* Tracey Wraight *Public Health*			Various events delivered to promote school meals and healthy menus: - Secondary schools Healthy Eating Week - Meat-Free Mondays in secondary schools - Awareness Days - Vegetarian Week

Shaping the environment to promote healthy eating and physical activity									
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	1.15	Encourage secondary schools to adopt policies that require children to stay on site at lunchtimes	More schools adopt a stay-on-site policy. Monitor via Healthy Schools applications.	Officer time	Report annually	Tracey Wraight *Public Health* *Charlotte Newman HES Catering*			All 18 secondary schools in Havering have a stay-on-site during lunchtime policy for Years 7-10 as a minimum. Year 11, 12 and 13 students are permitted to leave the site in some schools. The Healthy Schools programme continues to support schools to develop whole school food policies which includes a recommendation to implement a stay-on-site policy.
	1.16	Explore the possibility of making the Healthy Schools London programme universal so that all schools can be encouraged to meet healthy eating and physical activity standards	More schools engage in the Healthy Schools London programme	Public Health budget Officer time	Agree offer by November 2019 in line with timescales for publication of the 2020/21 Traded Services brochure.	Tracey Wraight *Public Health* Claire Alp *Public Health*			
	1.17	Work with schools to continue to improve playground physical activity environments	Monitor via Healthy Schools applications/ HSC. Training for playground supervisors offered by HSC/ HWiSS as required	PHS/ HSC Officer time School buy-in (PE and Sport Premium/ other school funding)	Training offered 2017/18	Sharon Phillips *HSC* Claire Alp *Public Health*			HSC continues to run sessions for midday supervisors/playleaders in positive play.

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Ensure Council acts as a positive role model	**2.1**	Explore cross-council commitment to Local Government Declaration on Healthier Food and Sugar Reduction	Declaration signed Progress made in each of the six key areas	Officer time	By July 2017	Claire Alp *Public Health*	Consider potential impact on other services during development		Proposed Havering LGD approved by Sustain, next step is for internal sign-off by DPH, Leader and Lead Member.
Continue to ensure that schools support healthy choices and lifestyles	**2.2**	Promote regular runnning schemes in schools	Monitor via Smarter Travel, Healthy Schools and HSC data Add to School Health Profiles in Sept 2017.	Officer time School staff time	Update School Health Profile for September 2017. Report annually	Jay Amin *Development & Transport Planning* Tracey Wraight *Public Health* Sharon Phillips *HSC*			Havering schools are encouraged to integrate regular running/ walking initiatives into school day via the Havering Mile, Daily Mile, Schools Run and Golden Mile. 'Active Mile' initiatives are encouraged in the national Childhood Obesity: A Plan for Action, Chapter 2 and further action will be taken in 2019/20 in line with this guidance.
	2.3	Continue to develop HWiSS offer and bring into line with national Healthy Rating Scheme for schools	Programmes align	Officer time	Awaiting introduction of national scheme	Tracey Wraight *Public Health*			Consultation on Healthy Rating Scheme responded to in 2018/19. Scheme has not yet been launched by government.
	2.4	Pilot introduction of Peas Please initiative in schools	Schools recruited to pilot initiative Initiative piloted	Officer time	By end of March 2020	Charlotte Newman *HES Catering* Tracey Wraight *Public Health*			
	2.5	Support schools to promote healthy eating/ physical activity in line with their choice of purchasing via Healthy Pupils Capital Fund	Schools signposted to relevant resources or training.	Officer time	By April 2019	Tracey Wraight *Public Health* Claire Alp *Public Health* Sally Shadrack *Education Asset Management*			£170,000 of HPCF distributed to schools for capital spend on improving health and wellbeing. Projects included playground markings, indoor and outdoor activity equipment, defibrillators, gardening areas/ tools, water fountains and creating wellbeing spaces. Appropriate support/ signposting/ resources were provided via Health and Wellbeing in Schools Service.
Continue to ensure that workplaces support healthy choices	**2.6**	Council and NHS organisations to actively participate in London Healthy Workplace Charter; share resources/ best practice	Up to date plan in place Evidence of on-going implementation	Officer time	Ongoing	Lindsey Sills *Public Health* Maria Healy *Human Resources* BHR			London Healthy Workplace Charter has been refreshed and is now known as the London Healthy Workplace Award. LBH plans to submit application for the Excellence award in 2020.
	2.7	LBH to continue to promote and deliver staff physical activity opportunities through the Workplace Wellbeing Operational Group	Activities promoted and run Monitor attendance at events/ activities	Officer time Health and Sports Development budget for activities	Report annually	Lindsey Sills *Public Health* Maria Healy *Human Resources* Darrell Braiden *Health & Sports Development*			Programme of lunchtime and after-work activities continues with lunchtime walks introduced during 2018/19. Havering Staff Games held June 2018. Sessions also delivered for staff on Cancer Awareness by CRUK and on CVD.

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	2.8	LBH to continue to promote and deliver healthy eating through the Workplace Wellbeing Operational Group	Activities promoted and run Monitor attendance at events/ activities	Officer time	By April 2018	Lindsey Sills *Public Health* Maria Healy *Human Resources*			Staff can access nutrition course on Learning Pool. The Pantry has reduced sugar in its own products by 5%, introduced 50/50 wholemeal/white pasta, discontinued drinks affected by the sugar tax and increased the price of others deemed high in sugar, reduced the price of water and other measures to improve the attractiveness of healthier items.
	2.9	Keep up-to-date with new guidance on Government Buying Standards for Food and Catering Services once published		Officer time	Dependent on central government introduction as indicated in Childhood Obesity: A Plan for Action, Chapter 2	Claire Alp *Public Health* Dennis Brewin *HES Catering*			Consultation on new guidance/ standards not yet launched.
	2.10	Explore opportunities to offer Pool Bike scheme to LBH staff (alternative to Pool Car scheme)	Scheme set up and available to staff	Reliant on funding availability		Martin Day *Development & Transport Planning*			On hold at present, cost and insurance the main issues
	2.11	Extend learning to private sector through Sustainable Travel pack	More businesses engage with sustainability agenda promoted via business pack	Officer time PH to offer input/ support	Ongoing	Martin Day *Development & Transport Planning*	Positive impact on employee health in private sector		Pack completed for distribution in summer 2019, starting with the Riverside BID and top 50 (by staff numbers) firms in Havering.
	2.12	Promotion of TfL Cycling Workplaces scheme via Sustainable Travel pack/ other communications	More businesses utilise funding to install showers, bike parking etc	Officer time	Report annually	Martin Day *Development & Transport Planning*			No longer funded by TfL
Continue to ensure community settings support and encourage healthy choices	**2.13**	Explore opportunities to provide fresh fruit and vegetable snacks at Stay and Play sessions in Children's Centres.	Fruit and vegetable snacks provided.	Officer time Budget to buy/ regular donation of fruit and vegetables	By end of 2016/17	Helen Anfield *Early Help Service*			All Children's Centre groups have free fruit provided - some is provided free by Tesco, other is funded by Early Help to ensure full coverage.
	2.14	Explore capacity to re-start Buggy Walks from Children's Centres and promote the Big Toddle	Buggy Walk Programme developed. Big Toddle promoted.	Officer time Volunteer time (to lead buggy walks)	By end of 2016/17	Helen Anfield *Early Help Service* Darrell Braiden *Health and Sports Development*			Training of volunteers as walk leaders due to commence in June 2019 with pilot walks programme being scoped for the north and south localities.

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	2.15	Deliver initiatives to increase uptake of school meals (L&A Service Plan)	School meal uptake increases	Officer time HCS budget and officer time	Report annually	Dennis Brewin *HES Catering*			Between April 2018 and April 2019, school meal uptake increased by 300,000 meals. This is thought to be primarily attributable to Veggie Run. Further details are provided in the Prevention of Obesity annual report. Continue to develop Veggie Run inclusing introduction of arch enemy character
	2.16	Ensure up-to-date, evidence-based nutrition advice provided in HES Catering menus and advertising	PH advises/ supports HCS as required	Officer Time	As required	Claire Alp *Public Health* Charlotte Newman *HES Catering*			In June 2018 HES Catering recruited a School Meals Nutritionist to lead on nutrition advice within HES Catering and link with other stakeholders such as the Health and Wellbeing in Schools Service.
	2.17	Bikeability training and road safety support continues to be offered to schools	Bikeability courses delivered Road Safety and 'Safe Drive Stay Alive' roadshow delivered	TfL funding Officer time School buy-in	Report annually	Martin Day Elaine Keeler *Development & Transport Planning*			Both continue to be delivered in schools.
	2.18	Focus on adult cycle training	Adult cycle training courses delivered	TfL funding	By April 2018	Martin Day *Development & Transport Planning*			Adult training took place during 2018/19 and will continue in 2019/20, predomniantly through the five cycle hubs. Target this year has increased from 250 to 500.
	2.19	Support schools to offer diverse programme of sport and health engaging whole school community	Monitored via Healthy Schools London bronze award/ HSC (No. of healthy lifestyle-related activities/ events for parents, no. of sports clubs coming into school etc) Support provided via HSC/ HWiSS where required	PHS/ HSC Officer time School Sport Premium/ other school funding School buy-in	2017/18 school year	Tracey Wraight *Public Health* Sharon Phillips *HSC*			To date at the end of March 2019, 34 schools had achieved Healthy Schools London bronze awards, 19 silver awards, 8 gold awards. HSC supports schools to run a Change4Life Sports Club and delivered associated 'C4L champions' training. HSC also delivers 'Health Days' or 'Smart Sessions' in schools that buy into the service.
	2.20	Develop links between HSC health offer and HWiSS	HSC and HWiSS offers align/ complement each other	Officer time	By Sept 2016	Claire Alp Sharon Phillips			Support provided by HWiSS to HSC to deliver Health Days and Smart Sessions.
	2.21	Roll out the Healthy Early Years London programme across Havering	Early Years settings achieve HEYL awards.	Officer time	Complete pilot by October 2018 Agree viability of wider rollout by April 2018	Celia Freeth *Early Years QA* Tracey Wraight *Public Health*			Borough-wide delivery of HEYL commenced in June 2018. At the end of March 2019, 41 settings had registered, 20 had achieved First Steps, seven the Bronze Award and six the Silver Award.

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	2.22	Align local promotion of Healthy Start with national Childhood Obesity: A Plan for Action, Chapter 2 developments	Uptake of Healthy Start vouchers by eligible families increase Market Traders accept Healthy Start vouchers	Staff time Public Health budget to fund cash card fees to enable weekly reimbursement of market traders	Commence pilot by end December 2018	Claire Alp John David Walsh	Potential increased footfall/ custom for market fruit and vegetable traders		Healthy Start scheme is being digitised so plans to increase promotion and acceptance of vouchers in Romford Market are on hold until this is launched in March 2020.
	2.23	Scope capacity to introduce Healthier Catering Commitment (HCC) scheme	Decision made on introduction of scheme	Officer time	Commence scoping when Environment Health restructure is complete.	Nichola Lund/ Sarah Quinn *Environ. Health* Nikita Sinclair *Public Health*			Public Protection restructure completed. Executive Decision process will commence Summer 2019 with aim to launch HCC in September 2019 as a phased rollout.
Coordinated programme of campaigns and marketing across partnership	**2.24**	Amplify national campaigns including Change4Life '10 Minute Shake Up', Change4Life 'Be Food Smart' and Sport England 'This Girl Can'	Increased awareness of campaign messages. Local press highlight support for campaign messages from Council / NHS partners	Staff time	In line with PHE marketing campaigns timeline	Claire Alp *Public Health* Yvonne Lamothe *Communications*			Campaign resources distributed to Council community facilities, incorporated into session plans where appropriate, and promoted via display boards and social media as follows: July 2018 - C4L Physical Activity January 2019 - C4L Nutrition March 2019 - S4L Weaning
	2.25	Deliver joint campaign to engage Havering businesses in: - Breastfeeding Welcome - Healthier Catering Commitment - Healthy Start - Water Refill - Sugar Smart - Target Your Trip - Healthy Workplace	Businesses register with relevant schemes	Staff time Business web portal and e-newsletter	Report annually	Nikita Sinclair *Public Health* Jolly Choudhury *Business Development*	Positive press coverage for restaurants and cafes signing up		
	2.26	Introduce Water Refill scheme	Venues register with www.refill.org.uk	Officer time Waste and Recycling team budget	April 2019	Natalie Naor *Waste & Recycling* Nikita Sinclair *Public Health*			Joint Waste and Recycling and Public Health Water Refill campaign delivered in September 2018 to co-promote reduction in sugary drink consumption and single-use plastic. Aim for 2019/20 is to sign up to the London Refill scheme and focus on promotion to businesses to encourage them to register their premises.

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	2.27	Promotion of Health & Wellbeing Team across all health related professionals and organisations. Health & Sports Dev team to contribute and assist partners.	Meet key partners to identify areas of need. Establish work plan. Joint intiatives established and sustained.	Officer time and budgets	Ongoing	Darrell Braiden *Health & Sports Dev* Sharon Adkins/ Debbie Bailey *Tapestry*			Health & Wellbeing team well placed to deliver a range of physical activity interventions across Havering. External funding actively sought to run additional sessions in areas where need is greater. Health and wellbeing team is represented across many forums and working groups both internal and external to the local authority and have established various partnership projects throughout the year. This is ongoing to ensure the team is promoted across Havering as the strategic lead for physical activity.

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Increase and import self-help capacity particularly regarding healthy eating	**3.1**	Train Early Years Practitioners and volunteers to deliver family cooking sessions	Delivery of Family Cooking sessions piloted	Budget for developing course content and training staff/ volunteers Staff time for delivery	Develop course content by September 2018 Pilot delivery by April 2019	Claire Alp *Public Health* Helen Anfield/ Linda Parsons *Early Help*			Planned for future introduction as part of commissioned HENRY programme (see action 3.26).
	3.2	Extend delivery of Starting Solid Food sessions to additional Children's Centres Evaluate pilot	Sessions offered at two additional Children's Centres	Early Help staff time Health Visiting staff time	First additional centre by September 2018 Second additional centre by March 2019	Helen Anfield/ Linda Parsons *Early Help* Breda Kavanagh *NELFT* Claire Alp			Evaluation of pilot completed - see Annual Report to Health and Wellbeing Board for further detail. During 2018/19 workshop delivery increased from 1 centre to 2. Delivery from 1 additional centre is being scoped for addition in 2019/20.
	3.3	Health and Sports Development to promote healthy eating in correspondence to sports clubs to raise awareness of evidence-based sources of information/ advice e.g. NHS Choices, HAC courses	Healthy eating information included in communications to sports clubs/ community organisations	Officer time Dedicated space in communications (e.g. e-newsletter) to organisations	By end March 2019	Darrell Braiden *Health & Sports Development*			Sports Development team tries to promote all aspects of health and wellbeing and has partner links on website. We also utilise social media to enhance health messages throughout Havering. A number of our coaches have attended Health Champion training enabling them to disseminate wider health messages to participants of our courses. Aiming extend this training to Walking for Health volunteers. Disseminate information to clubs via email and at monthly Sports Council meetings.
	3.4	Continue to deliver coordinated physical activity opportunities to enable to residents to participate and change behaviour e.g. healthy walks, adult physical activity programme, dance programme.	Programmes run	Culture and Leisure budget	Report Annually	Darrell Braiden *Health & Sports Development*			Sports Development Team organises and deliver a range of physical activity opportunities for all ages. All sessions are affordable and subsidised to ensure maximum participation. The team also puts on externally funded programmes and delivers to target groups when funding is secured to ensure underrepresented groups are catered for. Promotion of all events is integral to success.
	3.5	Introduce bespoke health-related activity for inactive population	Low impact sessions (tai chi, pilates, yoga) organised in local parks/ libraries linking with current partner activities in these areas.	Officer time Culture and Leisure budget	Report Annually	Darrell Braiden *Health & Sports Development*			Sports Development team organises range of low impact sessions across Havering working with various partner organisations. Older people - Walking for Health scheme to support return to physical activity after ill health, weekly tea dance as social activity. Staff sessions - e.g. yoga and pilates. Women and girls - summer activities to encourage lighter physical activity Also deliver Back to Netball and partnered with Our Parks to introduce boot camp style activities in local green spaces.
	3.6	Promote new online weight management service when launched by PHE.	Links to PHE weight management tools provided on LBH Healthy Weight webpage. Promote PHE weight management tools through communication channels and partners e.g. NELFT, Early Help Service	Officer time	Dependent on PHE timescale	Claire Alp *Public Health*			Digital Weight Management for children aged 4-11 and their families is currently in Discovery Phase. There is a commitment to deliver this in Childhood Obesity: A Plan for Action, Chapter 2 but further information has not yet been received.

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Ensure that residents and professionals working with them are aware of relevant (self-help) resources	**3.7**	As part of obesity care pathway development, ensure Council webpages list services and support relevant to healthy eating, physical	Residents can access the support that best meets their needs GPs and other health professionals signpost residents to these directories	Officer time	By April 2019	Claire Alp Katie Gray			Healthy Weight webpage maintained www.havering.gov.uk/achievingahealthyweight 0-5 webpage added. Continue to ensure Family Services Directory is up-to-date.
	3.8	Continue to recruit and train Health Champions	100+ Health Champions trained during 2017/18	PH grant	Health Champions trained by April 2018	Lindsey Sills *Public Health*	Communities/ businesses benefit from improved support/ knowledge		121 Health Champions trained (total 572 as of end of March 2019)
	3.9	Continue to offer Health Champions follow-on modules in healthy eating and physical activity	2 healthy eating and 2 physical activity courses offered during 2018/19	PH grant	Courses run by April 2019	Lindsey Sills *Public Health*	Communities/ businesses benefit from improved support/ knowledge		3 x RSPH Nutrition Level 2 accredited courses delivered to qualified Health Champions (45+ Health Champions trained) 3 x Diabetes Awareness sessions (45+ Health Champions attended)
	3.10	Health Champions continue to support/ deliver health promotion through community events	Healthy eating and physical activity information and signposting incorporated into events.	Officer time	Ongoing	Lindsey Sills *Public Health*			Community events supported throughout 2018/19.
	3.11	Explore options for low-cost/ cost-neutral MECC online training for NHS staff	Recommendation made subject to funding	Staff time		CCG			Free MECC face-to-face training being delivered and places available for train-the-trainer training in 2019/20.
Ensure care and support provided to vulnerable residents addresses wider health needs including healthy eating and physical activity	**3.12**	Encourage vulnerable families, in-house foster carers and care leavers etc to make use of available healthy lifestyle support and training e.g. healthy cooking sessions	Vulnerable families, in-house foster carers and adoptive parents attend available courses Timely and improved attendance in relation to health assessments	Officer time Training budgets for courses Existing information/ resources (e.g. NHS Choices)	By end March 2019	Robert South *Children's Services* Claire Alp *Public Health*			Action to be progressed in 2019/20.
	3.13	Integrate healthy eating and physical activity requirements into children's Care Plans	Children's social workers monitor via 6-weekly visits Independent reviewing officers monitor in biannual children's LAC reviews Supervising social workers monitor via annual review of foster carer	Officer time Existing information/ resources (e.g. NHS Choices) Consider capacity to monitor knowledge/ behaviour change amongst carers, children and young people (e.g. baseline and review questionnaire)	By end March 2018	Robert South *Children's Services* Claire Alp *Public Health*			Action to be progressed in 2019/20.
Ensure obese women are effectively supported during pregnancy	**3.14**	Review antenatal care pathway		As a minimum, officer/ clinician time	Ongoing	BHRUT NELFT			Action to be progressed in 2019/20.

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Ensure mothers are supported with infant feeding	**3.15**	Continue to strengthen links between LBH, BHRUT, NELFT and voluntary sector	BHRUT and LBH websites cross-reference each other LBH attends BHRUT Maternity and Neonatal Infant Feeding Working Group and BHRUT invited to LBH Infant Feeding Steering Group meetings	Officer time	Ongoing				Webpages cross-reference each other LBH regularly attends BHRUT infant feeding meetings and since early 2019 there has been midwife representation at the Infant Feeding Steering Group. Public events were held in the Liberty and Queens atrium to promote Breastfeeding Weeks and will be repeated in 2019/20.
	3.16	Extend delivery of infant feeding café to additional Children's Centre	Infant feeding cafés continue in two children's centres Additional session added at a third centre	Staff time		Helen Anfield *Early Help* Breda Kavanagh *NELFT* Claire Alp *Public Health*			During 2018/19, delivery of Infant Feeding Cafés has increased from 2 to 3 children's centres. A further venue (Harold Hill Health Centre) is being scoped as another potential future venue.
	3.17	Ensure Early Help and Health Visiting staff are trained to deliver consistent advice	Havering Infant Feeding Steering Group continues to meet regularly with cross-organisation representation	Budget fo training Staff time		Helen Anfield *Early Help* Breda Kavanagh *NELFT*			During 2018/19 a further 3 Early Years Practitioners completed Level 3 Unicef training taking total to 6. 6 other Early Help staff have completed Level 1 Unicef training Refresher is being identified for original practitioners to ensure up-to-date practice.
	3.18	Breastfeeding Welcome Scheme launched	Number of venues registered with the scheme	Budget for logo design, window stickers etc. Staff time	Launch by August 2018	Claire Alp *Public Health*			Breastfeeding Welcome Scheme was launched to Council premises and Early Years settings in June 2018 and publicly in August 2018 in line with World Breastfeeding Awareness Week. Communicated via press release, Living article and Time FM interview. At the end of March 2019, 29 venues had registered. Focus in 2019/20 will be on encouraging more businesses to register and the Havering Show will be Breastfeeding Welcome event.
	3.19	Children's Centres align actions with Unicef Baby Friendly Initiative framework to ensure a consistent, evidence based approach to infant feeding	Action plan produced in line with BFI framework	Staff time	Action plan completed by April 2019	Helen Anfield *Early Help* Claire Alp *Public Health*			Action plan has been written to guide the work of the Infant Feeding Steering Group.
	3.20	Write requirement for Health Visiting provide to achieve Baby Friend ly Initiative accreditation into new service specification	Progress made through Baby Friendly Initiative accreditation Stages 1, 2 and 3	Provider budget	Stage 1 accreditation achieved by end of March 2021	Claire Alp *Public Health* *HCP provider*			

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	3.21	Infant Feeding Steering Group members to develop and co-deliver PTI session for GPs	Session delivered	Staff time	By end of March 2020	Helen Anfield *Early Help* Claire Alp *Public Health*			
Ensure care pathway is in place for obese children and adults	**3.22**	Review and agree care pathway for obese children and adults	Equitable access according to need to limited resources	Officer time in first instance	Ongoing in line with STP development	Mark Ansell Nikita Sinclair CCG			No progress to date. Obesity is the the STP as one of the prevention priorities and pathway will be agreed in future.
	3.23	Everyone Active and HSC to look at options/seek external funding to deliver a childhood weight management programme at 2 leisure centres	Funding identified Delivery of Childhood weight management programme	Officer time, external funding	Ongoing April 18-March 19	Karen Heilbrunn *Everyone Active* Sharon Phillips *HSC*			Still seeking funding opportunities to deliver childhood weight management programme,
	3.24	In partnership with Everyone Health, Everyone Active to launch tier 2 weight management programme at Hornchurch Sports Centre (healthy eating information supported by physical activity sessions targeting adults who are overweight and obese (up to a BMI of 40)	Sessions trialled Minimum 10 participants attending first block of sessions	Officer time, partnership working with Everyone Health	June-Sept 18 development/launch then Sept 18 ongoing	Karen Heilbrunn *Everyone Active*			12 week pilot programme delivered in partnership with Everyone Health at Hornchurch Sports Centre Jan to April 2019. Programme incorporated nutrition education along with exercise class tailored to achieving weight loss. - 11 participants started, 10 completed. - 9 participants lost weight - 7 participants did lose weight, lost body fat, cm's from waist and altered their BMI - 7 participants achieved target weight loss of 3-5% Improved self- esteem for the majority of the attendees Eating habits changed Exploring funding options to expand to other centres in Havering.
	3.25	Everyone Active to continue to deliver the Everyone Active Referral Scheme - overweight, and obesity up to BMI of 40 is included in the referral criteria	Exercise Referral scheme delivered; increase in referrals, starters, completers	Officer time	Ongoing	Karen Heilbrunn *Everyone Active*			Ongoing delivery of Everyone Active Havering Exercise Referral Scheme, which includes overwight and obesity in the referral criteria. - 541 appropriate referrals (594 total referrals) - 460 clients were referred for obesity, along with 102 who were overweight (in most cases this is not the only reason for referral and to note that some GP's ticked both obesity and overweight for the same client) - 246 clients overall started the scheme - 79 clients completed the scheme - 40 clients had BMI 30-40, and 10 clients with a BMI 25-30

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