Havering
LONDON BOROUGH

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Subject Heading:	**Update on the Health and Wellbeing Strategy 2012-14**
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Policy context:	The Health and Wellbeing Strategy relates to all five Goals of the Corporate Plan 2011-14

SUMMARY

The Health and Wellbeing Strategy, published in 2012, is the responsibility of the Health and Wellbeing Board and sets out how those partner organisations will work together to improve the health and wellbeing of local people and improve the quality of, and access to, local healthcare services. It provides the overarching direction for the commissioning of health and social care services in Havering. Within the Strategy are eight priorities for action, each with a jointly agreed plan for how improved outcomes will be delivered for local people.

Over the course of 2013, the Health and Wellbeing Board has been monitoring progress on delivery of the Strategy and received updates from partners on four of the eight priorities, and an additional report on the future delivery of one priority. **This monitoring has satisfied the Health and Wellbeing Board that the Strategy continues to reflect the needs of Havering's population, supported by evidence developed as part of the Joint Strategic Needs Assessment and, as such, it has no current plans to revise the eight priorities.**

This report provides the Health Overview and Scrutiny Committee with an overview of the updates received by the Health and Wellbeing Board.

RECOMMENDATIONS

Members of the Health Overview and Scrutiny Committee are asked to review the report and note its content.

REPORT DETAIL

The Health and Wellbeing Strategy, published in 2012, is the responsibility of the Health and Wellbeing Board and sets out how those partner organisations will work together to improve the health and wellbeing of local people and improve the quality of, and access to, local healthcare services. It provides the overarching direction for the commissioning of health and social care services in Havering. Within the Strategy are eight priorities for action, each with a jointly agreed plan for how improved outcomes will be delivered for local people. The eight priorities contribute to three overarching themes:

- Prevention, keeping people healthy, early identification, early intervention and improving wellbeing
- Integrated support for people most at risk
- Quality of services and patient experience

Themes	Priority
Prevention, keeping people healthy, early identification, early intervention and improving wellbeing	1. Early help for vulnerable people to live independently for longer
	2. Improved identification and support for people with dementia
	3. Earlier detection of cancer
	4. Tackling obesity
Integrated support for people most at risk	5. Better integrated care for the 'frail elderly' population
	6. Better integrated care for vulnerable children
	7. Reducing avoidable hospital admissions
Quality of services and patient experience	8. Improving the quality of health services to ensure that patient experience and long-term health outcomes are the best they can be

Over the course of 2013, the Health and Wellbeing Board has been monitoring progress on delivery of the Strategy and received updates from partners on four of the eight priorities, and an additional report on the future delivery of one priority:

- Priority 1: Early help for vulnerable people to live independently for longer
- Priority 2: Improved identification and support for people with dementia
- Priority 5: Better integrated care for the 'frail elderly' population
- Priority 8: Improving the quality of health services to ensure that patient experience and long-term health outcomes are the best they can be

- Priority 4: Tackling obesity (additional report)

This monitoring has satisfied the Health and Wellbeing Board that the Strategy continues to reflect the needs of Havering's population, supported by evidence developed as part of the Joint Strategic Needs Assessment and, as such, it has no current plans to revise the eight priorities.

This report provides the Health Overview and Scrutiny Committee with an overview of the updates received by the Health and Wellbeing Board.

Updates

- **Priority 1: Early help for vulnerable people to live independently for longer**

Priority 1 focuses on the provision of healthcare support for older and vulnerable people through prevention and early intervention. An update on this priority was provided by Joy Hollister, Group Director for Children, Adults and Housing, London Borough of Havering to the Health and Wellbeing Board in July 2013.

Objectives	Progress
To help more vulnerable people maintain independence in the community and reduce use of acute/complex services	Assistive technology, falls prevention and the Community Treatment Team are helping more vulnerable people maintain their independence and reducing acute admissions. There are four Assistive Technology Projects, including Telehealth and Telecare. Telecare enables emergency services to respond following an alert from a personal trigger. At the time of the report, there were 881 Adult Social Care funded users of the Telecare service, of which 90% stated they felt better and that the technology prevented escalation to hospital or residential care. At the time of the update, the Falls Prevention Service reported a reduction in the number of falls (from 1,915 to 1,342); reduction of £2.6m hospital admission costs (from £6,993,020 to £4,368,668); reduction in falls admissions from residential and nursing homes (from 254 to 183); and a reduction in social care costs (from £2,300,000 to £1,225,000) since 2011/12. The Community Treatment Team is a multi-agency team that provides a rapid response to prevent admission to hospital (see Priority 5 on frail elderly'). They are focusing on interventions such as occupational health, COPD and urinary tract infections.

To tackle isolation and support vulnerable people to help maintain independent living	The Help Not Hospital project supports low level needs and prevents early need for acute health and social care services. The contract was awarded in September 2012, with service delivery from mid-October 2012. The project aims to support 250 non-FACS eligible people by increasing their independence, ability to self-manage and use established support systems. Volunteers have been recruited to support service users. The range of support includes: • Essential nutritional needs (shopping, preparing light snacks, providing drinks – provision or prompting through reablement) • Help with household management (light cleaning/ironing/washing clothes or prompting) • Emotional support and confidence building • Providing companionship (respite or befriending) • Supporting existing treatment plans (e.g. prompting exercises/escorting on local walks/public transport) • Maximising income (screening benefits/entitlements, help with household administration) • Escorting (to appointments/other venues) • Providing information and signposting (on other services/community resources/statutory services) • Safe and well checks (heating/safety and security)
To improve choice and control over the health and social care people receive	Choice and control is being expanded through the use of personal budgets, outpatient access, integrated case management, gold standards framework and reablement. Integrated Case Management (ICM) provides joined-up and co-ordinated care for patients at high risk of hospital admissions or those with Long Term Conditions. The service was reconfigured in April 2013, and consists of six teams comprising a District Nurse, GP, Social Worker, Community Matron and Case Co-ordinator have been established. The teams identify high risk patients and support them on co-ordinated care plans. At the time of the update, the project had produced benefits in reduced emergency admissions by 10%, as well as improving patient service and experience.
To deliver more community based support, including volunteer-led services for people recently discharged from hospital and provision of	The Joint Assessment and Discharge Service is taking a more joined-up/integrated approach to discharge from hospital to improve the quality of care. A recent change to seven day working is beginning to shift culture and already showing an improvement in patient experience.

reablement service to help them readjust to independent living	

- **Priority 2: Improved identification and support for people with dementia**

Dementia is a clinical syndrome characterised by a widespread loss of cognitive function. It is a priority for Havering due to its large and growing older population. Updates on this priority were provided by the London Borough of Havering and Havering Clinical Commissioning Group (CCG) to the Health and Wellbeing Board in April and September 2013.

The Dementia Partnership Board is a multi-agency partnership established to develop and deliver Havering's Strategic Dementia Plan, which is aligned to the National Dementia Strategy and seeks to improve the quality of life and services available for people with dementia and their carers. The Board reports into the Health and Wellbeing Board and is chaired by a CCG Board Member and the Clinical Director for Mental Health. It has access to £200,000 for dementia projects. A 1-year fixed term Dementia Programme Manager is being funded to oversee the Strategic Dementia Plan.

Objectives	**Progress**
To de-stigmatise dementia and ensure sufferers and carers receive best support in managing the condition	There have been a number of local public awareness campaigns about dementia and priority was currently being placed on establishing the true level of prevalence of dementia, and to understand the 'gap' in people receiving a diagnosis. Regular liaison with GP practices and the Havering Memory Service, provided by NELFT, is helping to improve a diagnosis, assessment and follow-up care and support. A pilot Vega "watch-style" assistive technology project involving 51 people has been running for approx. 18 months. An interim evaluation report has indicated positive outcomes such as delay in entering residential care and increased peace of mind and quality of life for users and their carers.
To ensure high quality care and accessible dementia information	A resource within the Commissioning Support Unit has been secured by the CCG to help review current patterns of referrals and activity against prevalence, scoring (dementia severity) etc. The CCG's Clinical Director leading on dementia and Practice Improvement Leads are working with GP practices to share information around dementia and to target improvement activity. A User Engagement sub-group is ensuring that the voices and views of people with dementia and their carers

	are heard and used to inform the development and implementation of services and initiatives.
To clinically train professional to recognise symptoms of dementia leading to earlier diagnosis	A Training and Education sub-group is overseeing the delivery of the Havering Dementia and Training Programme, which will ensure that all staff working with older people in the health, social care and voluntary sectors have access to dementia care training.
To deliver more universal services and better quality of care	A rapid response service is provided by NELFT and the CCG is using contract negotiations with NELFT around the inclusion of dementia services to improve urgent care for people with dementia and to increase the numbers of people with dementia remaining in their own homes with appropriate support. In 2013/14, peer support services facilitated 991 opportunities for Havering residents to receive peer support; the 'Singing for the Brain' sessions were operating weekly at full capacity and further weekly sessions agreed; and 'Information and Advice Outreach' was improving knowledge and awareness of dementia and local services amongst residents through travelling information 'surgeries' across the borough.

- **Priority 5: Better integrated care for the 'frail elderly' population**

Priority 5 focuses on the complex needs of the 'frail elderly' population, which provides one of the greatest challenges to our healthcare economy. An update was provided by Jacqui Van Rossum, Executive Director Integrated Care London & Transformation and Dr Steve Feast, Executive Medical Director, North East London Foundation Trust (NELFT) to the Health and Wellbeing Board in November 2013.

NELFT provides mental and community health services for Waltham Forest, Redbridge, Barking and Dagenham, South West Essex and Havering.

Objectives	**Progress**
To ensure seamless, integrated and efficient care pathways for 'frail elderly' people with care needs	The Community Treatment Team provides crisis intervention for patients in the community or as an alternative pathway on attendance at A&E. The service was fully launched in April 2013 to Havering patients and works with the CCG, Queens Hospital and the A&E interface, as well as the Integrated Care Coalition. It is a multi-disciplinary team consisting of medical, nursing, therapy and support staff. At the time of the update, the service had received 1,370 referrals for Havering patients and achieved a 14% reduction in admissions into acute care. A communications plan was in place to raise

	awareness of the service with GPs, residential and nursing homes, social care and the voluntary sector. The service operates 7 days per week 8am to 8pm.
To improve pathways into and through community based health services and general practice by working closely with the hospital and GPs	NELFT are building new relationships with the Integrated Care Coalition, Urgent Care Coalition and the provision of community mental health services to Barking Havering Redbridge University Trust (BHRUT) and Barts Health. The changes within the NHS and the inspection regime make for challenging times ahead. Following the Francis Report, NELFT staff are on 7-day working. However, the Trust needs to recruit more staff and are finding it difficult competing with the inner London Trusts. In response to the Francis Report, a number of initiatives have been organised, including the setting up of communication campaigns, conferences, focus groups and the promotion of relevant policies. NELFT have doubled their focus on quality and moved to borough based quality care. NELFT is looking to replicate the model for mental health, where only 3% of patients attend an inpatient unit, for the care of 'frail elderly' patients.
To reduce the incidence and impact of falls and improve the efficiency of care following injury as a result of a fall	NELFT has been providing a falls community exercise programme since February 2012, which incorporates exercise classes in various venues across the borough. Classes are run by a physiotherapist who provides evidence based falls management exercise classes (3 x 12 week programme) to residents over 65 who have suffered a fall or who suffer from balance impairment. There is also an outreach service into care homes, which provides cognition and environmental screening by an occupational therapist for patients at high risk of falls. Furthermore, an independent provider has been commissioned to deliver falls prevention and management training in care homes.
To enhance the independence and capability of individuals to manage their conditions at home	Havering's award winning service in dementia care has resulted in zero acute admissions for two years. As a result, wards had been closed and funds moved into the community. Rapid Assessment Interface and Discharge (RAID) teams have saved 2,600 bed days resulting in £1.4m in savings. There are now 2,200 staff in partner hospitals who have received training in working with people with mental illness in addition to a 24/7 helpline. There are close links with GPs/practice nurses, care homes and Community Mental Health teams with a consultant mobile number available, same day responses, clinic

	emergency slots for patients in crisis and contact with all patients who fail to attend clinic appointments. Patients are also encouraged to call the clinic if there are any problems. Stimulation and reminiscence therapy is available. As a result, care home admissions have dropped. Average waiting times have been reduced for Memory clinics, Havering has a three week waiting list, which compared to the national average is very positive. With regards to acute services, Havering has a new facility at Sunflowers Court and the number of acute admissions has fallen owing to the development of home treatment.
To provide support to people within the community who have recently been discharged from hospital or who are at risk of admission/ readmission	A new collaborative care team has been introduced at Queens Hospital to facilitate early discharge and admission avoidance.

- **Priority 8: Improving the quality of services to ensure that patient experience and long-term health outcomes are the best they can be**

Barking, Havering and Redbridge University Hospital Trust (BHRUT) and North East London Foundation Trust (NELFT) are the two main service providers for acute hospital and community services in Havering. The quality of care provided at Queens Hospital (BHRUT) has been a major concern over the past few years. The Chief Operating Officer of Havering CCG gave a presentation on progress on Priority 8 to the Health and Wellbeing Board in June 2013.

Objectives	**Progress**
To bring about big improvements in quality of care and patient safety, especially maternity services at Queens Hospital	Improvements in maternity services have been made - patient satisfaction; staffing levels and quality; maternity conditions and facilities - and the cap on the number of maternity patients has been lifted. There have been key issues, namely pressure ulcers, falls, Urinary Tract Infections (UTIs) and Venus Thromboembolism (VTE). These are to be closely monitored in 2013/14, as well as Accident and Emergency, with key performance indicators embedded within the contract. Serious incident management has significantly improved at BHRUT, with the number of cases overdue down from 143 in May 2012 to 11 in May 2013. Those overdue for 6

	months have fallen from 41 to 1 over same period.
To ensure patient experience in A&E is improved by reducing waiting times and diverting people away from A&E where appropriate	A&E quality and performance is still to improve and subject to further discussion with CQC, Trust Development Agency and CCG. It was acknowledged that the Trust has to achieve a significantly higher performance level on the national standard of patient waiting times – 95% of patients should wait no longer than 4 hours for treatment. As at 26 May 2013, BHRUT achieved 84.12% - although attendances remained relatively static. King George Hospital had met the target but has recently dipped and Queens Hospital has rarely met the target since April 2013. An improvement plan has been implemented, which comprises of the following: • An Integrated Care Plan to reduce attendances and support discharged patients at home. • Community Treatment Teams to provide a rapid response type service, so as to reduce attendances and admissions. • To promote use of Urgent Care Centres from 30% patient usage to 50%. • GP alignment to care homes in the borough, so as to reduce reliance on A&E. • Directory of services to increase use of community alternatives to A&E. Following CQCs visit to BHRUT, the Trust has submitted an updated improvement plan taking account of acute reconfiguration, plans for each workstream, leads, actions and key performance indicators, as well as the focus on patient experience and best practice suggestions itemised in the Department of Health checklist. The plan has been signed off and the Trust will be held to account.
To improve quality of care in community residential settings and increase primary medical care in nursing homes	The CCG nursing home scheme went live in March 2013. The scheme matches named GP practices with each of Havering's nursing and residential care homes ensuring regular visits are made to all residents: • 55 UTIs have been treated in the care homes; in addition only 8 UTIs has resulted in unplanned hospital admissions. • 2011/12 London Ambulance Service data showed an average of 108 call outs from care homes in Havering per month. In March 2013, this was down to 71 ambulance call outs. • 5 less admissions for Chronic Obstructive Pulmonary Disease (COPD) than the same month last year. • Intensive medicines management, including better

	utilisation of medicines and stock control.
To ensure sound financial management of the NHS budget for Havering so that quality of service is not compromised	Financial management practices include: • Monthly management of major providers through contractual arrangements. • Detailed financial information shared with practices to allow monitoring. • Quality Innovation, Productivity and Prevention (QIPP) plans agreed to deliver £11m financial savings. • Working closely with the Council to develop community budgets for 2014/15.
To manage risk systematically and accurately and reduce likelihood of occurrence of serious incidents	Monthly Clinical Quality Review Meetings consider the risks to quality and patient safety, as well as the CQC's Quality Risk profile around care and welfare of service users, staff support and service quality. Overall risks are considered by the CCG's Quality and Safety Committee Audits for 2013/14 - includes A&E, integrated care pathways and consultant-to-consultant referrals.
To commission and performance manage Healthwatch to high levels and ensure patient and public engagement	A joint appointment exercise was undertaken by the Council and CCG. Healthwatch is now fully established and a member of the Health and Wellbeing Board.

Future delivery

- **Priority 4: Tackling obesity**

Obesity is a complex issue that can be lead to a myriad of health problems such as diabetes, cancer and cardiovascular disease. Elaine Greenway, Acting Consultant in Public Health, provided a presentation to the Health and Wellbeing Board on the future work programme for Priority 4 in January 2014.

Objectives	Progress
To intervene early to slow down the rise in obesity level in adults and children	Havering has a significant number of assets that contribute to tackling obesity. However, much more needs to be done. These assets include: • Leadership (Health and Wellbeing Board) • Sports infrastructure (parks/facilities/gyms) • Physical activity strategy • Schools support for healthy lifestyles (e.g. Schools Sports Partnership, free breakfasts)
To promote healthier lifestyles and increase levels of physical activity to	

maintain healthy weight	• Voluntary sector (Havering Sports Council, Havering Circle) • School meals and Meals on Wheels • Healthy walks and Havering Active • Active travel: walk to school programme/cycling • Love Food/Hate Waste • Library services (on-line resources/newsletters/volunteers) • Primary care (GPs (Health Checks)/pharmacists) • School nurses, health visitors, midwives • Data: National Child Measurement Programme and Active People • Breastfeeding friendly environment A comprehensive needs assessment in underway to investigate how existing assets can be improved and developed and new innovative programmes introduced to halt the rise in obesity.
To raise awareness of health risks associated with being overweight and obese	

Progress reports on the outstanding three priorities will be provided to the Health and Wellbeing Board in 2014.

- **Priority 3: Earlier detection of cancer**

Cancer is a common disease, with one in 200 people in Havering being diagnosed with some form of cancer each year. Research has shown that more than 40% of cancers are attributable to avoidable risk factors such as smoking, alcohol, poor diet and lack of exercise and, as such, many people could significantly reduce their risk of developing cancer by living more healthily. The Health and Wellbeing Strategy sets out how partners will work together to:

- Maximise participation in cancer screening
- Raise public awareness of the signs and symptoms of cancer
- Further improve the identification and investigation of patients with the signs/ symptoms of cancer in primary care settings
- Improve the quality of cancer care

- **Priority 6: Better integrated care for vulnerable children**

Healthy, happy and educated children are more likely to become healthy, happy and productive members of society. Priority 6 focuses on improving the integration of care for our most vulnerable children in Havering by targeting those most at risk as part of our 'early help' offer. The Health and Wellbeing Strategy sets out how partners will work together to:

- Provide intensive, bespoke support to families with multiple complex needs
- Improve the stability of care placements
- Improve health outcomes for children and young people, particularly those in care

- Improve the transition from children's to adults care packages for young people with disabilities
- Reduce teenage conceptions and improve sexual health
- Reduce numbers of children experiencing poverty in Havering
- Provide access to high quality therapies for vulnerable children and young people

- **Priority 7: Reducing avoidable hospital admissions**

Avoidable hospital admissions are extremely costly to the NHS and cause disruption not only to the lives of those affected but friends and family as well. Long or frequent spells in hospital can increase dependency and reduce people's confidence in managing at home, particularly older people. Avoidable admissions include conditions that can be managed in the community. The Health and Wellbeing Strategy sets out how partners will work together to better integrate community services and avoid unnecessary admissions:

- Manage the care of patients proactively in the community through ICM
- Increase independence skills of people within the community who have been recently discharged from hospital or at risk of admission/readmission
- Reduce inappropriate and unplanned discharges, which lead to readmission
- Safeguard vulnerable people from neglect and abuse in care homes
- Ensure high quality prescribing of medications to reduce unnecessary admission

IMPLICATIONS AND RISKS

Financial implications and risks:

The partners of the Health and Wellbeing Board are working together to better integrate services and achieve the best possible healthcare outcomes for the residents of Havering. Any decisions, working practices or arrangements that may have financial implications or risks will be considered as part of service planning.

Legal implications and risks:

The partners of the Health and Wellbeing Board are working together to better integrate services and achieve the best possible healthcare outcomes for the residents of Havering. Any decisions, working practices or arrangements that may have legal implications or risks will be considered as part of service planning.

Human Resources implications and risks:

The partners of the Health and Wellbeing Board are working together to better integrate services and achieve the best possible healthcare outcomes for the residents of Havering. Any working arrangements that may have human resources implications or risks will be considered as part of service planning.

Equalities implications and risks:

The partners of the Health and Wellbeing Board are working together to better integrate services and achieve the best possible healthcare outcomes for the residents of Havering. Any decisions, working practices or arrangements that may have equalities implications or risks will be considered as part of service planning. The Strategy is focused on reducing the health inequalities that exist in Havering. With particular interventions, particularly in public health, health equity audits are carried out to ensure interventions designed to reduce inequalities are having the desired effect.

BACKGROUND PAPERS

- Health and Wellbeing Strategy 2012-14