Public Document Pack

Havering
LONDON BOROUGH

CABINET

7.30 pm	Wednesday 21 November 2012	Council Chamber - Town Hall

Members 10: Quorum 5

Councillor Michael White (Leader of the Council), Chairman

	Cabinet Member responsibility:
Councillor Steven Kelly (Vice-Chair)	(Deputy Leader) Individuals
Councillor Michael Armstrong	Transformation
Councillor Robert Benham	Community Empowerment
Councillor Andrew Curtin	Culture, Towns & Communities
Councillor Roger Ramsey	Value
Councillor Paul Rochford	Children & Learning
Councillor Geoffrey Starns	Community Safety
Councillor Barry Tebbutt	Environment
Councillor Lesley Kelly	Housing & Public Protection

Ian Buckmaster
Committee Administration & Member Support Manager

For information about the meeting please contact:
Andrew Beesley 01708 432437
andrew.beesley@havering.gov.uk

Webcast

Please note that this meeting will be webcast. Members of the public who do not wish to appear in the webcast will be able to sit in the balcony, which is not in camera range.

AGENDA

1 ANNOUNCEMENTS

On behalf of the Chairman, there will be an announcement about 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 DISCLOSURES OF PECUNIARY INTEREST

Members are invited to disclose any pecuniary interests in any of the items on the agenda at this point of the meeting. Members may still disclose any pecuniary interests in an item at any time prior to the consideration of the matter.

4 MINUTES (Pages 1 - 6)

To approve as a correct record the minutes of the meeting held on 7 November 2012, and to authorise the Chairman to sign them.

5 HEALTH & WELLBEING STRATEGY 2012-14 (Pages 7 - 90)

6 PUBLIC HEALTH TRANSITION TO HAVERING COUNCIL (Pages 91 - 108)

7 EXCLUSION OF THE PUBLIC

To consider whether the public should now be excluded from the meeting on the grounds that it is likely that, in view of the nature of the business to be transacted or the nature of the proceedings, if members of the public were present during the following item there would be disclosure to them of exempt information within the meaning of paragraph 3 of Schedule 12A to the Local Government Act 1972 which it is not in the public interest to publish; and, if it is decided to exclude the public on those grounds, Cabinet to resolve accordingly on the motion of the Chairman.

8 CHIEF EXECUTIVE'S REPORT CONTAINING EXEMPT INFORMATION (Pages 109 - 116)

MINUTES OF A CABINET MEETING
Council Chamber - Town Hall
Wednesday, 7 November 2012
(7.30 - 8.30 pm)

Present:
Councillor Michael White (Leader of the Council), Chairman

	Cabinet Member responsibility:
Councillor Steven Kelly (Vice-Chair)	(Deputy Leader) Individuals
Councillor Michael Armstrong	Transformation
Councillor Robert Benham	Community Empowerment
Councillor Andrew Curtin	Culture, Towns & Communities
Councillor Roger Ramsey	Value
Councillor Paul Rochford	Children & Learning
Councillor Geoffrey Starns	Community Safety
Councillor Lesley Kelly	Housing & Public Protection

Apologies were received for the absence of Councillor Barry Tebbutt.

Councillors Clarence Barrett, Keith Darvill, Michael Deon Burton, Paul McGeary, Garry Pain and Jeffrey Tucker were present for the meeting.

Unless otherwise indicated, all decisions were agreed unanimously.

The Chairman reminded those present of the action to be taken in the event of an emergency.

24 **MINUTES**

The minutes of the meeting of Cabinet held on 26 September 2012 were agreed as a correct record and signed by the Chairman.

25 **PEER CHALLENGE**

The Chairman explained that the Council had recently taken part in a 'Peer Challenge' where a team of senior officers and councillors from a variety of local authorities visited Havering to review the Council's strategic direction and its leadership, corporate capacity and financial resilience.

The review group provided positive feedback, considering that the Council had developed and implemented a strategic approach to the challenges it faced and continued to face, and that it should be proud of its achievements, particularly its

central transformation programme which had maintained customer-driven frontline services despite financial constraints.

The Chairman announced that a strategic work-plan would be formulated in response to findings due to be outlined in a report from the Peer Challenge review group which had yet to be released.

26 THE COUNCIL'S FINANCIAL STRATEGY

Councillor Roger Ramsey, Cabinet Member for Value, introduced the report.

Over the course of the previous two years, the Council had agreed a package of savings to mitigate the impact of very significant cuts in central government funding to local authorities.

Government plans for radical changes to a number of areas had been announced over this period, with more detail gradually emerging. These changes would fundamentally alter the way in which local authorities were to be funded. The report updated Cabinet on a number of developments in relation to the following changes.

- Localisation of business rates
- Localisation of Council Tax support
- The Social Fund Replacement Scheme
- School Funding Reform
- Academies
- Public Health Transfer
- Local Government Pension Scheme.

The report also set out the position in the current financial year, and a number of other relevant issues, as these need to be taken into account in developing the detailed budget for 2013/14.

Reasons for the decision:
It was essential that the Council's financial strategy took due account of Government plans, and any other material factors where these were likely to have an impact on the Council's financial position. The report provided an update to Cabinet on issues relevant to the budget setting process.

Other options considered:
None. The Constitution required the submission and consideration of the report as part of the Council's budget-setting process.

Cabinet **AGREED**:

1. To note the current position with developments relating to the funding of local authorities and other related changes.

2. To note the Government announcement relating to a further extension to the Council Tax freeze grant and a change in the referendum level, as set out in Section 2.9 of the report.

3. To note that the budget strategy statements for the revenue and capital budgets, along with the procurement strategy, would be presented for Cabinet's approval at a future meeting.

4. To approve the corporate charging policy, as set out in Appendix A of the report.

5. To approve the proposed standard rise in fees & charges for 2013/14 as 2%, subject to any exceptions, as set out in Section 5.9 of the report.

6. To note the position in the current financial year, as set out in Section 3 of the report.

27 ARRANGEMENT FOR THE PROVISION OF DOMICILIARY CARE TO ADULTS

Councillor Steven Kelly, Cabinet Member for Individuals, introduced the report.

The report provided Members with an overview of the recently concluded domiciliary care tender process for which the top scoring twelve providers were recommended for inclusion in the new framework agreement.

The invitation to tender stated that twelve to fifteen providers would be chosen from the submissions. Following evaluation, the tender panel recommended awarding at the lower end of the range indicated to tenderers, given the impact of personal budget take up on the size of the commissioned homecare market and the need for providers to attract enough business to be sustainable.

It was explained that the new framework agreement would support the delivery of the personalisation agenda within Adult Social Care and offer greater control over the resources used to provide care. The new specification, to which providers would be held accountable, contains an expectation of a truly personalised service. Providers would be expected to work within enabling methodologies to improve independence and minimise dependency, thus offering opportunities to minimise cost appropriately.

In reaching its decision, members were advised that an Equalities Impact Assessment had been conducted from which it was concluded that there would be no identified adverse impacts.

Reasons for the decision:

1. To ensure the continued delivery of domiciliary care to adults in Havering.

2. To make arrangements to ensure the delivery of that care under the new framework from January 2013 onwards.

Other options considered:

1. Do nothing. The current contract arrangements would come to an end and all future domiciliary care packages would need to be procured on an individual (spot purchase) basis. This was not a practical option and would lead to a potential decrease in quality and value for money. Furthermore the vetting and monitoring of multiple spot providers on an ongoing basis would require considerably more resources than monitoring an agreed pool of framework providers.

2. Attempting to extend the current contracts would only offer the Council a short-term solution and would be in contravention of European procurement rules. The latest executive decision to extend the current arrangements had been taken to bridge the time until the new framework contract (which was still being tendered) was in place. The current contracts did not acknowledge many of the legislative changes of the past five years, the introduction of technologies to better manage the domiciliary process and did not offer the opportunity to establish real efficiency savings or allow for flexibility. All of the aforementioned were now seen as essential to deliver on the personalisation agenda.

Cabinet **AGREED**:

1. To approve the 12 providers as listed in Appendix 1 to the report for the provision of domiciliary care services to adults under a framework agreement with the Council.

2. To approve the Council entering into a framework agreement with those providers in relation to the provision of domiciliary care services to adults.

3. To approve the Council from time-to-time and as required entering into service contracts to call-off the services on an individual basis under the framework agreement.

28 DISUSED LAND ADJACENT TO MELVILLE ROAD ALLOTMENTS, RAINHAM

Councillor Roger Ramsey, Cabinet Member for Value, introduced the report.

It was reported that at various occasions over the last few years Cabinet approval had been given to the disposal of a number of Council owned sites that had been identified as surplus, either as a result of specific projects or more general property reviews carried out by Strategic Property Services.

As the Council pursued a policy of selling surplus sites for many years it had become more difficult to identify new sites for disposal that did not pose challenges, either technically or in terms of planning, and especially in respect of objections to disposal that arise in many cases. Nonetheless, constant and ongoing appraisal of property assets to identify disposal opportunities was a requirement on all local authorities and at Havering was essential in providing capital receipts to fund spending to support and enhance Council services.

The report identified a site comprising of 2.13 acres of land adjoining Melville Road allotments that had remained unused for 24 years. It was recommended that the site could be re-used in part to extend the adjoining allotment site with the remainder being sold for residential development.

A full title search had been conducted on the land and legal advice sought on the detail of the existing covenants which did not restrict the land being used for potential planning developments.

Members were assured that the waiting list for allotments had reduced in number and that priority was given to Havering residents when sites became available.

Reasons for the decision:

In order to improve the efficiency of the Council's portfolio of land and property assets and to generate further capital receipts it was important to ensure that surplus assets continue to be identified for disposal. It was also good practice to appropriate to formally acknowledge a proposed change of use for the site.

Other options considered:

1. If the site was not sold, the most likely alternative was that it would remain in its current use or remain vacant.

2. If the site was not sold, it was likely that the capital programme would have to be reduced or funded from borrowing which would incur additional revenue costs.

Cabinet **AGREED:**

1. **That the disused land adjacent to Melville Road Allotments be declared surplus and authorisation be given for a disposal of about 1.53 acres and for the creation of additional allotment plots in respect of about 0.6 acres of land in accordance with the allotment waiting list requirements for the site. The disposal would be subject to obtaining any necessary planning permissions and other consents as appropriate. The Property Strategy Manager in consultation with the Assistant Chief Executive (Legal and Democratic Services) to be authorised to deal with all matters arising and thereafter to complete the disposal of the site identified. The disposal would be subject to the approval of the Secretary of State for Communities and Local Government.**

2. **To approve the principle that the land should be appropriated for planning purposes subject to the relevant statutory processes and that the Property Strategy Manager, in consultation with the Assistant Chief Executive (Legal & Democratic Services) be authorised to undertake these processes and for the Lead Member for Value to consider any objections received and whether to confirm the appropriation.**

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Chairman

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Havering
LONDON BOROUGH

CABINET

21 November 2012

Subject Heading:	Health and Wellbeing Strategy 2012-14
Cabinet Member:	Councillor Steven Kelly
CMT Lead:	Lorna Payne, Group Director Adults and Health
Report Author and contact details:	Claire Thompson, Corporate Policy and Community Manager Claire.thompson@havering.gov.uk 01708 431003
Policy context:	There will be a statutory requirement to produce a Health and Wellbeing Strategy under the Health and Social Care Act 2012. The strategy sets out the key priorities for health and health service improvement in Havering.
Financial summary:	There are no specific financial implications arising from adopting the aims within strategy. However achievement of these aims will be subject to the budgetary constraints of the various organisations and any financial implications identified as service delivery plans are formulated will need to the raised through the appropriate channels as they arise.
Is this a Key Decision?	No
When should this matter be reviewed?	November 2013
Reviewing OSC:	Joint Health O&S Committee

The subject matter of this report deals with the following Council Objectives

Ensuring a clean, safe and green borough	[]
Championing education and learning for all	[]
Providing economic, social and cultural activity in thriving towns and villages	[]
Valuing and enhancing the lives of our residents	[X]
Delivering high customer satisfaction and a stable council tax	[]

SUMMARY

This report outlines the 8 priorities of the Health and Wellbeing Strategy (attached in full as an appendix to this report). Its intention is to improve the health of the population in areas where Havering's performance is worse than the regional or national average. The strategy focuses on prevention and targeting people most at risk. It also has a specific priority focussing on improving the quality of health services in Havering.

Each section of the strategy identifies specific actions for delivery and targets for measuring performance improvement.

The Strategy has been endorsed by the Shadow Health and Wellbeing Board, and now requires formal ratification from Cabinet.

RECOMMENDATIONS

Members are asked to agree the content of the strategy and formally endorse its implementation.

REPORT DETAIL

1. BACKGROUND

1.1 The Health and Social Care Act 2012 will make an amendment to the Local Government and Public Involvement in Health Act 2007 imposing a duty upon the Council and the NHS Commissioning Board or the Clinical Commissioning Group (CCG) to prepare a joint Health and Wellbeing Strategy for meeting the needs identified in the local Joint Strategic Needs Assessment (JSNA). When it comes into force, this duty is to be discharged by the Health and Wellbeing Board. It will also place a legal obligation on

the CCG to take the JSNA and Health and Wellbeing Strategy into account when preparing and revising its commissioning plan.

2. HAVERING'S HEALTH AND WELLBEING STRATEGY

2.1 A workshop to identify the priorities for the HWBS was held with key stakeholders in March 2012. These included clinical commissioners (GPs), local authority and health commissioners, elected members and other agencies with an interest in improving the health and wellbeing of local people. The workshop identified the key health and social care issues emerging from the JSNA, as well as other practical intelligence, and looked at Havering's performance (in comparison with London and England) to identify areas where improvement was needed.

2.2 The HWBS sets out the vision "for the people of Havering to live long and healthy lives, and have access to the best possible health and care services". To help the Board achieve this vision, eight priorities have been identified. Under each priority, the strategy sets out:

- why the issue is important in Havering;
- what the current situation is in Havering;
- where we want to be in Havering; and
- how we will deliver improved outcomes, including key actions and performance targets.

2.3 The shadow Health and Wellbeing Board approved the content of the Strategy at a Special Meeting on 19th October 2012.

2.4 The Strategy is a key requirement of the Havering CCG's authorisation process, which takes place on 1st November, and as such the development of this strategy has been carried out to align with this timescale. The CCG has confirmed it is satisfied with the content and aims of the strategy and that it aligns to their strategic commissioning plan.

2.5 Havering's Health and Wellbeing Board has been set up in shadow form since last year, and will become a statutory Board from 1st April 2013. The Board will need to monitor the progress of the strategy to ensure commissioning plans align to its overarching priorities, which will also be a requirement of the new statutory duty.

3. THEMES, PRIORITIES AND OUTCOMES

3.1 Theme A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

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

Older and vulnerable people, especially those with long-term conditions, are the most intensive and costly users of health and social care services and

there is a clear need for their experience and outcomes achieved to be improved. They account for half of all GP appointments, two thirds of all outpatient appointments and nearly three quarters of all inpatient bed days. As our older population continues to grow, we are faced with increasing demands on these services. By focusing on prevention and early intervention, we hope to relieve some of this pressure on services and enable more people to live independently and safely in their own homes for longer and with a better quality of life.

We will:

- Help more vulnerable people, including those with long-term conditions and complex needs, maintain their independence in the community and reduce use of acute/complex services
- Tackle isolation and support vulnerable people to help maintain independent living
- Improve choice and control over the health and social care people receive
- Deliver more community based support, including volunteer-led services for people recently discharged from hospital and provision of reablement services to help them re-adjust to independent living.

3.1.2 Priority 2: Improved identification and support for people with dementia

Dementia is a clinical syndrome characterised by a widespread loss of cognitive function, including memory loss, language impairment, disorientation, change in personality, self-neglect and behaviour that is out of character. It is an extremely distressing illness and a particularly pertinent issue for Havering due to our large, and growing, older population.

We will:

- De-stigmatise dementia and ensure sufferers and their carers receive the best possible support in managing their condition
- Ensure high quality and accessible dementia information by improving data collection on the prevalence of dementia and data sharing between organisations
- Clinically train professionals to recognise the symptoms of dementia leading to earlier diagnosis and improved outcomes for sufferers and their carers
- Deliver more universal services and better quality of care for people with dementia.

3.1.3 Priority 3: Earlier detection of cancer

About 1,200 people in Havering (one in every 200) are diagnosed with some form of cancer each year and more than 600 a year die of the disease. National research shows that more than 40% of all cancer cases are attributable to avoidable risk factors such as smoking, alcohol, poor diet and lack of exercise. Most people could significantly reduce their risk of developing cancer by living more healthily.

We will:

- Maximise participation in the three cancer screening programmes, particularly for bowel cancer, which is a relatively recent development
- Raise public awareness of the signs and symptoms of cancer. To this end, we will evaluate the recently commissioned local awareness raising campaign and continue to support relevant national and London wide campaigns.
- Further improve the identification and investigation of patients with signs and symptoms suggestive of cancer in primary care settings
- Improve quality of cancer care services and patients' experience of care, including maintaining excellent performance on waiting times between referral of patients with suspected cancer and first consultant contact (two week waits) and 31/62 day targets for receiving treatment quickly after diagnosis; and increasing access to optimal treatment, particularly radiotherapy and surgery.

3.1.4 Priority 4: Tackling obesity

Being overweight or obese increases a person's risk of developing diabetes, cancer and cardiovascular disease. Being obese can restrict mobility and contribute to poorer mental health, which can limit a person's participation in their community and reduce their quality of life. Obesity is a complex issue that is affected by a range of behavioural, psychological, social, cultural and environmental factors.

We will:

- Intervene early to slow down the rise in obesity levels in adults and children
- Promote healthier lifestyles and increase levels of physical activity to maintain healthy weight
- Raise awareness of the health risks associated with being overweight and obese.

3.2 Theme B: Integrated support for people most at risk

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

Future demographic change will significantly increase the proportion of older people in the population. As a result, the number of 'frail elderly' residents will also increase. These are people with the most complex needs that currently provide the greatest challenge to health and social care providers.

We will:

- Ensure with partners, seamless, integrated and efficient care pathways for 'frail elderly' people with care needs
- Improve pathways into and through community-based health services and general practice by working closely with the hospital and GPs

- Reduce the incidence and impact of falls that often lead to the hospitalisation of older people and improve the efficiency of care following injury as a result of a fall, including hip fracture
- Enhance independence and capability of individuals to manage their conditions at home
- Provide support to people within the community who have recently been discharged from hospital or who are at risk of admission/re-admission
- Improve care in nursing and residential homes, including better management of demand to reduce avoidable hospital admissions and monitoring of safeguarding controls
- Improve support to people not currently engaged with social care such as self funders and those with lower levels of need to ensure that greater opportunities to benefit from prevention, improved health and wellbeing and support are provided
- Ensure informed choice on end of life care through robust information and guidance for patients and carers.

3.2.2 Priority 6: Better integrated care for vulnerable children

Healthy, happy and educated children are more likely to become healthy happy and productive adult members of society. Setbacks experienced in childhood as a result of troubled family backgrounds can result in long-lasting harm that persists throughout life and has a spiral effect leading to significantly reduced outcomes for those young people. Vulnerable children, such as those in care or with learning disabilities, face particular, more complex, issues and our priority is to support them to realise the same positive and sustainable outcomes as rest of the population.

We will:

- Provide intensive, bespoke, support to families with multiple complex needs to address their problems earlier
- Improve the stability of care placements and reduce placement breakdown, including reducing the number of placements between foster care and adoption
- 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 through the delivery of targeted campaigns that raise awareness of health risks
- Commission universal and targeted access to health visitors and schools nurses to deliver the Healthy Child Programme
- Reduce the numbers of children experiencing poverty in Havering by working collectively to deliver actions in the Child Poverty Strategy
- Provide access to high-quality therapies for vulnerable children and young people.

3.2.3 Priority 7: Reducing avoidable hospital admissions

Hospital admissions, especially avoidable admissions, are extremely costly to the NHS and disrupt the lives of those affected, as well as causing unnecessary distress to family and friends. Long and frequent hospital stay also cause increased dependency and ill health and reduce people's confidence to manage at home. We are keen to reduce unnecessary and unplanned hospital admissions, particularly for ill-health or injury that could have been avoided and repeat hospital admissions where individuals are admitted into hospital on a frequent basis.

We will:

- Manage the care of patients proactively in the community through planned care transformation such as integrated case management
- Increase independence skills of people within the community who have recently been discharged from hospital or who are at risk of admission/re-admission
- Reduce inappropriate and unplanned discharges, which lead to re-admissions and seek greater collaborative approaches to ensure that planning for discharges takes place closer to an individual's point of admission
- Ensure that vulnerable people are safeguarded from neglect and abuse when receiving care at home
- Ensure high quality prescribing of medications to reduce unnecessary hospital admissions.

3.3 Theme C: Quality of services and patient experience

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

Ensuring patients, and their families and carers, receive the best quality health and social care services is crucial to achieving the best long-term outcomes for patients. We would like to see consistently high levels of quality of care in all health and care services provided in Havering. Through collaborative working and robust provider performance management, the CCG will continue to improve the quality and safety of services to deliver its aim of improving patient, family and carer experience. We want patient experience of health and care services in Havering to be positive.

We will:

- Bring about big improvements in quality of care and patient safety, especially maternity services in Queens Hospital
- Minimise the incidence of avoidable harms in hospital and community settings, including pressure sores, falls, urinary tract infections and VTE
- Ensure patient experience in A&E is improved by reducing waiting times and diverting people away from A&E where appropriate

- Focus on quality of care in community residential settings and implementation of a scheme to increase medical care in nursing homes
- Ensure sound financial management of the NHS budget for Havering so that quality of services is not compromised
- Risk is managed by providers systematically and accurately to reduce likelihood of occurrence of serious untoward incidents
- Commission and performance manage Healthwatch to high levels of ensure patient and public engagement activity that can affect improvement.

REASONS AND OPTIONS

Reasons for the decision:
The Council has a prospective duty to produce a Health and Wellbeing Strategy. This version has been progressed to an advanced stage and it is considered appropriate to ratify this to assist the CCG in their authorisation process.

Other options considered:
The current draft version could be used as a working document and would still suffice for the CCG authorisation process.

The Council could wait until the legislative changes are made and the finalised guidance is produced.

This has been rejected because it is considered more appropriate that the Council formally endorses the plan to be submitted by the CCG

IMPLICATIONS AND RISKS

Financial implications and risks:
There are no specific financial implications arising from adopting the strategy which is a set of aims/value for the Council and our Health Partners to consider in delivering our services. Achievement of these aims through service delivery will be subject to the budgetary constraints of the various organisations and will depend on the actions which are developed in order achieve the various aims.

Any financial implications arising from the delivery of specific services lin order to achieve these aims will need to the raised through the appropriate channels as they arise.

Legal implications and risks:

It will be a statutory requirement under the Local Government and Public Involvement in Health Act 2007 as amended by the Health and Social Care Act 2012 for the Council, in partnership with the NHS Commissioning Board or the CCG, to prepare a health and wellbeing strategy although no date has yet been set for implementation. Draft statutory guidance has been subject to consultation and again no date has yet been set for publication.

There will be a number of requirements as to how the strategy should be devised which are set out in the proposed new statutory duty.. This is likely to mean that once the duty comes into force it will be necessary for the Strategy to be revised and fresh consultation undertaken.

Human Resources implications and risks:

There are no HR implications arising from this report.

Equalities implications and risks:

The strategy is intended to promote inclusion and the health and wellbeing of the borough's most vulnerable residents, including children at risk and the 'frail elderly' population.

A full equality analysis on the strategy has been carried out and is attached as a supporting document.

BACKGROUND PAPERS

- Appendix A is the full Health and Wellbeing Strategy
- Appendix B is the Equalities Analysis of the Health and Wellbeing Strategy.
- Havering's JSNA is published at www.haveringdata.net/research/jsna.htm
- The draft statutory guidance on health and Wellbeing Strategies and JSNA's was published in July 2012. The document can be found at http://www.dh.gov.uk/health/2012/07/consultation-jsna/

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Havering Health & Wellbeing Strategy 2012-14

Havering
LONDON BOROUGH

Contents

Executive Summary

Our vision is for the people of Havering to live long and healthy lives, and have access to the best possible health and care services. To help us move towards this vision, we have identified the most pressing health and social care issues in the borough and, by working collectively as a strategic partnership, we will prioritise the actions we need to take to deliver improved outcomes for local people. These are set out clearly in the Health and Wellbeing Strategy, which focuses on three overarching themes and eight priorities for action.

Theme A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

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

Older and vulnerable people, especially those with long-term conditions, are the most intensive and costly users of health and social care services and there is a clear need for their experience and outcomes achieved to be improved. They account for half of all GP appointments, two thirds of all outpatient appointments and nearly three quarters of all inpatient bed days. As our older population continues to grow, we are faced with increasing demands on these services. By focusing on prevention and early intervention, we hope to relieve some of this pressure on services and enable more people to live independently and safely in their own homes for longer and with a better quality of life.

We will:

- Help more vulnerable people, including those with long-term conditions and complex needs, maintain their independence in the community and reduce use of acute/complex services
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- Deliver more community based support, including volunteer-led services for people recently discharged from hospital and provision of reablement services to help them re-adjust 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, including memory loss, language impairment, disorientation, change in personality, self neglect and behaviour that is out of character. It is an extremely distressing illness and a particularly pertinent issue for Havering due to our large, and growing, older population.

We will:

- De-stigmatise dementia and ensure sufferers and their carers receive the best possible support in managing their condition
- Ensure high quality and accessible dementia information by improving data collection on the prevalence of dementia and data sharing between organisations
- Clinically train professionals to recognise the symptoms of dementia leading to earlier diagnosis and improved outcomes for sufferers and their carers
- Deliver more universal services and better quality of care for people with dementia.

Priority 3: Earlier detection of cancer

About 1,200 people in Havering (one in every 200) are diagnosed with some form of cancer each year and more than 600 a year die of the disease. National research shows that more than 40% of all cancer cases are attributable to avoidable risk factors such as smoking, alcohol, poor diet and lack of exercise. Most people could significantly reduce their risk of developing cancer by living more healthily.

We will:

- Maximise participation in the three cancer screening programmes, particularly for bowel cancer, which is a relatively recent development
- Raise public awareness of the signs and symptoms of cancer. To this end, we will evaluate the recently commissioned local awareness raising campaign and continue to support relevant national and London wide campaigns.
- Further improve the identification and investigation of patients with signs and symptoms suggestive of cancer in primary care settings
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Priority 4: Tackling obesity

Being overweight or obese increases a person's risk of developing diabetes, cancer and cardiovascular disease. Being obese can restrict mobility and contribute to poorer mental health, which can limit a person's participation in their community and reduce their quality of life. Obesity is a complex issue that is affected by a range of behavioural, psychological, social, cultural and environmental factors.

We will:

- Intervene early to slow down the rise in obesity levels in adults and children
- Promote healthier lifestyles and increase levels of physical activity to maintain healthy weight
- Raise awareness of the health risks associated with being overweight and obese.

Theme B: Integrated support for people most at risk

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

Future demographic change will significantly increase the proportion of older people in the population. As a result, the number of 'frail elderly' residents will also increase. These are people with the most complex needs that currently provide the greatest challenge to health and social care providers.

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- Provide support to people within the community who have recently been discharged from hospital or who are at risk of admission/re-admission
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Priority 6: Better integrated care for vulnerable children

Healthy, happy and educated children are more likely to become healthy happy and productive adult members of society. Setbacks experienced in childhood as a result of troubled family backgrounds can result in long-lasting harm that persists throughout life and has a spiral effect leading to significantly reduced outcomes for those young people. Vulnerable children, such as those in care or with learning disabilities, face particular, more complex, issues and our priority is to support them to realise the same positive and sustainable outcomes as rest of the population.

We will:

- Provide intensive, bespoke, support to families with multiple complex needs to address their problems earlier
- Improve the stability of care placements and reduce placement breakdown, including reducing the number of placements between foster care and adoption
- 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 through the delivery of targeted campaigns that raise awareness of health risks
- Commission universal and targeted access to health visitors and schools nurses to deliver the Healthy Child Programme
- Reduce the numbers of children experiencing poverty in Havering by working collectively to deliver actions in the Child Poverty Strategy
- Provide access to high-quality therapies for vulnerable children and young people.

Priority 7: Reducing avoidable hospital admissions

Hospital admissions, especially avoidable admissions, are extremely costly to the NHS and disrupt the lives of those affected, as well as causing unnecessary distress to family and friends. Long and frequent hospital stay also cause increased dependency and ill health and reduce people's confidence to manage at home. We are keen to reduce unnecessary and unplanned hospital admissions, particularly for ill-health or injury that could have been avoided and repeat hospital admissions where individuals are admitted into hospital on a frequent basis.

We will:

- Manage the care of patients proactively in the community through planned care transformation such as integrated case management
- Increase independence skills of people within the community who have recently been discharged from hospital or who are at risk of admission/re-admission

- Reduce inappropriate and unplanned discharges, which lead to re-admissions and seek greater collaborative approaches to ensure that planning for discharges takes place closer to an individual's point of admission
- Ensure that vulnerable people are safeguarded from neglect and abuse when receiving care at home
- Ensure high quality prescribing of medications to reduce unnecessary hospital admissions.

Theme C: Quality of services and patient experience

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

Ensuring patients, and their families and carers, receive the best quality health and social care services is crucial to achieving the best long-term outcomes for patients. We would like to see consistently high levels of quality of care in all health and care services provided in Havering. Through collaborative working and robust provider performance management, the CCG will continue to improve the quality and safety of services to deliver its aim of improving patient, family and carer experience. We want patient experience of health and care services in Havering to be positive.

We will:

- Bring about big improvements in quality of care and patient safety, especially maternity services in Queens Hospital
- Minimise the incidence of avoidable harms in hospital and community settings, including pressure sores, falls, urinary tract infections and VTE
- Ensure patient experience in A&E is improved by reducing waiting times and diverting people away from A&E where appropriate
- Focus on quality of care in community residential settings and implementation of a scheme to increase medical care in nursing homes
- Ensure sound financial management of the NHS budget for Havering so that quality of services is not compromised
- Risk is managed by providers systematically and accurately to reduce likelihood of occurrence of serious untoward incidents
- Commission and performance manage Healthwatch to high levels of ensure patient and public engagement activity that can affect improvement.

Foreword

The Health and Wellbeing Strategy sets out how we will work together to improve the health and wellbeing of local people and improve the quality of, and access to, local healthcare services.

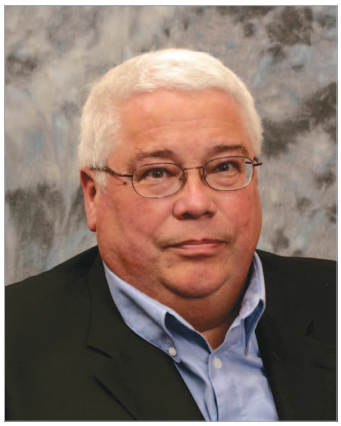
We have a lot to be proud of in Havering. Life expectancy is high and residents feel that the borough offers a very good quality of life. The borough is one of the greenest in London, with plenty of parks and open spaces. There are a wealth of entertainment and shopping facilities, high quality cultural facilities, excellent schools, good transport links and relatively high levels of employment.

However, when it comes to people's health and social care, we know there are things we can improve on, such as the quality of our local hospitals and community care services. We can do more to improve cancer survival through better provision of healthcare services and by raising people's awareness of the signs and symptoms of cancer so they come forward for treatment at an earlier stage. We can also do more for our older residents by improving support for people with dementia and doing all we can to prevent older people ending up in hospital unnecessarily.

This strategy has been developed after listening to the concerns of our residents, engaging with local health and social care professionals about how we can improve our health system, and analysing the evidence we have on the health and wellbeing of our population and the performance of local health services.

We are in a period of great change in the way health services are commissioned. From 2013, clinical commissioning groups, made up of local GPs, will control most of the health service budget. The Council will also have specific responsibilities around improving the health of the public. A new Health and Wellbeing Board, made up of GPs, local councillors, and healthcare professionals, as well as other commissioners of health services and patient involvement networks, will oversee the delivery of the strategy. The Health and Wellbeing Board will monitor and publish its progress against this strategy each year.

Good health is everyone's responsibility. We hope that this new direction of partnership working will deliver improvements in local healthcare services and raise the health and wellbeing of Havering residents.



Cllr Steven Kelly

Chair of Havering Health and Wellbeing Board

Dr Atul Aggarwal

Chair of Havering Clinical Commissioning Group

Introduction

Our vision

Our vision is for the people of Havering to live long and healthy lives, and have access to the best possible health and care services.

Purpose of the strategy

The Health and Wellbeing Strategy sets out how we 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 and is the responsibility of the new Health and Wellbeing Board. Within the strategy are our priorities for action and each has a jointly agreed plan for how we will deliver improved outcomes for local people. The strategy will be delivered by partners of the Health and Wellbeing Board (see Appendix A for membership details of the Board).

The Board is committed to ensuring that health and social care services in Havering are effective and cost-effective. Plans will be continually reviewed against the best available evidence and amended, where necessary, to ensure that the best possible outcomes are achieved within the resources available.

Havering's Joint Strategic Needs Assessment

The JSNA analyses the health and wellbeing needs of the local population by drawing upon a range of data and intelligence from various sources, including feedback from local people. It enables us to compare Havering's performance with other areas, and identify where health and care services perform well and where we need to improve. The collection of JSNA resources and information, which includes other needs assessments and reports, is regularly updated and made publicly available on the Havering Data Intelligence Hub at **www.haveringdata.net/research/jsna.htm**

Stakeholder engagement

In March 2012, a workshop was held with partners of the shadow Health and Wellbeing Board, which included clinical commissioners (GPs), local authority and health commissioners, elected members and other agencies with an interest in improving the health and wellbeing of local people. The workshop focused on the key issues emerging from the JSNA. It also looked at the indicators contained within the three national outcomes frameworks for the NHS, public health and social care, and identified where Havering's performance was above or below the national average against these measures. From this session, the key priorities for the Health and Wellbeing Strategy emerged and were subsequently agreed at the next Health and Wellbeing Board meeting. Further to this, stakeholder engagement took place through the Integrated Care Strategy to test priorities for health and social care, most recently in June 2012.

Public consultation

A summary of the strategy, providing an overview of the themes, priorities and outcomes, was made available for public comment on the Council's website during September and October 2012.

Equality analysis

In line with the Council's obligations under the Public Sector Equality Duty, the strategy has been assessed for its equality implications and the impact of the proposed actions on disadvantaged groups of the population. This document is available on the Council's website.

Havering, the Place

Overview

The population of Havering is generally fairly healthy. It has long life expectancy rates, excellent schools, a strong local economy, an active cultural scene and plenty of pleasant green open spaces. As an outer north east London borough, transport connections to the centre of London and surrounding areas are good.

However, dig deeper beneath the surface of these facts and there are stark differences in how long people can expect to live, depending on where they live and the circumstances of their upbringing; significant inequalities in how likely certain groups of people are to develop certain illnesses or make unhealthy lifestyle choices; large variations in affluence and poverty; pockets of poor housing; and in some areas, relatively high levels of worklessness.

Population

Havering has 237,200 residents and 243,508 people registered with a Havering GP. It has one of the largest older populations in London, with 21% (49,000 people) of retirement age. It has a large younger population too, with 24% (56,700 people) aged 19 and under. Population projections show that the population is likely to grow at a faster rate than the London average – 5.4% (12,699 people) by 2016 and 11.5% (27,095 people) by 2021. The projected increase in the older population is likely to result in larger numbers of residents experiencing cardiovascular disease (CVD), cancer, respiratory illnesses (e.g. bronchitis and pneumonia), dementia, osteoporosis (and fractures due to falls), incontinence and hearing impairment, placing further demand on local health and social care services, hospitals and community services to help manage long-term conditions.

Deprivation

Havering is ranked 177 out of 326 local authorities for deprivation (with 1 being most deprived and 326 being least deprived). However, pockets of deprivation still exist, with two small areas of Havering falling into the 10% most deprived areas in England (areas in Gooshays and South Hornchurch). When compared to other London boroughs, Havering has a relatively small proportion of children living in poverty. However, 19.3% of children are still estimated to be living in poverty in Havering.

Public perception

Results from the 2011 'Your Council, Your Say' residents survey, carried out by the Council, identified health services as the top priority for local people in making the borough a good place to live. It also found that 25.3% of residents class themselves as having a 'long standing illness or disability'.

Havering's Health & Wellbeing Priorities

The Health and Wellbeing Board has agreed the following eight priorities, which are focused around three overarching themes:

Themes	Priorities for Action
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
Better 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

A plan for action

The strategy contains actions for improving key outcomes under the eight priorities. Within each, a variety of interventions will be required that include individual, targeted and population-wide initiatives. Each intervention seeks to provide the most beneficial outcome for individuals, whilst operating within the constraints of health and social care budgets. Where appropriate, performance indicators are included to measure the individual and collective outcomes that the strategy aims to achieve.

Monitoring

Performance against the key actions and indicators set out in this strategy will be monitored and published every six months by the Health and Wellbeing Board, and the strategy will be critically reviewed and revised at the end of the two-year period.

THEME A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

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

Why is this important in Havering?

Older and vulnerable people, especially those with long-term conditions, are the most intensive and costly users of health and social care services and there is a clear need for their experience and outcomes achieved to be improved. They account for half of all GP appointments, two thirds of all outpatient appointments and nearly three quarters of all inpatient bed days. As our older population continues to grow, we are faced with increasing demands on these services. By focusing on prevention and early intervention, we hope to relieve some of this pressure on services and enable more people to live independently and safely in their own homes for longer and with a better quality of life.

One of the most effective prevention methods is to reduce the isolation and social exclusion experienced by many older and vulnerable people, which can contribute to mental health conditions such as depression. Tackling isolation will be a focus of our preventative work and more will be done within the community to better support these people.

Our continued focus on reablement and rehabilitation services after a period of illness and support for older and vulnerable people in managing long-term conditions will help to maintain independent living.

THEME A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

What is the current situation in Havering?

Our Joint Strategic Needs Assessment[1] tells us that;

- The retirement population (21%) is much larger than the London average
- 39,000 people are estimated to have one or more long-term health conditions
- 1,200 older people have particularly complex health and social care needs, with around 900 older people accounting for 38% of all emergency bed days
- A smaller proportion of people receive residential care, nursing care and community services than in England generally
- 16,300 older people are estimated to be living alone and this is predicted to rise to 17,948 by 2020
- Nearly 15,000 older residents are estimated to be unable to manage at least one self-care task on their own and more than 18,000 are estimated to be unable to manage at least one domestic task on their own (e.g. shopping, washing etc)
- 3,760 older people are estimated to have depression and this is predicted to rise to 4,146 by 2020 (although the level of depression across all age groups is lower than the London and national averages)
- More than 1,100 people are registered blind or partially sighted
- 5,276 older people are estimated to have diabetes
- There are around 140 excess winter deaths annually, most of whom are older and vulnerable people
- More than 1,900 people are admitted to hospital annually as a result of a fall
- 3,050 older people are estimated to have dementia and this is predicted to rise to 4,691 by 2030
- There are approximately 560 users of learning disability services, of which around 70 are aged 60 plus
- 45.2% (2,656) of adult social care clients receive some form of self-directed support, with 22% of these (578) using a personal budget or direct payment.

[1] JSNA 2011/12, Chapter 10: Supporting Vulnerable Adults and Older People

THEME A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

The number of people recorded as having a long-term health condition on Havering's GP registers is significantly below the number that might be expected given the results of national population surveys. This suggests that many people may be undiagnosed and, therefore, not benefiting from treatments that could slow progression and improve wellbeing.

A small number of patients have complex problems and therefore receive regular and multiple types of health and social care services. Despite this, these patients have persistent poor health and, in many cases, frequent hospital admissions. Our targeted response to reducing avoidable hospital admissions is set out under Priority 7.

A range of public and voluntary sector organisations provide services to support older and vulnerable people in Havering, including: integrated health and social care services; the information and advice centre 'Care Point' based in Romford; day centres; dementia support services; and support for those with specific long-term health conditions to remain independent for longer.

The Council is also encouraging the development of volunteer-led initiatives such as Help not Hospital (a volunteer scheme to offer to support to vulnerable people recently discharged from hospital), Cold Weather Befrienders, to help prevent the effects of fuel poverty and a range of befriending schemes to combat social isolation.

There are also a wealth of cultural activities and services provided through local libraries, parks and open spaces, museum, theatre and leisure centres aimed at improving the health and wellbeing of older people e.g. housebound library services, Knit and Natter and other social activity groups and physical activity programmes.

Where do we want to be in Havering?

By working collectively as a strategic partnership, the Health and Wellbeing Board will deliver improved outcomes for vulnerable people.

Our objectives are to:

- Help more vulnerable people, including those with long-term conditions and complex needs, maintain their independence in the community and reduce use of acute/complex services. We will do this by better co-ordinating health and social care provision in individuals' own homes; developing rehabilitation strategies; and better utilising assistive technologies through targeting people who will benefit from them most
- Tackle isolation and support vulnerable people to help maintain independent living. We will do this by commissioning innovative and targeted volunteer-led schemes that focus on befriending and supporting vulnerable people, including people recently discharged form hospital
- Improve choice and control over the health and social care people receive. We will do this by increasing personal health budgets to a greater proportion of eligible users
- Deliver more community based support, including volunteer-led services for people recently discharged from hospital and provision of reablement services to help them re-adjust to independent living. We will do this by working with the voluntary and community sector to support people in the community.

How will we deliver improved outcomes?

Below are the key actions that we will take to deliver improved outcomes for vulnerable people. Each action is owned by a lead partner(s) of the Health and Wellbeing Board. Our performance will be measured by the successful delivery of these actions and improvements against key indicators.

THEME A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

Objectives	Actions	Lead Partners
Help more vulnerable people, including those with long-term conditions and complex needs, maintain their independence in the community and reduce use of acute/complex services	Through joint working, provide co-ordinated health and social care support to individuals in their own homes, including identifying vulnerable patients living with long-term conditions through risk stratification and commissioning appropriate primary care and community responses	LBH (Adults and Health) & HCCG
	Develop and implement community rehabilitation strategies for COPD, diabetes and chronic heart failure	LBH (Adults and Health) & HCCG
	Utilise assistive technologies to support the needs of a targeted group of vulnerable people with long-term conditions and complex needs, including people with COPD, chronic heart failure, cardiovascular disease, diabetes and dementia	LBH (Adults and Health) & HCCG
	Commission a rapid response service that reduces demand on urgent care centres and reduces avoidable admissions	HCCG
	Redirect people attending the urgent care centre back to primary care	HCCG
	Increase identification of people with learning disabilities and improve access to primary care services for this population and their carers	LBH (Adults and Health) & HCCG
	Enhance primary care support to nursing and residential homes to ensure proactive early intervention, thus increasing the quality of care and reducing avoidable hospital admissions	HCCG
	Ensure that contracted services have systems in place for safeguarding adults that are consistent with local and national guidance	LBH (Adults and Health)
Tackle isolation and support vulnerable people to help maintain independent living	Commission innovative and targeted volunteer-led schemes that focus on befriending and supporting vulnerable people, including people recently discharged from hospital i.e. Activate Havering and Help Not Hospital	LBH (Adults and Health) & (Culture and Leisure)
	Better market social and activity groups for older people provided by the libraries and voluntary and community sector and continue to engage older people in our parks and open spaces, museum, theatre and leisure centres	LBH (Culture and Leisure)
Improve choice and control over the health and social care people receive	Increase personal budgets to a greater proportion of eligible social care users	LBH (Adults and Health)
	Increase choice of venues for people to access outpatient services enabling care to be delivered closer to home	HCCG
	Implement integrated case management to enable people to proactively manage their long-term condition	HCCG
	Implement the Gold Standard Framework across all practices enabling people to die in their preferred choice of place	HCCG

THEME A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

Objectives	Actions	Lead Partners
Deliver more community based support, including volunteer-led services for people recently discharged from hospital and provision of reablement services to help them re-adjust to independent living	Work with the voluntary and community sector to support vulnerable people in the community, including provision of respite care	LBH (Adults and Health) & (Culture and Leisure)

Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Proportion of people who having undergone reablement and returned to Adult Social Care 91 days after completing reablement and require an ongoing service	H: 7.8% L: local indicator, therefore no benchmark E: local indicator, therefore no benchmark (2011/12)	7% (2012/13)	LBH (Adults and Health)
Proportion of adults with learning disabilities who live in their own home or with their family	H: 51.4% L: 65.1% E: 70.4% (2011/12)	52% (2012/13)	LBH (Adults and Health)
People with learning disabilities in settled accommodation	H: 43.9% E: 59.1% (2011 DIH)	N/A	LBH (Adults and Health)
Proportion of adults in contact with secondary mental health services living independently with or without support	H: 89.4% L: 73.8% E: 59.6% (2011/12 NASCIS)	88% (2012/13)	LBH (Adults and Health)
Proportion of people who use services who have control over their daily life	H: 68.9% L: 69.9% E: 75.3% (2011/12 NASCIS)	To achieve an improvement relative to the London average	LBH (Adults and Health)
Employment for those with a long-term health condition including those with a learning disability/ difficulty or mental illness	H: 6.1% (adults with learning disabilities in employment); 8.7% (adults receiving mental health services in employment) (2011/12) E: 6.6% (adults with learning disabilities in employment); 9.5% (adults receiving mental health services in employment) (2011 DIH)	8% (adults with learning disabilities in employment); 11% (adults receiving mental health services in employment) (2012/13)	LBH (Adults and Health)
Proportion of people using social care who receive self-directed support and those receiving direct payments	H: 45.2% L: 47.0% E: 43.0% (2011/12 NASCIS)	60% (2012/13)	LBH (Adults and Health)
Direct payments as a proportion of self-directed support	H: 9.8% L: 17.5% E: 13.8% (2011/12)	15% (2012/13)	LBH (Adults and Health)
Proportion of people feeling supported to manage their condition	H: 56% L: 57% E: 64% (2011 GP Patient Survey)	No target set yet	HCCG

THEME A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Access to non-cancer screening programmes – diabetic retinopathy	H: 85.58% L: E: 90.92% (2009/10 NHS IC)	No target identified	PHE
Excess winter deaths (compared to summer)	H: 14.4% (06-08) 18.1% (06-09) L: 15.3% (06-08) E: 15.6% (06-08) 20% (06-09) (2006-08 ONS; 2006-09 Excess Winter Deaths Atlas)	Achieve a reduction year on year	LBH (Adults and Health) & HCCG
Proportion of people who use services and carers who find it easy to find information about support	H: 50.90% L: N/A E: N/A (2010/11)	Achieve an increase year on year	LBH (Adults and Health)
Proportion of people who use care services who feel safe	H: 56.20% L: N/A E: N/A (2010/11)	Achieve an increase year on year	LBH (Adults and Health)
Seasonal influenza vaccine uptake in those aged 65 years and over	H: 72.8% L: 72.2% E: 74% (2011/12 DH)	75% (2012/13)	LBH (Public Health)
Number of new cases of psychosis served by Early Intervention teams	H: 16	29 (2012/13)	HCCG
Crisis Resolution Home Treatment	H: 152	384 (2012/13)	HCCG
Improved access to Psychological Services	H: 1.9%	1.2%	HCCG

THEME A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

Priority 2: Improved identification and support for people with dementia

Why is this important in Havering?

Dementia is a clinical syndrome characterised by a widespread loss of cognitive function, including memory loss, language impairment, disorientation, change in personality, self neglect and behaviour that is out of character. The most common types of dementia are Alzheimer's disease and Vascular Dementia, which affect about 62% and 17% of sufferers. It is an extremely distressing illness that costs the national economy around £17 billion a year.

We know that:

- Dementia is more common in women than in men, especially in the older age groups
- On average, people with dementia live for seven or eight years after the illness has been first diagnosed, although there are wide individual variations
- Many of the carers of older people with dementia are themselves elderly. Up to 60% are partners/spouses
- Carers of people with dementia generally experience greater stress than carers of people with other kinds of needs, with a large proportion experiencing some kind of mental health problem themselves.

Supporting people with dementia is a high priority both nationally and locally. The National Dementia Strategy[2] sets out the strategic framework for local services to operate in. It includes clear objectives for delivering improvements in the quality of services and promoting a wider understanding of the causes and effects of dementia. Dementia is a particularly pertinent issue for Havering due to our large, and growing, older population.

[2] Living Well with Dementia, 2009

THEME A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

What is the current situation in Havering?

Our Joint Strategic Needs Assessment[3] tells us that:

- In 2007, 2,440 people were estimated to have dementia in Havering and this is predicted to rise by 23.5% to 3,014 people by 2021 (compared to an overall London projected increase of 12.3%)
- A more recent estimate, however, suggests that 3,101 people have dementia in Havering and this is predicted to rise by more than 50% in the next 20 years as the population continues to age
- The majority of cases are currently undiagnosed and thus unmanaged
- In 2010/11, dementia-related costs to Havering (health and social care) were in excess of £2 million. Another £2.9 million was spent on dementia-related care home placements. Additional activity and costs to universal services incurred in caring for people with dementia is not captured and hence is difficult to quantify
- As well as the costs to health and social care, the bulk of care for dementia sufferers, particularly for the undiagnosed, is provided by family and friends. In 2001, more than 1 in 10 Havering residents identified themselves as a carer; the highest proportion of any borough in London.

Where do we want to be in Havering?

Our objectives are to:

- De-stigmatise dementia and ensure sufferers and their carers receive the best possible support in managing their condition. We will do this by establishing a Dementia Partnership Board to oversee the implementation of the Havering Dementia Strategy, in line with the national strategic framework
- Ensure high quality and accessible dementia information. We will achieve this by improving our data collection on the prevalence of dementia in Havering and improving data sharing between organisations. This will ensure seamless, high quality care as people pass through the dementia care pathway
- Clinically train professionals to recognise the symptoms of dementia leading to earlier diagnosis and improved outcomes for sufferers and their carers. Patients will only go into hospital if this will secure the best clinical outcome
- Deliver more universal services and better quality of care for people with dementia. As part of this, we will investigate the potential to develop a dementia centre of excellence community facility that works effectively with outreach and local services.

How will we deliver improved outcomes?

Below are the key actions that we will take to deliver improved outcomes for people with dementia. Each action is owned by a lead partner(s) of the Health and Wellbeing Board. Our performance will be measured by the successful delivery of these actions and improvements against key indicators.

[3] JSNA 2011/12, Chapter 4: Dementia

THEME A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

Objectives	Actions	Lead Partners
De-stigmatise dementia and ensure sufferers and their carers receive the best possible support in managing their condition	Establish a multi-agency Dementia Partnership Board to implement a Havering Dementia Strategy, in line with the national strategy	LBH (Adults and Health) & HCCG
	Mainstream the application of assistive technologies to support people with dementia as part of a programme of purposeful walking	LBH (Adults and Health)
Ensure high quality and accessible dementia information by improving data collection on the prevalence of dementia and data sharing between organisations	Establish a system to monitor GP recorded prevalence and practice (any reporting unusually low prevalence will be encouraged to participate in training to aid diagnosis)	HCCG
	Share practice data to allow the CCG to monitor and take accountability for quality assurance, enabling prioritisation of dementia strategy work targeted to practices	HCCG
	Link care for people with dementia to deliver seamless care across all agencies	LBH (Adults and Health) & HCCG
Clinically train professionals to recognise the symptoms of dementia leading to earlier diagnosis and improved outcomes for sufferers and their carers	Develop a new training strategy/pathway for professionals working with and supporting people with dementia	LBH (Adults and Health) & HCCG
	Support the National Dementia and Antipsychotic Prescribing Audit and Reduction Exercise	HCCG
	Review assessed and diagnosed cases, to assess success of early diagnosis and performance against QOF/DES targets.	HCCG
	Develop a training package for staff working with people with dementia, to include monitoring to record training sessions/people attending/feedback	HCCG
	Embed workforce development plans/appraisals programme into practices	HCCG
	Make available mentoring support system to key professionals, including clinical supervision	HCCG
Deliver more universal services and better quality of care for people with dementia	Investigate the potential for a dementia centre of excellence community facility and progress plans for this accordingly	LBH (Adults and Health)
	Commission a rapid response service for people with dementia and their carers to provide support and medical assistance during times of crisis or escalation of symptoms/deterioration	HCCG
	Incorporate end of life planning into services for people with dementia, to enable them to have a dignified and painless death, and adequate provision of support for their families	HCCG
	Develop education sessions for families about how to best support someone with dementia	LBH (Adults and Health) & HCCG

THEME A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Rated 'green' for each of the five aims of the National Dementia Strategy	'Green' for four of the five projects	'Green' for each of the five projects comprising Havering's response to the National Dementia Strategy	LBH (Adults and Health)
Trusts to demonstrate that for 90% of discharges of patients with dementia the information has been provided to the patient's GP and family/ carer where appropriate within 2 weeks	No data	90%	HCCG
All patients aged 75 and over who have been screened following admission to hospital, using the dementia screening questionnaire	H: 47%	25%	HCCG
All patients aged 75 and over, who have been screened as at risk of dementia, who have had a dementia risk assessment within 72 hours of admission to hospital, using the hospital dementia risk assessment tool	H: 97%	90%	HCCG
All patients aged 75 and over, identified as at risk of having dementia who are referred for specialist diagnosis	H: 99%	90%	HCCG
Dementia and its impacts (all people with dementia and percentage of people expected to have dementia in 2021)	H: 1.08% (2007); 1.29% (2021) L: 0.77% (2007); 0.78% (2021) E: 1.14% (2007); 1.43% (2021) (2007-21 DIH)	To achieve an improvement relative to the national average	LBH (Adults and Health) & HCCG
Ratio of diagnosed to expected cases of dementia	3:1 Diagnosed 1,248 (2011 QOF) Expected 3,273 (2012 POPPI)	Improve diagnosis ratio	LBH (Adults and Health) & HCCG
Minimising mental health delayed transfers of care	July 2012 data shows Trust meeting target	<7.5%	HCCG

THEME A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

Priority 3: Earlier detection of cancer

Why is this important in Havering?

Cancer is a common disease. About 1,200 people in Havering (one in every 200) are diagnosed with some form of cancer each year and more than 600 a year die of the disease.

National research shows that more than 40% of all cancer cases are attributable to avoidable risk factors such as smoking, alcohol, poor diet and lack of exercise. Most people could significantly reduce their risk of developing cancer by living more healthily e.g. by making one or more of the following changes – stopping smoking, reducing their consumption of alcohol, improving their diet and taking more exercise.

The immediate costs of cancer treatment, ignoring wider societal costs, are very large, accounting for about 6% of the total NHS expenditure in Havering.

What is the current situation in Havering?

Our Joint Strategic Needs Assessment[4] and Public Health Annual Report 2010 tell us that:

- The age standardised incidence rate of cancer in Havering is lower (better) than the national average and mortality rates are similar to the England average
- Nonetheless, large numbers of residents are diagnosed with (1,200) and die (600) from cancer each year; due in part to Havering's relatively old population. Numbers will increase still further as the population continues to age
- Breast, bowel and lung cancer are the most common cancers in women, with prostate, lung and bowel cancer being the most common in men
- There are health inequalities within Havering with regard to cancer related health outcomes e.g. death rates from cancer and the prevalence of lifestyle related risk factors for cancer are higher in more disadvantaged communities

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- The majority of residents are aware that smoking greatly increases the risk of developing cancer – but 1 in 5 continue to smoke
- Public awareness of other risk factors for cancer, including diet and obesity, is much lower
- In addition, relatively few residents are aware of the early signs and symptoms of cancer or that early diagnosis greatly increases the likelihood of survival for many cancers
- Rates of survival one year after diagnosis have stayed more or less unchanged in Havering over recent years, whereas they have increased across England as a whole. As a result, survival rates in Havering are now significantly below (64.2%) the national average (66.5%).

Poor short term survival rates are often attributed to late diagnosis. Late diagnosis can result from one or more of:

- Low participation in population screening programmes
- Late presentation by patients with the early signs of cancer
- Failure by GPs to identify patients with symptoms suggestive of cancer
- Delays in the investigation of patients referred with suspected cancer.

We know that, in Havering:

Although uptake of cancer screening programmes could be improved, particularly for the newly introduced bowel cancer programme, levels of participation are generally similar to those achieved nationally and above national minimum targets.

- On average, GP referral practice in Havering is similar to, if not better than, the national average
- Delays in the investigation of patients with suspected cancer are uncommon
- Therefore, whereas we must seek to improve all aspects of the cancer care pathway, work to increase public awareness of the early signs and symptoms of the disease is a particular priority locally.

Where do we want to be in Havering?

By working collectively as a strategic partnership, the Health and Wellbeing Board will deliver improved outcomes in cancer.

Our objectives are to:

- Maximise participation in the three cancer screening programmes, particularly for bowel cancer, which is a relatively recent development
- Raise public awareness of the signs and symptoms of cancer. To this end, we will evaluate the recently commissioned local awareness raising campaign and continue to support relevant national and London wide campaigns
- Further improve the identification and investigation of patients with signs and symptoms suggestive of cancer in primary care settings
- Improve quality of cancer care services and patients' experience of care, including maintaining excellent performance on waiting times between referral of patients with suspected cancer and first consultant contact (two week waits) and 31/62 day targets for receiving treatment quickly after diagnosis; and increasing access to optimal treatment, particularly radiotherapy and surgery.

[4]JSNA 2011/12, Chapter 9: Cancer

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How will we deliver improved outcomes?

Below are the key actions that we will take to deliver improved outcomes for earlier detection of cancer. Each action is owned by a lead partner(s) of the Health and Wellbeing Board. Our performance will be measured by the successful delivery of these actions and improvements against key indicators.

Objectives	Actions	Lead Partners
Maximise participation in the three cancer screening programmes	Promote breast screening for women aged 50-70 and, if possible, extend to women aged 47-73, ahead of the 2016 national deadline	PHE
	Promote cervical screening to younger women who are currently least likely to participate	PHE, NHSCB & HCCG
	Promote uptake of bowel cancer screening to achieve levels significantly above the national minimum target of 60%	PHE
	Extend bowel cancer screening from those aged 60-70 to those aged 60-75 ahead of the national deadline	PHE
	Through primary care improvement, make screening for cancer a priority	HCCG
Raise public awareness of the signs and symptoms of cancer	Evaluate effectiveness of, with a view to roll out to additional wards, the community engagement campaigns to raise awareness of cancer in the four wards with the highest mortality in Havering (delivered by Age Concern)	LBH (Public Health)
	Run local campaigns to complement and maximise the impact of national and regional awareness campaigns. Undertake evaluation to ensure cost effective investment	LBH (Public Health), PHE & LHIB
	Raise awareness of prostate cancer, its signs and symptoms, and link to the national awareness programme "Prostate cancer risk management". Undertake evaluation to ensure cost effective investment	LBH (Public Health) & HCCG
Further improve the identification and investigation of patients with signs and symptoms suggestive of cancer in primary care settings	Provide regular educational updates for GPs and other health professionals relevant to the early detection of cancer	LBH (Public Health) & HCCG
	Regularly provide GPs with comparative data regarding their cancer referral practice	LBH (Public Health) & HCCG
	Provide GPs with direct access to four diagnostic tests recommended by the Department of Health	HCCG
Improve quality of cancer care services and patients' experience of care	Use results of national cancer audits and national patient cancer survey to ensure that BHR and London Cancer (the integrated cancer system for North and North East London) improve the quality and patient's experience of cancer care	HCCG

Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Cancer screening coverage – breast (coverage of women aged 53-64, less than 3 years since last test)	H: 78.7% L: 69.3% E: 77.4% (2011 NHS IC)	Maintain coverage above national minimum target (70%)	PHE

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Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Cancer screening coverage – cervical (aged 25-64, less than 5 years since adequate test)	H: 80.2% L: 74.0% E: 78.6% (2010/11)	Maintain coverage above national minimum target (80%)	PHE, NHSCB & HCCG
Cancer screening coverage – bowel (aged 60-69, within 6 months of invitation)	H: 54.3% E: 57.5% (2010/11 NCIN)	Surpass national minimum target for coverage (60%)	PHE
Cancer diagnosed at stage 1 and 2	New indicator – data not available	No target identified	LBH (Public Health), PHE, HCCG & LHIB
All cancer two-week wait (patients urgently referred for suspected cancer by their GP seen by a specialist within 14 days of referral)	H: 93%	93%	HCCG
31 day (diagnosis to first treatment) wait for all cancers (patients receiving their first definitive treatment for cancer and began that treatment within 31 days)	H: 96%	96%	HCCG
62 day (urgent GP referral to first treatment) wait: all cancers (patients receiving first treatment for cancer following an urgent GP referral for suspected cancer and began treatment within 62 days of referral)	Target not met (as at June 2012)	85%	HCCG
Percentage cancer survival at 1 year	H: 68.5% L: 75% E: 75% (2007-09)	To improve survival within Havering faster than that achieved nationally so that survival rates within Havering are similar to the average for England within 3 years	LBH (Public Health), PHE, HCCG & LHIB
Under 75 mortality rate from all cancers	H: 111.4 L: 102.9 E: 108.1 (2010/11 NHS IC)	Maintain current performance relative to England average	LBH (Public Health), PHE, HCCG & NHSCB

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Priority 4: Tackling obesity

Why is this important in Havering?

Obesity is defined as an excess of body fat, to the point where it is often detrimental to a person's health. Being overweight or obese increases a person's risk of developing diabetes, cancer and cardiovascular disease. Being obese can restrict mobility and contribute to poorer mental health, which may limit a person's participation in their community and reduce their quality of life. Obesity is a complex issue that is affected by a range of behavioural, psychological, social, cultural and environmental factors, which can make it difficult for people to maintain a healthy weight.

Obesity is measured using Body Mass Index (BMI) which is a ratio of a person's weight to their height, and adults with a BMI of 30kg/m2 are considered obese. Some people or sections of the community are at greater risk of becoming obese, such as children of obese parents, babies whose mother was obese during pregnancy and babies who are bottle-fed, people with certain learning disabilities or physical disabilities that limit activity, older people, disadvantaged groups and some ethnic groups.

The National Obesity Strategy[5] sets out a new approach to public health that will enable effective action on obesity. It encourages people to reduce their consumption of excess calories, make healthier lifestyle choices and calls on industry, as well as more traditional partners, to take responsibility for tackling obesity.

[5]Healthy Lives, Healthy People: A call to action on obesity in England, 2011

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What is the current situation in Havering?

Our Joint Strategic Needs Assessment[6] tells us that:

- An estimated 27.3% of adults in Havering are obese. This is higher than the England average of 24.2% and the London average of 20.7%
- Obesity rates are particularly high in Harold Hill and South Hornchurch
- 1 in 5 children in Havering are obese by the age of 11, which is similar to the national average
- 12% are obese by the age of 5, which is significantly higher than the national average of 10%
- High rates of breastfeeding are associated with lower levels of obesity and rates of breastfeeding in Havering are very low.

Services for preventing and treating obesity in Havering include universal services such as leisure and recreational facilities; targeted services such as the national child measurement programme and breastfeeding support; and specialist services such as obesity medication, weight-loss programmes and bariatric surgery.

Where do we want to be in Havering?

By working collectively as a strategic partnership, we will deliver improved outcomes for tackling obesity.

Our objectives are to:

- Intervene early to slow down the rise in obesity levels in adults and children. We will do this by commissioning targeted obesity prevention, weight management programmes and breastfeeding support services
- Promote healthier lifestyles and increase levels of physical activity to maintain healthy weight. We will do this by continuing to deliver and facilitate, and where possible, increase, the amount of organised sport and physical activity in local parks and open spaces
- Raise awareness of the health risks associated with being overweight and obese. We will do this through targeted campaign work and making the most of contact points such as the National Child Measurement Programme and NHS Health Checks.

How will we deliver improved outcomes?

Below are the key actions that we will take to deliver improved outcomes for tackling obesity. Each action is owned by a lead partner(s) of the Health and Wellbeing Board. Our performance will be measured by the successful delivery of these actions and improvements against key indicators.

Objectives	Actions	Lead Partners
Intervene early to slow down the rise in obesity levels in adults and children	Continue to offer a high quality school food service that meets nutritional standards and work to increase the uptake of free school meals	LBH
	Commission targeted community obesity prevention/weight management services for adults and children. Undertake evaluation to ensure cost effective investment	LBH (Culture and Leisure), (Public Health) & HCCG
	Encourage women who are pregnant or trying for a baby to achieve a healthy weight before and after the birth by offering weight management support as part of ante and post-natal care	LBH (Public Health)

[6]JSNA 2011/12, Chapter 3: Obesity

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Objectives	Actions	Lead Partners
Promote healthier lifestyles and increase levels of physical activity to maintain healthy weight	Continue to deliver and facilitate, and where possible, increase the amount of organised sport and physical activity in local parks and open spaces	LBH (Culture and Leisure)
	Continue to deliver the leisure centre investment programme and support the development of a new leisure facility in Romford to increase physical activity	LBH (Culture and Leisure)
Raise awareness of health risks associated with being overweight and obese	Continue to deliver campaigns on healthy eating, physical activity and breastfeeding to raise awareness of the health risks associated with obesity. Undertake evaluation to ensure cost effective investment	LBH (Culture and Leisure) & (Public Health)
	Health professionals to raise the issue of obesity during routine and targeted appointments, including NHS health checks, and refer individuals to support where appropriate	LBH (Public Health)
	Continue to commission the Child Measurement Programme	LBH (Public Health)

Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Excess weight in 4-5 and 10-11 year olds (prevalence of overweight children in reception and in Year 6)	H: 13.5% (4-5); 16% (10-11) L: 12.4% (4-5); 15.1% (10-11) E: 13.2% (4-5); 14.4% (10-11) (2011 DH)	To reduce prevalence of obesity at a faster rate than achieved nationally so that the prevalence of obesity amongst reception age children in Havering is similar to or better than the national average within 5 years	LBH (Public Health), HCCG, NHSCB & PHE
Excess weight in 4-5 and 10-11 year olds (prevalence of obese children in reception and in Year 6)	H: 10.8% (4-5); 19.3% (10-11) L: 11.1% (4-5); 21.9% (10-11) E: 9.4% (4-5); 19% (10-11) (2011 DH)	To maintain performance relative to national average	LBH (Public Health)
Mothers initiating breastfeeding (percentage of maternities where status of breastfeeding initiation is known)	H: 66.7% L: 86.3% E: 73.6% (2010 DH)	No target identified	LBH (Public Health) & HCCG
Breastfeeding (prevalence at 6-8 weeks after birth)	H: 39.9% L: 66.5% E: 44.4% (Qtr1 2010 DH)	To increase initiation and prevalence faster than achieved across England so that both are similar to or better than the national average within 5 years	LBH (Public Health)

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Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Proportion of physically active and inactive adults (adults participating in recommended levels of physical activity)	H: 9.87% L: 9.99% E: 11.45% (2010 DH)	To increase rates of activity faster than achieved nationally so that rates are similar to or better than the average for England within 5 years	LBH (Public Health)
Take up of the NHS health checks programme by those eligible	H: 9.4% eligible population (8,066 checks) (2010/11)	To offer a check to 20% of eligible patients each year/100% over 5 year cycle	LBH (Public Health)

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Priority 5: Better integrated care for the 'frail elderly'

Why is this important in Havering?

Future demographic change will significantly increase the proportion of older people in the population. As a result, the number of 'frail elderly' residents will also increase. These are people with the most complex needs that currently provide the greatest challenge to health and social care providers. Given Havering's demographics, this priority is extremely important in ensuring Havering's 'frail elderly' people experience the best possible quality of care in later life.

A large amount of resources are allocated to managing the care of this very vulnerable group. Significant reasons for this are delays in hospital discharges - there is an overreliance on bed-based rather than community-based solutions - and a higher incidence of repeat hospital admissions than any other population group.

Outcomes for the 'frail elderly' people are better where independence is promoted and adequate support is given to help them do things for themselves, rather than the worse outcomes that come from lack of independence and moving into residential care homes. Priority 7 of this strategy is dedicated to the work that will take place to reduce avoidable hospital admissions.

What is the current situation in Havering?

Our Joint Strategic Needs Assessment[7] tells us that:

- Nearly 15,000 older people are estimated to be unable to manage at least one self care task on their own, and more than 18,000 are estimated to be unable to manage at least one domestic task on their own (e.g. shopping, washing etc)
- 3,760 older people are estimated to have depression, which is predicted to rise to 4,146 by 2020

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- 16,300 older people are estimated to be living alone, which is predicted to rise to 17,948 by 2020
- More than 1,100 people are registered as being blind or partially sighted
- There are around 140 excess winter deaths annually among Havering residents, many of whom are vulnerable older people
- More than 1,900 people are admitted to hospital annually as a result of a fall
- St Francis' Hospice end of life care services were used nearly 19,000 times by Havering residents in 2010/11 and demand for services is increasing.

Innovative collaborative work is taking place between the Council, Havering CCG and the Integrated Care Coalition, working on cross-borough strategic solutions to achieving integrated care to make wide ranging health and social care improvements.

Where do we want to be in Havering?

By working collectively as a strategic partnership locally and more broadly across the local health and social care economies in Barking & Dagenham and Redbridge, we will deliver improved outcomes for the 'frail elderly'.

Our objectives are to:

- Ensure with partners, seamless, integrated and efficient care pathways for 'frail elderly' people with care needs. We will do this by bringing together all existing provision based around prevention, reducing hospital admission, combating social exclusion and protecting those most at risk. The Integrated Care Pilots programme and evidence reviews undertaken by the King's Fund have demonstrated that integration can result in significant benefits for individuals where this is targeted at those whose care is currently poorly co-ordinated
- Improve pathways into and through community-based health services and general practice by working closely with the hospital and GPs
- Reduce the incidence and impact of falls that often lead to the hospitalisation of older people and improve the efficiency of care following injury as a result of a fall, including hip fracture
- Enhance independence and capability of individuals to manage their conditions at home
- Provide support to people within the community who have recently been discharged from hospital or who are at risk of admission/readmission
- Improve care in nursing and residential homes, including better management of demand to reduce avoidable hospital admissions and monitoring of safeguarding controls
- Improve support to people not currently engaged with social care such as self funders and those with lower levels of need to ensure that greater opportunities to benefit from prevention, improved health and wellbeing and support are provided
- Ensure informed choice on end of life care through robust information and guidance for patients and carers. We will do this by working collectively with colleagues to develop an end of life care pathway and implement the Gold Standard Framework of care within primary care.

The Integrated Care Commissioning Strategy is being developed across the Barking & Dagenham, Havering and Redbridge Integrated Care Coalition, which will further develop and facilitate delivery of the above outcomes.

[7]JSNA 2011/12, Chapter 10: Supporting Vulnerable Adults and Older People and Chapter 11: Keeping People Out of Hospital

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How will we deliver improved outcomes?

Below are the key actions that we will take to deliver improved outcomes for better integrating care for the 'frail elderly'. Each action is owned by a lead partner(s) of the Health and Wellbeing Board. Our performance will be measured by the successful delivery of these actions and improvements against key indicators.

Objectives	Actions	Lead Partners
Ensure seamless, integrated and efficient care pathways for 'frail elderly' people with care needs	Develop and deliver an Integrated Care Strategy that will bring together all existing provision based around prevention and protecting those most at risk	LBH (Adults and Health) & HCCG
	Develop a single set of performance and outcome metrics for integrated care against which performance can be measured and support further steps and recommendations in relation to the Integrated Care Strategy	LBH (Adults and Health) & HCCG
	Develop a new model for the Social Work team and seek opportunities for closer integration and support improved pathway access	LBH (Adults and Health)
	Develop Community Treatment Teams model to provide alternative to emergency admission/ hospital care for older people with ambulatory care sensitive conditions.	LBH (Adults and Health)
Improve pathways into and through community-based health services and general practice by working closely with the hospital and GPs	Implement plan to improve pathway after a stay in hospital to include reduction in transfers between like for like units, improved length of stay and better discharge planning	LBH (Adults and Health)
Reduce the incidence and impact of falls that often lead to the hospitalisation of older people and improve the efficiency of care following injury as a result of a fall, including hip fracture	Support the implementation of the Falls Prevention Strategy across Adult Social Care working with Health and Housing	LBH (Adults and Health
	Undertake a falls audit within non-acute health services to inform Integrated Care Coalition thinking on further development of the Falls Strategy	LBH (Adults and Health
	Commission a Falls Community Exercise programme and an outreach service into care homes and telecare clients	LBH (Adults and Health)
	Commission a falls prevention and management training programme for staff in care homes and assistive technologies staff	LBH (Adults and Health)
	Hold BHRUT to account for achievement of 'blue book' standards	HCCG
Enhance independence and capability of individuals to manage their conditions at home	Develop improved pathways to ensure greater opportunities and impacts for Havering residents to access support	HCCG & Out of Hours Services
	Increase the take up of Telecare and Telehealth services as part of the Council's reablement offer	LBH (Adults and Health)
	Develop a Self-Funders Strategy to improve the outcomes of people not eligible for free state support	LBH (Adults and Health)
Provide support to people within the community who have recently been discharged from hospital or who are at risk of admission/readmission	Provide low-level intervention to support people following hospital discharge or to prevent them being admitted such as Help Not Hospital volunteer led services	LBH (Adults and Health)

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Objectives	Actions	Lead Partners
Improve care in nursing and residential homes, including better management of demand to reduce avoidable hospital admissions and monitoring of safeguarding controls	Commission an enhanced and equitable primary care led service for care homes, leading to improved management of long-term conditions and reduce unnecessary admissions to acute hospitals and the inappropriate use of out of hours services	HCCG
	Improve the identification and treatment of malnutrition and prescribing of oral nutritional supplements in care homes	HCCG
	Improve the prescribing of wound care products. Implement a 'limited wound care formulary' and 'buffer stock" first aid list for emergency use in nursing homes.	HCCG
Improve support to people not currently engaged with social care such as self funders and those with lower levels of need to ensure that greater opportunities to benefit from prevention, improved health and wellbeing and support are provided	Provide support to nursing and residential homes in order to maintain residents within the home environment	LBH (Adults and Health)
Ensure informed choice on end of life care through robust information and guidance for patients and carers	Develop an end of life care pathway	LBH (Adults and Health)
	Implement the Gold Standard Framework of care within primary care based service and care homes	HCCG

Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Life expectancy at age 65 years	H: 18.2 (male); 21.4 (female) L: 18.7 (male); 21.5 (female) E: 18.2 (male); 20.8 (female) (2008-10 ONS)	To improve life expectancy at age 65 at the same or faster rate than that achieved nationally	LBH (Public Health), HCCG, NHSCB & PHE
Emergency hospital admissions for hip fractures in over 65s (directly age standardised rate)	H: 424 L: 423 E: 452 (2010/11 APHO)	To reduce rate of fracture in line with national average	LBH (Adults and Health)
Permanent admissions to residential and nursing care homes (aged 65 plus) per 100,000 population	H: 551.8 L: 531.2 E: 713.8 (2011/12 NASCIS)	470 (2012/13)	LBH (Adults and Health)
Integrated Care Coalition indicators	In development	No target identified	HCCG & LBH (Adults and Health)

THEME B: Better integrated support for people most at risk

Priority 6: Better integrated care for vulnerable children

Why is this important in Havering?

Healthy, happy and educated children are more likely to become healthy happy and productive adult members of society. Setbacks experienced in childhood as a result of troubled family backgrounds can result in long-lasting harm that persists throughout life and has a spiral effect leading to significantly reduced outcomes for those young people. A significant and growing body of evidence shows that the care and support a child receives in the early years of their life, including pre-birth, is critical to their development and their behaviour, mental and physical wellbeing in the long-term. For these reasons, targeting children most 'at risk', as part of our 'early help' offer, will be our focus going forward.

Vulnerable children, such as those in care or with learning disabilities, face particular, more complex, issues and our priority is to support them to realise the same positive and sustainable outcomes as rest of the population. Young women who become pregnant in their teenage years are also vulnerable and at risk of significantly poorer outcomes.

Research has found that children and young people in care experience significantly worse mental health than their peers. In Havering, there were 183 looked after children in 2011/12. These children are extremely vulnerable. They are less likely to achieve qualifications or have employment prospects; are more at risk of exploitation; are more likely to get involved in criminal activity; and are more susceptible to drug and alcohol abuse.

THEME B: Better integrated support for people most at risk

What is the current situation in Havering?

Our Joint Strategic Needs Assessment[8] tells us that:

- Of 30,000 families in Havering, around 400 are categorised as having 'multiple complex needs' and over 200 are 'barely coping'. Of these, a significant proportion will reach a level of need where they require expensive specialist or statutory services. The Council's new Troubled Families initiative is working to improve the outcomes of these families through better integrated early support
- 35% of the budget of Children and Young People's Services is spent on specialist services; a disproportionate amount considering the number of individuals in receipt of these services. Preventing need for these services will reduce the level of spend, thus enabling a more equitable balance of expenditure on the under 18 population
- There were 183 looked after children in 2011/12 (equating to 36 in 100,000 population aged under 18). Educational attainment of these children and young people is significantly below the average for their peers
- Although the under 18 conception rate at 29.3 (per 1,000 girls) is lower than the London and national rates, the needs of this vulnerable group of teenagers remain a priority
- 20% of children in Havering live in poverty, and two small areas of Havering (in Gooshays and South Hornchurch) fall into the 10% most deprived areas in England
- The number of children with learning difficulties and disabilities is projected to increase 7.5% by 2017, mainly among children aged 5-11
- The most common categories of learning difficulties and disabilities are moderate learning disability (30%); behaviour, emotional and social difficulties (19%); and speech, language and communication needs (17%).

Specialist services available to vulnerable children and young people in Havering include child protection and safeguarding; youth offending; child and community psychology; Foundation Years and Independent Advice Service (FYIAS); short breaks and activities for disabled children and young people; Havering Community Alcohol Team (HCAT); Havering Children's Rights and Advocacy Service; learning difficulties and disabilities and physical and sensory disabilities teams; family and carer support; domestic violence forum; Multi-Agency Safeguarding Hub (MASH); Havering Child and Adolescent Mental Health Service (CAMHS); and several children's centres catering to different needs, providing access to our 'early help offer'.

Where do we want to be in Havering?

Effective preventative and 'early help' services, delivered at the earliest opportunity, such as our Troubled Families initiative, aim to avoid escalation of common problems experienced by families with multiple problems, which may include domestic violence, alcohol and/or substance misuse and mental health issues. Targeting our efforts on children at risk will be the most effective way to reduce demand for expensive specialist and intensive services, prevent negative outcomes and save money in future years. By working collectively as a strategic partnership, we will better integrate care for vulnerable children.

Our objectives are to:

- Provide intensive, bespoke, support to families with multiple complex needs to address their problems earlier. We will do this by identifying families who are most at risk of failing and working collectively to support them
- Improve the stability of care placements and reduce placement breakdown. We will do this by increasing the number of foster families and by placing children more quickly with adoptive families; better engaging with children and young people; and improving access to CAMHS

[8]JSNA 2011/2, Chapter 12: Supporting Vulnerable Children

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- 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 by working with young people earlier to better plan this transition
- Reduce teenage conceptions and improve sexual health through the delivery of targeted campaigns that raise awareness of health risks
- Commission universal and targeted access to health visitors and school nurses to deliver the Healthy Child Programme
- Reduce the numbers of children experiencing poverty in Havering by working collectively to deliver actions in the Child Poverty Strategy
- Provide access to high-quality therapies for vulnerable children and young people. We will improve access to Child and Adolescent Mental Health Services (CAMHS), speech and language therapies and occupational therapies.

Over and above these priorities, we will continue to put the safety of children and young people first and ensure that safeguarding arrangements in Havering are second to none.

How will we deliver improved outcomes?

Below are the key actions that we will take to deliver 'early help' and improved outcomes for better integrating care for vulnerable children. Each action is owned by a lead partner(s) of the Health and Wellbeing Board. Our performance will be measured by the successful delivery of these actions and improvements against key indicators.

Objectives	Actions	Lead Partners
Provide intensive, bespoke, support to families with multiple complex needs to address their problems earlier	Identify with all partners those families who are most at risk of failing without the right sort of help	LBH (Children's Services) & HCCG
	Deliver better joined up intervention for complex families through our Troubled Families initiative	LBH (Children's Services)
	Provide a more proactive children's safeguarding service through the Multi Agency Safeguarding Hub (MASH)	LBH (Children's Services)
Improve the stability of care placements and reduce placement breakdown	Undertake fostering recruitment campaign to increase in-house fostering families and reduce placement breakdown, and improve the matching of children and young people with foster carers	LBH (Children's Services)
	Restructure services to enable better continuity of social work support	LBH (Children's Services)
	Introduce parallel planning for children to place more quickly with permanent/adoptive families	LBH (Children's Services)
	Better engage with children and young people through training, mentoring and befriending	LBH (Children's Services)
	Improve access to CAMHS through working with partners on the re-established CAMHS commissioning board, reviewing current use of provision, undertaking a commissioning exercise this year and introducing new ways of working including advice surgeries for social care staff	LBH (Children's Services)

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Objectives	Actions	Lead Partners
Improve health outcomes for children and young people, particularly those in care	Deliver the children and young people physical activity programme	LBH (Culture and Leisure)
	Improve the immunisations of looked after children	LBH (Childrens Services) & (Public Health)
	Ensure all looked after children receive regular health and dental checks	LBH & HCCG
Improve the transition from children's to adults care packages for young people with disabilities	Work with young people earlier to better plan the transition between children's and adults care packages	LBH (Adults and Health) & (Children's Services)
Reduce teenage conceptions and improve sexual health	Targeted campaigns to reduce numbers of conceptions in under-18s and rates of Chlamydia in 15-24 year olds	LBH (Public Health) & (Children's Services)
	Commission sexual health and contraception services to meet the needs of Havering's teenagers	LBH (Public Health) & (Children's Services)
Reduce numbers of children experiencing poverty in Havering	Work with partners to continue to reduce child poverty and deliver actions from the Child Poverty Strategy	LBH (Children's Services)
Provide access to high-quality therapies for vulnerable children and young people	Improve access to Child and Adolescent Mental Health Services (CAMHS), speech and language therapies and occupational therapies	LBH (Children's Services) & HCCG

Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Children with three or more placements	H: 20% L: 11.3% E: 10.7% (2011/12)	13%	LBH (Children's Services)
Placements lasting at least two years	H: 50.9% L: 68.1% E: 68.6% (2011/12)	75%	LBH (Children's Services)
Under 18 conceptions (rate per 1,000 15-17 year olds)	H: 38.34 (2011/12) L: 43.7 E: 40.2 (2007-09 DIH)	35	LBH (Public Health) & (Children's Services)
Chlamydia diagnoses 15-24 year olds (diagnosis rate per 100,000 aged 15-24)	H: 1250.6 L: No data available E: 1940.2 (2011/12 HPA)	No target identified	LBH (Public Health) & (Children's Services)
Total Looked After Children with up-to-date health assessment	H: 83.9% (104) (2011/12)	100%	LBH (Public Health) & (Children's Services)

THEME B: Better integrated support for people most at risk

Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Looked After Children continuously looked after for at least one year	H: 124 (2011/12)	No target identified	LBH (Public Health)
Looked After Children with immunisations up to date	H: 96% L: 81% E: 79% (2011)	100%	LBH (Children's Services)
Looked After Children with dentist check-ups	H: 96% L: 87% E: 82% (2011)	100%	LBH (Children's Services)
Looked After Children with substance misuse problems	H: 4% L: 6% E: 4% (2011)	Below 4%	LBH (Children's Services)
Emotional wellbeing of Looked After Children (emotional and behavioural health)	H: 14.4 E: 13.8 (2009)	No target identified	LBH (Children's Services)
Children in poverty (children in families in receipt of IS/ JSA or where income is less than 60% of median income)	H: 21.65% (9,300) E: 24.45% (2008 DIH)	To reduce the proportion of child poverty in Havering	LBH (Children's Services)

THEME B: Better integrated support for people most at risk

Priority 7: Reducing avoidable hospital admissions

Why is this important in Havering?

Hospital admissions, especially avoidable admissions, are extremely costly to the NHS and disrupt the lives of those affected, as well as causing unnecessary distress to family and friends. Long or frequent hospital stays also cause increased dependency and ill health and reduce people's confidence to manage at home – particularly older people. From a financial perspective, hospital admissions, especially emergency or unplanned admissions and repeat admissions, are extremely costly to the NHS and can disrupt the delivery of elective (planned) care.

Avoidable admissions include conditions that can often be managed in the community; an unplanned readmission that might have been avoided had the original discharge been better planned or that plan implemented better; and the absence of more appropriate, community-based, models of care.

Unplanned re-admissions occur as an emergency within a short time of an initial admission. The initial admission may itself have been planned or unplanned. The subsequent readmission may be due to an entirely unrelated problem but a significant proportion is due to surgical complications or a failure at discharge. Unplanned admissions account for nearly two thirds of all hospital bed days in England, with 15-20% thought to be avoidable.

THEME B: Better integrated support for people most at risk

What is the current situation in Havering?

Our Joint Strategic Needs Assessment[9] tells us that:

- Emergency hospital admissions are significantly lower (better) than the average for London and England. Nonetheless in 2010/11 there were more than 21,000 admissions at a cost of nearly £43 million (more than 10% of the total HCCG budget)
- Moreover, both the number (up 27%) and cost (up 18%) of emergency admissions have increased steadily in the three years 2008/09-2010/11
- A number of groups including the old, the very young, disadvantaged communities, those with pre-existing long-term conditions or who live close to A&E units are at greater risk of unplanned admission
- In 2010/11, there were 1,500 admissions of residents aged 65 or older following a fall. Age standardised rates of admission were higher, but not significantly higher, than the national average and at least 20% higher than PCTs in the best performing quartile
- More than 300 residents were admitted to hospital following a stroke in 2009/10. Rates of admission for stroke were very similar to the national average
- The majority of unplanned admissions follow from an A&E attendance. Avoiding the use of A&E services wherever possible would help to reduce avoidable hospital admissions. There were 64,000 A&E attendances in 2010/11. The indirectly age standardised rate of A&E attendance was 252 per 100,000; significantly below the national average (387) and lowest for any borough in London. Moreover, attendance rates in Havering have declined over the last three years whereas rates have increased nationally
- There were 2,329 readmissions within one month of discharge in 2009/10 (12% of all patients discharged that year). This is higher than the national average of 11%. Readmission rates have risen by more than 4% over the last 10 years, in line with national trends
- BHRUT has a high readmission rate (6.5%) relative to the national average (5.5%) and Acute Trusts serving similar populations. Excluding cancer treatment, the highest rates of readmission occur in geriatric medicine, general medicine and general surgery
- The likelihood of readmission increases following discharge to nursing homes.

Some admissions may reflect the lack of availability of more appropriate forms of community based care. Although almost 75% of people say they would prefer to die at home, a majority continue to die in hospital. Admissions ending in death are the biggest single cause of complaint against hospitals, demonstrating how difficult it is to meet the needs of patients and their families for end of life care in an acute setting. Although the proportion of people dying at home has increased in Havering over the last three years, it is still only 35% compared with a national average of more than 40%. The majority of the remaining deaths (1,309 in 2010/11-2011/12) would have occurred in hospital at considerable cost (see Priority 5 for more information on end of life care.

There is a professional consensus that unplanned admissions can be reduced. Many different approaches have been advocated, focused on different stages along the patient journey and varying in complexity from simply increasing rates of vaccination amongst vulnerable groups to proactive disease management. Similarly, 'out of hours' arrangements that minimise the likelihood of unnecessary presentation at A&E are thought likely to reduce hospital admissions.

The Havering Commissioning Strategy Plan 2012-15 sets out the strategic priorities of the HCCG including *"shifting services from hospital to the community through integration of services across primary, secondary and social care, and ensuring the community and primary care infrastructure*

[9]JSNA 2011/12, Chapter 11: Keeping People Out Of Hospital

is in place to enable this". The ONEL Primary Care Strategy sets out plans to ensure consistently high quality primary care services for residents across the cluster. In addition, plans[10] to consolidate A&E services, coupled with the implementation of the ONEL model of urgent care, will ensure that senior clinical cover is available to all those needing emergency care.

Where do we want to be in Havering?

We are keen to reduce unnecessary and unplanned hospital admissions, particularly for ill-health or injury that could have been avoided and repeat hospital admissions where individuals are admitted into hospital on a frequent basis. By working collectively as a strategic partnership, we will reduce avoidable hospital admissions.

Our objectives are to:

- Manage the care of patients proactively in the community through planned care transformation such as integrated case management. We will identify patients most at risk of being admitted to hospital and manage their care in the community via a multi-disciplinary team across health and social care, led by general practice
- Increase independence skills of people within the community who have recently been discharged from hospital or who are at risk of admission/re-admission. We will do this by providing low level interventions such as the Help Not Hospital project and developing a Rapid Response installation process for installation of assistive technologies
- Reduce inappropriate and unplanned discharges, which lead to re-admissions and seek greater collaborative approaches to ensure that planning for discharges takes place closer to an individual's point of admission
- Ensure that vulnerable people are safeguarded from neglect and abuse when receiving care at home
- Ensure high quality prescribing of medications to reduce unnecessary hospital admissions.

How will we deliver improved outcomes?

Below are the key actions that we will take to deliver improved outcomes on reducing avoidable hospital admissions. Each action is owned by a lead partner(s) of the Health and Wellbeing Board. Our performance will be measured by the successful delivery of these actions and improvements against key indicators.

Objectives	Actions	Lead Partners
Manage the care of patients proactively in the community through integrated case management	Establish a joint working group consisting of health and social care leaders to lead and support development of an Integrated Care Strategy across the wider community served by BHRUT	LBH (Adults and Health) & HCCG
	Provide support to those most at risk of hospital admission through Integrated Case Management, a multi-disciplinary health and social care team led by general practice	LBH (Adults and Health) & HCCG
	Establish pulmonary rehabilitation sessions throughout the borough at accessible community venues to reduce demand for oxygen from GPs and A&E	LBH (Adults and Health) & HCCG
	Increase access to home oxygen assessment and review services	HCCG
	Reduce the number of hospital admissions as a result of falls and fractures from falls and the number of excess bed days	LBH (Adults and Health)
	Utilise assistive technologies for COPD patients to reduce use of hospital services by 50%	LBH (Adults and Health)

[10] H4NEL

THEME B: Better integrated support for people most at risk

Objectives	Actions	Lead Partners
Increase independence skills of people within the community who have recently been discharged from hospital or who are at risk of admission/re-admission	Through the Help Not Hospital project, provide low level interventions to support people following hospital discharge or to prevent them being admitted	LBH (Adults and Health) & HCCG
	Develop a specialist Rapid Response installation process facilitating the identification, referral and installation of a range of assistive technologies as patients are discharged from hospital	LBH (Adults and Health)
	Address unmet demand by converting 13 empty/void bedsit units at Royal Jubilee Court into reablement units	LBH (Adults and Health)
	Substantially increase the capacity of the reablement service to extend the alternatives to hospital and residential care and continue to enable more people to remain in their own homes	LBH (Adults and Health)
Reduce inappropriate and unplanned discharges, which lead to re-admissions	Ensure that planning for discharges takes place closer to an individual's point of admission into hospital	LBH (Adults and Health) & HCCG
Vulnerable people are safeguarded from neglect and abuse when receiving care at home	Ensure safeguarding controls for care agencies employed to care for people in their own homes	LBH & HCCG
Ensure high quality prescribing of medications to reduce unnecessary hospital admissions	Ensure optimal use of medicines in primary care to reduce acute admissions and improve patient outcomes.	HCCG
	Ensure continued clinical training and monitoring around prescribing of medications in primary care	HCCG
	Maintain a primary care antimicrobial prescribing formulary and adhere to specific medications monitored	HCCG
	Develop a joint medication formulary with BHRUT	HCCG

Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Emergency hospital admissions (all causes) (standardised ratio)	H: 86.35 L: 94.44 E: 100 (2003-07)	No target identified	HCCG
Emergency admissions for conditions that should not usually require hospital admission (indirectly age and sex standardised rate per 100,000)	H: 151.81 E: 181.81 (2009/10 NHS IC)	No target identified	HCCG
Emergency readmissions within 30 days of discharge from hospital (indirectly age, sex standardised percent)	H: 11.92 L: 11.9 E: 11.61 (2009/10 DIH)	No target identified	HCCG

THEME B: Better integrated support for people most at risk

Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Proportion of older people (65 plus) still at home 91 days after discharge from hospital into reablement/ rehabilitation	H: 77.2% L: 84.4% E: 82.5% (2011/12 NASCIS)	85% (2012/13)	LBH (Adults and Health)
Proportion of older people offered rehabilitation following discharge from acute or community hospital	H: 76.6% E: 81.9% (2010/11 NHS IC)	No target identified	LBH (Adults and Health)
Overall number of delayed transfers of care from hospital per 100,000 population	H: 13.3 L: 7.6 E: 9.9 (2011/12 NASCIS)	5 (2012/13)	LBH (Adults and Health)
Number of delayed transfers of care from hospital attributable to Adult Social Care and Health per 100,000	H: 5.5 L: 3.0 E: 3.7 (2011/12 NASCIS)	3 (2012/13)	LBH (Adults and Health) & HCCG
Permanent admissions to residential and nursing care homes (aged 18-64) per 100,000 population	H: 9.0 L: 15.1 E: 18.9 (2011/12 NASCIS)	9 (2012/13)	LBH (Adults and Health)
Ambulatory care sensitive admissions (NHS)	H: 457/1000 (2011/12)	No target identified	HCCG & LAS
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (number of admissions)	E: 1,820 (2010/11)	No target identified	LBH (Adults and Health) & HCCG
Top 10 ICD codes for long-term conditions	H: 1,020 emergency admissions (Q1 2012/13)	3,562 admissions (2012/13)	HCCG

THEME C: Quality of services and patient experience

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

Why is this important in Havering?

Ensuring patients and their families and carers, receive the best quality health and social care services is crucial to achieving the best long-term outcomes for patients and for the borough's population as a whole. Services should be delivered efficiently, sustainably and safely.

In Havering, we want all patients to have a positive an experience as possible from the care they receive when they become unwell. Monitoring patients' experience of the care they receive is a vital tool in monitoring how well health services are responding to the needs of the local population.The Government has made explicit that quality of care is a national priority for the NHS and defines quality as having three dimensions.

These are:

- **Clinical effectiveness** – good quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes
- **Patient safety** – good quality care is care which is delivered so as to avoid all avoidable harm and risks to the individual's safety
- **Patient experience** – good quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect.

The Health and Wellbeing Board also recognises organisational integrity as a fourth explicit local priority for Havering, in recognition of the serious quality and patient safety concerns that have emerged from the care provided by some of our providers. Recent Care Quality Commission (CQC) reports have identified specific concerns with our major acute care provider, BHRUT.

THEME C: Quality of services and patient experience

What is the current situation in Havering?

In Havering, the two main service 'provider' organisations are Barking, Havering and Redbridge University Hospital Trust (BHRUT) for acute hospital services and North East London NHS Foundation Trust (NELFT) for community (such as district nursing) and mental health services (such as specialist help for people with acute mental health conditions). Community and mental health services are provided in clinics, hospitals and in people's own homes.

In 2011, following a number of warning notices being issued to BHRUT, as well as unannounced inspections during 2010/11 and feedback from patients and the public on poor quality care, the CQC investigated the quality of care provided at the Trust and found some key areas for urgent improvement around quality and safety, particularly at Queens Hospital in Romford. Concerns were particularly raised around maternity services, A&E services, patient experience and the handling of patient complaints, as well as serious workforce and governance issues.

BHRUT has begun to deliver some improvements following the CQC report, and in 2012 the CQC acknowledged that improvements have taken place in the management, culture and working practices of the Trust but that more still needed to be done. All CQC restrictions that were placed on BHRUT following identification of the quality and patient safety issues have now been lifted. BHRUT in partnership with health commissioners are working on a clinical strategy to continue to address all quality, patient experience and financial issues to ensure they are a sustainable organisation with the capability of delivering high quality patient care.

Healthwatch will be the new organisation created to ensure that the voice of local patients of health and social care services and the wider community are heard on the Health and Wellbeing Board. The Council is responsible for commissioning Healthwatch and to ensure it engages with local people on the issues that matter to them about health and that this is used to affect health and social care service improvement.

THEME C: Quality of services and patient experience

Where do we want to be in Havering?

We would like to see consistently high levels of quality of care in all health and care services provided in Havering. Through collaborative working and robust provider performance management, the CCG will continue to improve the quality and safety of services to deliver its aim of improving patient, family and carer experience. We want patient experience of health and care services in Havering to be positive.

Nationally, the Department of Health has some key headline areas of focus which it believes will drive up quality of care. This is written into the Commissioning for Quality and Innovation (CQUIN) Framework that allows commissioners of services to incentivise performance in these areas. The NHS Safety Thermometer is one of these key CQUIN measures, focusing on four key indicators to improve the monitoring of quality of care in hospital and community providers, specifically to reduce harm from pressure ulcers, falls, urinary tract infections in patients with catheters and VTE (venous thromboembolism – also known as blood clots). With more proactive nursing interventions, these are all largely avoidable conditions and are key indicators that quality of care in a provider organisations may be below standard.

Our objectives are to:

- Bring about big improvements in quality of care and patient safety, especially maternity services in Queens Hospital
- Minimise the incidence of avoidable harms in hospital and community settings, including pressure ulcers, falls, urinary tract infections and VTE as measured in the NHS Safety Thermometer
- Ensure patient experience in A&E is improved by reducing waiting times and diverting people away from A&E where appropriate
- Focus on quality of care in community residential settings and implementation of a scheme to increase primary medical care in nursing homes
- Ensure sound financial management of the NHS budget for Havering so that quality of services is not compromised
- Risk is managed by providers systematically and accurately to reduce likelihood of occurrence of serious incidents
- Commission and performance manage Healthwatch to high levels of ensure patient and public engagement activity that can affect improvement.

How will we deliver improved outcomes?

Below are the key actions that we will take to deliver improved outcomes on quality of services and patient experience. Each action is owned by a lead partner(s) of the Health and Wellbeing Board. Our performance will be measured by the successful delivery of these actions and improvements against key indicators.

Objectives	Actions	Lead Partners
Bring about big improvements in quality of care and patient safety, especially maternity services in Queens Hospital	Ensure the CQC 2011 key findings for improvements are delivered across BHRUT	HCCG
	Deliver the four key areas of the NHS Safety Thermometer to minimise the incidence of avoidable harms in hospital and community settings, including pressure ulcers, falls, urinary tract infections and VTE	HCCG
	Improve Serious Incident Management through improved reporting and risk management	HCCG
Ensure patient experience in A&E is improved by reducing waiting times and diverting people away from A&E where appropriate	Improve patient experience in A&E by reducing waiting times and processing patients efficiently	HCCG

THEME C: Quality of services and patient experience

Objectives	Actions	Lead Partners
Improved quality of care in community residential settings and increase primary medical care in nursing homes	Implement the nursing homes scheme to match named GP practices with each of Havering's nursing and residential care homes, ensuring regular visits are made to all residents in care homes and thereby improving medical care and reducing admissions to hospital	LBH (Adults and Health) & HCCG
Ensure sound financial management of the NHS budget for Havering so that quality of services is not compromised	Ensure the CCG and health providers operate within their budgets to avoid overspends	HCCG
Risk is managed systematically and accurately to reduce likelihood of occurrence of serious incidents	Ensure providers are reporting risk accurately and robustly through benchmarking and undertaking audits	HCCG
Commission and performance manage Healthwatch to high levels of ensure patient and public engagement activity that can affect improvement	Council to commission Healthwatch in Havering, putting in robust performance management arrangements to ensure its effectiveness	LBH (Adults and Health)

Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Incidence of category 3 and 4 pressure ulcers (BHRUT)	H: 5 (July 2012)	0	HCCG
Number of (MRSA) bacteraemia	H: 6 cases (September 2012/13)	7 cases for the year	HCCG
Number of Clostridium difficile infections	H: 26 cases (September 2012/13)	59 cases for the year	HCCG
Increase in patients seen by a senior clinician within 12 hours of being admitted, and consultant within 24 hours	H: No data available	75%	HCCG
Breeches of single sex accommodation	H: 19 (August 2012/13)	0	HCCG
Serious untoward incidence – percentage reported within 48 hours (quarterly)	H: 53% (July 2012)	50%	HCCG
Women's experience of maternity services	H: 20/24 questions BHRUT performed worse than other Trusts; 3/24 performed similarly to other Trusts' 1/24 performed better than other Trusts (2009/10 BHRUT Maternity Survey)	BHRUT perform favourably to other Trusts against all 24 questions	HCCG
Complaints responded to in line with agreement with patients	H: 87% (July 2012)	80%	HCCG

THEME C: Quality of services and patient experience

Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Patient experience of outpatient services	H: 27/50 questions BHRUT performed worse than other Trusts; 23/50 performed similarly to other Trusts (2009/10 Survey of Adult Outpatients)	BHRUT perform favourably to other Trusts against all 50 questions	HCCG
Category A ambulance response times: target 75% within eight minutes	H: 67% L: 73% (May 2012)	75%	HCCG & LAS
A&E: From arrival to admission / transfer / discharge (maximum waiting times of 4 hours)	H: 88.4% (A&E weekly activity statistics, NHS and independent sector organisations in England)	95%	HCCG
Discharge plan put in place within 24 to 48 hours of admission to A&E	H: No data available	95%	HCCG
Patient experience of hospital care and A&E	H: 26/73 questions BHRUT performed worse than other Trusts; 47/73 BHRUT performed similarly to other Trusts (2009/10 Survey of Adult Inpatients)	BHRUT perform favourably to other Trusts against all 73 questions	HCCG
Patient experience of out of hours services	H: 64% E: 71% (2011)	Havering performs at or above the national average	HCCG
From point of referral to treatment in aggregate (RTT) – non admitted	H: Currently above 95%	95%	HCCG
Patients able to see a GP within 2 days	H: No data available	2012/13 is the baseline year	HCCG
Patients would recommend a practice	H: No data available	2012/13 is the baseline year	HCCG
Patient experience of GP services	H: 23/38 questions GP practices performed better than national average; 9/38 performed similarly to national average; 6/38 performed worse than national average (2010/11 GP Practice Survey)	All GP practises perform at the national average of better for patient experience	HCCG

Appendix 1: Membership of Havering Health and Wellbeing Board

Name	Position
Cllr Steven Kelly	Deputy Leader of the Council and Cabinet Member for Individuals and Health
Cheryl Coppell	Chief Executive, the London Borough of Havering
Dr Gurdev Saini	CCG Board Member (Lead for the Local Authority)
Dr Stephen Farrow	Interim Director of Public Health
Cllr Paul Rochford	Cabinet Member for Children and Learning
Cllr Andrew Curtin	Cabinet Member for Towns and Communities, with special responsibility for Culture
Cllr Lesley Kelly	Cabinet Member for Housing
Lorna Payne	Director of Adult Social Care, the London Borough of Havering
Sue Butterworth	Director of Children's Services, the London Borough of Havering
Conor Burke	Accountable Officer (Designate) CCG
Dr Atul Aggarwal	CCG Chair
TBC	Healthwatch Representative
Non Voting Member:	
Jacqui Himbury	Borough Director, Havering NHS ONEL

Appendix 2: Glossary

A&E	Accident & Emergency
APHO	Association of Public Health Observatories
ASC	Adult Social Care
BHRUT	Barking, Havering and Redbridge University Hospitals National Health Service Trust
CAMHS	Child and Adolescent Mental Health Services
CCG/HCCG	Clinical Commissioning Group / Havering Clinical Commissioning Group
CSU CCT	Commissioning Support Unit Cancer Commissioning Team
CQUIN	Commissioning for Quality and Innovation
DH	Department of Health
DIH	Data Intelligence Hub
HPA	Health Protection Agency
JSNA	Joint Strategic Needs Assessment
LAS	London Ambulance Service
LBH	London Borough of Havering
LHIB	London Health Improvement Board
NASCIS	National Adult Social Care Intelligence Service
NHSCB	National Health Service Commissioning Board
NHS IC	National Health Service Information Centre
NELC	North East London and City
NELFT	North East London Foundation Trust
NCIN	National Cancer Intelligence Network
ONEL	Outer North East London
ONS	Office for National Statistics
PCT	Primary Care Trust
PH	Public Health
PHE	Public Health England
POPPI	Projecting older People Population Information System
QOF	Quality and Outcomes Framework

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Havering
LONDON BOROUGH

LONDON BOROUGH OF HAVERING EQUALITY ANALYSIS

HEALTH AND WELLBEING STRATEGY

SCOPE OF PROPOSAL

1. What is the scope and intended outcomes of the activity being assessed; in terms of both the Council's organisation and staffing, and services to the community?

1 (a) Organisation and Staffing

The Health and Wellbeing Strategy is an overarching document that reflects on recent changes in legislation and builds on existing plans to improve the health and wellbeing for local residents, including employees who live locally.

The main objectives of the strategy are to:

- Raise public awareness and understanding of health and risks to health
- Reduce health inequalities, and
- Improve health outcomes and quality of life

Underpinning the strategy is our recognition that people in Havering should be well informed and in control of decisions affecting them, and our ambition to empower them to be as healthy and independent as possible for as long as possible.

The strategy will also:

- Drive and inform the development of commissioning within local areas, and
- Improve partnership working and increase coordination between Health and Social Care services.

The strategy and its corresponding Action Plans will ensure that the health of all residents improves and those with the worst health benefit the most.

1 (b) Services to the Community

The Health and Wellbeing Strategy reflects on recent changes in legislation and builds on existing plans to improve the health and wellbeing for local residents, including employees who live locally.

The main objectives of the strategy are to:

- Raise public awareness and understanding of health and risks to health;
- Reduce health inequalities, and
- Improve health outcomes and quality of life.

The Health and Wellbeing Strategy is informed by the 2011/12 Joint Strategic Needs Assessment (JSNA). The JSNA is a statement of population needs and assets in Havering, based on a collection of datasets and information. The JSNA takes a population based approach, so would consider all of Havering's population including Havering staff members who live and/or work locally.

The priorities identified in the Health and Wellbeing Strategy are drawn from the 2011/12 JSNA and are consistent with the areas flagged as 'high risk', 'red risk' or poor performance areas in the three relevant outcome frameworks: the Public Health Outcomes Framework, the NHS Outcomes Framework, and the Adult Social Care Outcomes Framework. For further information, please refer to *Appendix 1 (Outcomes Framework Performance)*.

The eight key priority areas are:

1) Early help for vulnerable people in the community
2) Dementia – improved identification and support
3) Early detection of cancer
4) Tackling obesity
5) Frail elderly – more integrated care
6) Focusing on vulnerable/high risk children
7) Reducing avoidable hospital admissions
8) Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

In addition, the strategy aims to tackle health inequalities and improve information and community engagement. Underpinning the strategy is also our recognition that people should be in control of decisions affecting them, be informed and take personal responsibility such as self-care, use of direct payments, etc.

Our plans will ensure that the health of all residents improves and those with the worst health benefit the most.

PEOPLE AFFECTED

2. Which individuals and groups are likely to be affected by the activity?

2 (a) Staff Individuals and Groups

The strategy aims to improve the health and wellbeing of local residents, including staff members who live locally (currently, over 70% of the workforce).

For further information, please refer to 2(b).

2 (b) Community Individuals and Groups

The aim of this strategy is to ensure that the health and wellbeing of all residents improves and those with the worst health benefit the most. Amongst the groups that would benefit the most would be vulnerable adults and children at high risk, older people, service users with Dementia, and people who have or are at risk of cancer.

For further information, please refer to Table 2 in point 5(b).

DATA AND INFORMATION

3. What data/information do you have about the people with 'protected characteristics' *(age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation)* or **other socio-economic disadvantage** *(e.g. disabled and part-time workers, low income and/or lone parents (mothers and fathers), looked-after children, other vulnerable children, families and adults)* **among these individuals and groups? What information do you have about how they will be affected by the activity? Will you be seeking further information in order to assess the equalities impact of the activity? How is this information being used to influence decisions on the activity?**

3 (a) Staff

Over 70% of LBH staff members live in Havering and are considered as part of the community. For further information, please refer to 3(b).

3 (b) Community

When developing the Health and Wellbeing Strategy, we have taken into account Havering's 2012 demographic and socio-economic profile as well as the 2011/12 JSNA findings.

Some of the major trends in the Borough are:

- It is estimated that around 236,100 people currently live in Havering. Havering's population is predicted to rise up to: 246,900 people by 2016 and 267,600 people by 2026.
- Of Havering's population, 52% are female and 48% are male. The percentage of women in Havering is slightly above the average for London (50%) and England (51%). The greater number of females than males in Havering's population may in part be explained by the longer life expectancy of females.
- The Borough predominately has a white population and the ethnic minority population is 11.4%. This percentage is well below the London average and slightly below the average for England. The school census reported that nearly 23% of school pupils in Havering were from non-White ethnic

groups in 2011, with the most common ethnic group being Black or Black British (9%).

- Around 23% of the population in Havering is aged 0-19. This percentage is roughly average for England (14%). Just below 18% of the population are aged 65 and over. This percentage is above the average for London (11.5%) and for England (16.5%).
- 17.5% of Havering's working age population have identified themselves as being disabled. 4% of people in Havering are claiming Disability Living Allowance, over 2% of which receive the Higher Rate Mobility award. Just below 18% of older people in Havering are claiming Attendance Allowance, 53% of whom receive Higher Rate award. Nearly 4% of people in Havering are claiming Incapacity Benefits, 77% of whom have been Incapacity Benefits claimants for five or more years.
- Over three quarters (76%) of Havering's population stated that they are Christian, followed by 13% with no religion and just below 8% who preferred no to state their religion. Other religions in the borough are: Hindu (0.77%), Sikh (0.42%), Buddhist (0.18), Muslim (0.8%), Jewish (0.5%). Just below 40% of people with no religion are White British or White other.
- There are pockets of deprivation in Havering, with two small areas (an area in Gooshays and an area in South Hornchurch) falling into the 10% most deprived areas in England, and 11 small areas in Havering falling into the 20% most deprived areas in England. Overall, Gooshays remains the most deprived ward in Havering.
- Female life expectancy in Havering (83.4) remains higher than male life expectancy (78.8), which is in line with the national trends. Longer life expectancies may result in increased burden of disease if extended survival is accompanied by longer average period of morbidity.
- Female disability free life expectancy in Havering (65.6) is higher than male disability free life expectancy (63.4). However, disability free life expectancy rates are slightly higher than London and national trends.
- There is a 4.2 year difference in the life expectancy of women living in the most advantaged and disadvantaged parts of the borough. The inequality in male life expectancy is 6.9 years.
- Population ageing and increases in the older old (ages over 80) is contributing to increases in diseases, and in mortality and hospitalisations resulting from illnesses of the frail elderly e.g. pneumonia and bronchitis.
- Due to the older age profile of the borough, relatively large numbers of residents live with long term health conditions including cardiovascular disease (heart attack, stroke, heart failure etc), respiratory disease (emphysema, bronchitis etc), dementia and osteoporosis (which increases the risk of serious fractures due to falls). The likelihood of most if not all of these conditions increases with age. Thus the number of people needing support from health and social care services will increase as the population continues to grow and age.

- There are new illness patterns among the population relating to ethnicity (e.g. increased sickle cell anaemia), sexual orientation (e.g. higher rates of breast cancer amongst gay women) and other equality groups.
- Many people are diagnosed with cancer each year and short term survival is poor. Large sections of the population have lifestyles and behaviours such as smoking, obesity, poor diet and harmful alcohol consumption that increase the risk of long term conditions and cancer.
- Health services are the top priority for local people in making the Borough a nice place to live, followed by the level of crime and clean streets.

The priorities in the Health and Wellbeing Strategy are drawn by the 2011/12 Joint Strategic Needs Assessment (JSNA). The JSNA is a statement of population needs and assets in Havering, based on a collection of datasets and information. The JSNA takes a population based approach, so would consider all of Havering's population including Havering staff members who live and/or work locally.

The 2011/12 JSNA includes:

1) JSNA chapters on specific topics: CVD, dementia, cancer, domestic violence, obesity, smoking, breastfeeding, demographics, vulnerable adults and older people, vulnerable children and younger people and keeping people out of hospital.
2) JSNA datasets on Havering Data Intelligence Hub: a range of datasets about the health and wellbeing of Havering residents.

Table 1: Main findings from the 2011/12 JSNA

Priorities	Evidence
Early help for vulnerable people to live independently for longer	- There are currently estimated to be 39,000 Havering residents with one or more long term conditions. Demographic change will result in still greater numbers. - Nationally, those with long term conditions are the most intensive users, accounting for half of all GP appointments, two thirds of all outpatient appointments and nearly three quarters of all inpatient bed days. - 1,200 older people in Havering have particularly complex health and social care needs. Around 900 of this group account for 38% of all emergency bed days. - The prevalence of long term conditions varies in the same way as life expectancy with poorer health outcomes in more disadvantaged areas. - The number of people recorded as having long term conditions on GP disease registers is significantly below the number expected, given the results of national population surveys. This suggests that many people with long term conditions remain undiagnosed and are therefore not benefitting from treatments which could improve their wellbeing and slow disease progression.

Priorities	Evidence
Improved identification and support for people with Dementia	- It is currently predicted that there are approximately 3,101 people with dementia in Havering, although this is predicted to rise by more than 50% in the next 20 years as the population ages still further. However, most recent records indicate that there are approximately 1,015 patients registered with NHS Outer North East London as having some form of dementia, thereby resulting in an estimated under-diagnosis of around 65%. - At any one time, about a quarter of all inpatients at Queens' Hospital have dementia, often un-diagnosed, complicating their management and discharge planning and resulting in longer lengths of stay. - The bulk of care for dementia patients, particularly for the undiagnosed, is provided by family and friends. In 2001, more than 1 in 10 Havering residents identified themselves as a carer; the highest proportion of any borough in London. The majority of care tends to be provided by a spouse or partner, meaning that they are often elderly and experience poor health themselves.
Early detection of cancer	- About 1200 local residents (1 in every 200) are diagnosed with some form of cancer each year and more than 600 die of the disease. - More than 40% of all cancer cases are attributable to avoidable risk factors. - Cancer survival is a particular priority locally as short term (one year after diagnosis) cancer survival in Havering (64.2%) has not improved in recent years and is now significantly worse than the England average (66.5%). - If survival rates for breast, colorectal and lung cancer could be improved to the level achieved in the best performing PCTs in the country, 61 deaths would be avoided in Havering each year.
Tackling obesity	- There are proportionally more obese adults in Havering (26%) than in London (21%) or England (24%) as a whole. - 1 in 5 children in Havering are obese by age 11 which is similar to the national average. 12% are obese by age 5 which is significantly higher than the national average of 10%. - Obesity rates are particularly high in Harold Hill and South Hornchurch. - Most people in Havering are not getting enough physical activity to benefit their health, and many struggle to eat healthily. - High rates of breast feeding are associated with lower levels of obesity, but rates of breastfeeding in Havering are very low.
Better integrated care for the 'frail elderly' population	Currently, 36% of Havering's population are aged 50+ (85,999 people), of which 21% are of retirement age (60+ females, 65+ males; 49,122 people). Women of retirement age are almost twice as many (17,372 people) than men of retirement age (31,750 people).

Priorities	Evidence
	Some of these people have long term conditions or support needs: - Nearly 15,000 older residents are estimated to be unable to manage at least one self care task on their own, and more than 18,000 are estimated to be unable to manage at least one domestic task on their own (e.g. shopping, washing etc). - It is estimated that 3,760 older people have depression, which is predicted to increase to 4,146 by 2020. - 16,300 older Havering are estimated to be living along, which is predicted to increase to 17,948 by 2020. - More than 1,100 residents are registered as being blind or partially sighted in Havering. - There are around 140 excess winter deaths annually among Havering residents, many of whom are vulnerable older people - More than 1,200 Havering residents are admitted to hospital annually as a result of a fall. - St Francis' hospice end of life care services were used nearly 19,000 times by Havering residents in 2010/11 and demand for services is increasing. - In 2011, there were approximately 560 users of learning disability services in Havering (of all ages), of which around 70 were aged 60+. - It is estimated that 3,760 people aged 65+ in Havering have depression. This is estimated to increase to 3,925 by 2015 and 4,146 by 2020. - It is estimated that around 3,050 older people in Havering have dementia, which is predicted to rise to 4,691 by 2030. - There are estimated to be 5,276 older residents with diabetes. - Recent research estimates there to be 39,000 Havering residents with one or more long term conditions. Of these, the number of older people (age 65+) in Havering with long term conditions is estimated at 18,600 where 1,200 older people have particularly complex health and social care needs. Around 900 of these 1,200 people account for 38% of all emergency bed days. - The Indices of Multiple Deprivation for Older People 2010 (IDAOPI) show that in 10.1% of small areas in Havering, older people are within the 20% most deprived nationally (15 small areas across the Borough) and in 1.3% of small areas in Havering, older people are within the 10% most deprived nationally (2 small areas across the Borough). - It is estimated that 16,300 Havering residents aged 65+ are living alone in 2012. This is predicted to increase to 17,948 older people living alone by 2020. Older people living alone can be an indicator of social isolation and may require more support from health and social care services. - It is estimated that in 2012, 4,752 Havering residents aged 65+ are providing unpaid care. It is estimated that this will rise to 5,005 by 2015.

Priorities	Evidence
Better integrated care for vulnerable children (high risk children)	A number of factors may indicate increased vulnerability: - Disadvantage - 20% of children live in poverty; two small areas of Havering falling into the 10% most deprived areas in England (an area in Gooshays and an area in South Hornchurch), and 11 small areas in Havering falling into the 20% most deprived areas in England. - Child protection issues - there are lower numbers of children on child protection plans or in the care of the Council, than many areas of London, but high numbers of referrals to children's social care which do not meet child protection thresholds (avg. 66%). - Family issues - of the 30,000 families in Havering; about 400 are categorised as 'families with multiple complex needs' and over 2000 are 'barely coping '. Of the 400 that are 'families with multiple complex needs', a significant proportion will reach a level of need where they require expensive specialist or statutory services. - Lone-parent families - 27% of children in Havering live in lone-parent families. - Looked after children - There were 183 looked after children in Havering in 2011/12, equating to 36 looked after children for every 10,000 population aged under 18 years. In 2011/12, 80.4% of looked after children were White British, with White and Black Caribbean (4.7%) and other mixed backgrounds (3.9%) representing the second and third largest ethnic groups. There are significantly more male children in care in Havering than female – in 2011/12 61.4% of looked after children were male, compared to 38.6% female children. - Teenage conceptions and sexual health – rates of conception among teenage girls (under 18 years) remain lower than the average for both England and London but have not improved in recent years and therefore the advantage over England has decreased overtime. The rate of conceptions among girls aged under 16 years is higher than that in England as a whole and the needs of this very vulnerable group is a priority. There is an established link between deprivation and young pregnancies. Wards that have higher rates of teenage pregnancies are also the wards that generally have higher rates of deprivation and poverty: Gooshays, Rainham, Wennington, Heaton, Havering Park, and South Hornchurch. - Not in Education, Employment or Training (NEET) - the % of 16-19 year olds NEET is lower than national or London averages. - Learning disabilities – current projections suggest an overall increase of 7.5% across all categories of learning difficulties and disabilities by 2017. The most common categories of learning difficulties and disabilities are: Moderate Learning Disability (30%); Behaviour, Emotional & Social Difficulties (19%); Speech, Language and Communication Needs (17%). - Mental health - In 2009, 1,959 (5.8%) of children in Havering were reported as having conduct disorders. 1,249 (3.7%) had emotional

Priorities	Evidence
	disorders.
Reducing avoidable hospital admissions	**Emergency admissions** account for nearly two thirds of hospital bed days in England and are costly compared to other types of care. - In Havering, there were 21,214 emergency admissions in 2010/11. - Rates of emergency hospital admission in Havering are significantly lower (better) than the average for England (89.0) and London but are increasing. - A and E attendances in Havering are significantly below the national average and lowest for any borough in London. Attendance rates have also declined in recent years. **Ambulatory Care Sensitive (ACS) admissions** are a subset of all emergency admissions caused by 1 of 19 conditions that are considered to be manageable in the community i.e. without the need for hospital admission. Nationally, ACS admissions account for 1 in 6 of all emergency admissions. - In Havering during 2010/11, ACS conditions accounted for 4.9% of all hospital admissions and 15.5% of emergency hospital admissions in 2010/11. This equates to 6,728 admissions due to ACS conditions. - The main health conditions responsible for ACS admissions are chronic obstructive pulmonary disease (16.5% of all ACS conditions), influenza and pneumonia (15.1%) and dehydration and gastroenteritis (11.3%). - There are wide variations between Havering GP practices in avoidable hospital admissions, ranging from 7 per 1000 population to 32 per 1000 population. - There are pockets across the Borough with high rates of avoidable hospital admissions, however there is a cluster of high rates around Brooklands and Romford Town as well as some areas within Rainham and Wennington, Heaton, South Hornchurch and Harold Wood. - Benchmarking exercises suggest that reductions of about 20% in such admissions are possible. **Readmission rates** in Havering have risen more than 4% over the last 10 years in line with national trends. However, when emergency re-admissions are analysed by age, Havering has consistently had a significantly higher (worse) percentage of older people (aged 75+) who are re-admitted to hospital in an emergency within 28 days of discharge, compared with England. - In 2009/10, there were 2329 readmissions within 1 month of discharge for Havering residents, representing 12.1% of all patients discharged that year, compared with a national average of 11.4%. 52% of those with a long term health condition in Havering feel they have had enough support from local services or organisations in managing their condition (England 55%; London 52%).

Priorities	Evidence
Improving quality of health services to ensure that patient experience and long-term health outcomes are the best they can be	The Government has made explicit that quality of care is a national priority for the NHS and defines quality as having three dimensions. These are: • **Clinical effectiveness** – good quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes • **Patient safety** – good quality care is care which is delivered so as to avoid all avoidable harm and risks to the individual's safety • **Patient experience** – good quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect. Organisational integrity has been identified as a fourth explicit local priority for Havering, in recognition of the serious quality and patient safety concerns that have emerged from the care provided by some of our providers. Recent Care Quality Commission (CQC) reports have identified specific concerns with our major acute care provider, BHRUT. In Havering, the two main service 'provider' organisations are Barking, Havering and Redbridge University Hospital Trust (BHRUT) for acute hospital services and North East London NHS Foundation Trust (NELFT) for community (such as district nursing) and mental health services (such as specialist help for people with acute mental health conditions). Community and mental health services are provided in clinics, hospitals and in people's own homes. In 2011, following a number of warning notices being issued to BHRUT, as well as unannounced inspections during 2010/11 and feedback from patients and the public on poor quality care, the CQC investigated the quality of care provided at the Trust and found some key areas for urgent improvement around quality and safety, particularly at Queens Hospital in Romford. Concerns were particularly raised around maternity services, A&E services, patient experience and the handling of patient complaints, as well as serious workforce and governance issues. BHRUT has begun to deliver some improvements following the CQC report, and in 2012 the CQC acknowledged that improvements have taken place in the management, culture and working practices of the Trust but that more still needed to be done. All CQC restrictions that were placed on BHRUT following identification of the quality and patient safety issues have now been lifted. BHRUT in partnership with health commissioners are working on a clinical strategy to continue to address all quality, patient experience and financial issues to ensure they are a sustainable organisation with the capability of delivering high quality patient care. Healthwatch will be the new organisation created to ensure that the voice of local patients of health and social care services and the wider community

Priorities	Evidence
	are heard on the Health and Wellbeing Board. The Council is responsible for commissioning Healthwatch and to ensure it engages with local people on the issues that matter to them about health and that this is used to affect health and social care service improvement.

CONSULTATION

4. If no data and information is available about the groups likely to be affected by the activity, how would you inform your EA? Will you be considering carrying out some consultation to inform your EA?

4 (a) Staff

A number of consultation exercises involving key stakeholders were carried out during the draft of the Health and Wellbeing Strategy.

In February 2012, a development workshop was held to discuss health and wellbeing in Havering and inform the strategy. The workshop included partners from public health, the local authority, Councillors and GP commissioners.

The objectives for the workshop were, as follows:

- Identify high level needs in Havering PCT
- Develop top line priorities and outcomes
- Commence engagement with stakeholders

Two main themes were identified at the development workshop as being crucial to improving the health and wellbeing of the population, and the quality of services commissioned for them.

Theme 1: Prevention - Keeping people healthy; early identification of people at risk; early intervention to maintain and improve wellbeing

Theme 2: Supporting those most at risk

At the health and wellbeing workshop it was agreed that there were a number of areas relating to health and wellbeing which are particularly important in Havering and which partners need to focus further actions on. These areas were informed by the 2011/12 JSNA:

1) Early help for vulnerable people in the community
2) Dementia – improved identification and support
3) Early detection of cancer
4) Tackling obesity
5) Frail elderly – more integrated care
6) Focusing on vulnerable/high risk children
7) Reducing avoidable hospital admissions

The priorities identified in the workshop were drawn from the 2011/12 JSNA and were consistent with the areas flagged as ‘high risk’, ‘red risk’ or poor performance areas in the three relevant outcome frameworks: the Public Health Outcomes Framework, the NHS Outcomes Framework, and the Adult Social Care Outcomes Framework

In addition, staff members from Havering Council and NHS Outer North East London (Havering) were consulted as part of the JSNA consultation earlier in the year.

4 (b) Community

The Joint Health and Wellbeing strategy is directly informed by the priorities identified by the Joint Strategic Needs Assessment. The evidence base for the strategy priorities was therefore built on a range of consultation groups for the JSNA chapters. These groups were identified as being affected by and having an interest in the topics considered by the chapters. This included community groups and third sector organisations representing service users.

Consultees on the JSNA chapters included:

- The Obesity Forum (Obesity Chapter)
- The Dementia Implementation Group (Dementia Chapter)
- The Children's Trust (Obesity, Domestic Violence and Breastfeeding Chapters)
- Breastfeeding Stakeholders (Breastfeeding Chapter)
- The Children's South Partnership (Domestic Violence Chapter)
- The ONEL Cardiovascular Network (CVD Chapter)
- Council Heads of Service (All Chapters)
- Havering Public Health Team (All Chapters)
- Smoking cessation stakeholders (Smoking Chapter)
- The Domestic Violence Forum (Domestic Violence Chapter)
- Havering Cancer Locality Group (Cancer Chapter)

The chapters also contain a section on "local views" to reflect community/service user views. Further information is available at the JSNA page.

As the key priorities in the Health and Wellbeing Strategy were based on the evidence coming from the 2011/12 JSNA chapters which were broadly consulted with both internal and external stakeholders a further formal consultation was not required.

In March 2012, a workshop was held with partners of the shadow Health and Wellbeing Board, which included clinical commissioners (GPs), local authority and health commissioners, elected members and other agencies with an interest in improving the health and wellbeing of local people. The workshop focused on key issues emerging from the JSNA. It also looked at the indicators contained within the three national outcomes frameworks for the NHS, public health and social care, and identified where Havering's performance was above or below the national average against these measures. From this session, the key priorities for the Health and Wellbeing Strategy emerged and were subsequently agreed at the next Health and Wellbeing Board meeting. Further to this, stakeholder engagement took place through the Integrated Care Strategy to test priorities for health and social care, most recently in June 2012.

A summary of the strategy, providing an overview of the themes, priorities and outcomes, was however made available for public comment on the Council's website from September 2012. All responses will be considered and implemented in the final draft of the strategy.

LIKELY IMPACT

5. Based on the collected data and information, what will be the likely impact of the activity on individuals and groups with protected characteristics or other socio-economic disadvantage?

5 (a) Staff

Please refer to Table 2 below.

5 (b) Community

Please refer to Table 2 below.

Table 2: Likely impact on people with protected characteristics and other disadvantaged groups

Priorities	Likely impact on people with protected characteristics and other disadvantaged groups
Early help for vulnerable people to live independently for longer	The work coming from this priority will primarily target and benefit vulnerable adults who are more likely to be: women, older people, people with physical, sensory, hearing and/or learning disabilities, people with mental health needs, people with long-term illnesses, as well as other disadvantaged groups such as: victims of domestic violence and abuse (usually women), lone parents (usually women), people on low income, single people and carers. Historically LGBT communities, certain BME groups (Gypsy, Roma and Irish Travellers, non-English speakers, refugees and asylum seekers) and people from certain religious groups (e.g. Muslim) are more likely to face barriers when accessing services and/or information about services, hence, are more likely to be disadvantaged and vulnerable. Evidence also suggests that members of these groups are also more likely to be subject to discrimination, harassment and victimisation. The Health and Wellbeing Strategy recognises that vulnerable people have specific needs and wherever possible will consider and address these in its corresponding Action Plan.
Improved identification and support for people with dementia	The work coming from this priority will potentially benefit everyone as dementia can affect people of any age. However, evidence suggests that the majority of people with dementia in Havering are predominantly white, older (70+), and that there are considerably more female dementia cases than male. People with learning disabilities are also more likely to develop dementia compared to the general population, with a significantly increased risk for people with Down's syndrome and at an earlier age. There is also evidence suggesting that people from disadvantaged groups such as older people who live alone, carers and people who live on low incomes and in deprived areas are more likely to develop dementia. It is estimated that there are a small number of people in Havering with

Priorities	Likely impact on people with protected characteristics and other disadvantaged groups
	dementia who are from BME backgrounds which is representative of the demographic profile of Havering. However, with the increase of the BME communities in Havering, the potential impact on BME communities needs to be further explored. Although uncommon, dementia can also affect younger people, and their needs will differ from the older age group. It is estimated that there are currently 61 cases of early on-set dementia in Havering. There are currently gaps in data about potential relationships between dementia and sexual orientation or gender reassignment. However, the work coming from this priority will aim at engaging people from all protected characteristics, including religion, sexual orientation and transgender.
Early detection of cancer	The work coming from this priority will potentially benefit all as cancer can affect anyone, regardless of their age, gender, race, etc. However, evidence suggests that high numbers of Havering residents are diagnosed with and die from cancer each year due in part to the older population. These numbers will increase even further as the population continues to get older. Prostate, lung and bowel cancer are the most common cancers in men, whereas breast, bowel, and lung cancer are the most common cancers in women, with gay women being more likely to develop breast cancer than other women. Evidence also suggests that mortality rates of people from disadvantaged groups (people on low incomes, people living in deprived areas, etc) are much higher. There are currently gaps in data about potential relationships between cancer and: race, pregnancy, sexual orientation and gender reassignment.
Tackling obesity	The work coming from this priority will primarily target and benefit people that are (or are more likely to be) clinically obese. Certain individuals or sections of the community who are more likely to be obese include the children of obese parents or whose mother was obese during pregnancy, some people with physical and learning disabilities, older people. People with some specific learning difficulties are more susceptible to obesity. Certain physical disabilities may also increase the risk of obesity due to restrictions on physical activity. Certain ethnic groups including Black African and Black Caribbean women and South Asian populations are more at risk of the metabolic complications of excess body fat and so a lower obesity ‘cut off’ (BMI 28 kg/m2) is applicable. It is also worth noting that the risk of obesity and ethnicity may be confounded by deprivation. Rates of overweight and obesity in total are higher for men however the proportion of adults of each gender in the obese or morbidly obese category is the same. Evidence suggests that disadvantaged groups (people living on low income and in deprived areas) are less likely to live healthy lives. In addition, the built environment can have an impact on levels of obesity. For instance,

Priorities	Likely impact on people with protected characteristics and other disadvantaged groups
	people living in urban areas with poor access to green spaces and sports facilities are at higher risk of obesity. This priority will partly focus on children and young people who are overweight or obese as they are much more likely to become obese adults with the increased health risks this entails. They may also experience harm during childhood or teenage years. Pre-existing asthma may be harder to control. Musculo-skeletal problems may reduce their ability to take part in sports or active play. Obese children and young people are more likely to suffer from low self esteem and be bullied, and this can cause them to take time off school which can have negative impacts on their education. Rates of childhood and teenage obesity are higher in deprived areas than in more affluent neighbourhoods. As there is clear evidence that children whose mother was obese during pregnancy are more likely to become overweight, the strategy will ensure that women who are pregnant or trying for a baby are supported to achieve a healthy weight before or after the birth. No strong evidence suggests that there is a relationship between obesity and protected characteristics such as sexual orientation, transgender or religion.
Better integrated care for the 'frail elderly' population	The demographic trends show that Havering's aging population will continue to increase steadily which would increase demand on health and social care services. The work coming from this priority will primarily target and benefit older and frail people who are more likely to have multiple disabilities (physical, sensory, hearing, learning, as well as mental health needs) and long-term illnesses. Evidence also shows that older people are more likely to be living alone, in poor conditions and/or in deprived areas. The prevalence of long term conditions varies in the same way as does life expectancy with poorer health outcomes in more disadvantaged areas. Evidence shows that older women and widows (particularly from some religious groups such as Muslim) are more likely to be frail than older men, older women are also more likely to be frail older carers. There is also evidence that older LGBT people/couples who are isolated from their families due to their 'coming out' at a later stage of their lives are at a higher risk of becoming frail. These groups of frail older people are also more likely to become victims of domestic violence, homophobic and hate crimes and abuse. Social isolation among older people is another important public health issue that is associated with poor outcomes such as increased mortality and increased susceptibility to dementia. The Health and Wellbeing Strategy recognises the current service model is both ineffective and expensive in terms of the outcomes achieved for older and frail people, and that a more coordinated and customer-care approach between health and social care services is required. The strategy will address this issue in its corresponding Action Plan. In addition, a separate Havering's Integrated Care strategy will be developed to bring together all existing provision based around prevention

Priorities	Likely impact on people with protected characteristics and other disadvantaged groups
	and protecting those most at risk.
Better integrated care for vulnerable children	Our vision is for Havering to be a place where all children and young people are valued and safe; feel good about themselves and each other; get the best start to life and enjoy it to the full; have high aspirations and are given every opportunity to achieve their full potential; and are encouraged and supported to contribute positively to their community. We recognise that some children and young people living in Havering are more vulnerable than their peers and are more likely to be at high risk due to a number of factors (see Table 1 above). Therefore, we need to ensure that that such children and young people get adequate support. The work coming from this priority will focus on and benefit vulnerable and high risk children and young people. Some of the groups that we would be focusing on are: – Disabled children and young people, a high proportion of whom are with learning difficulties and have special education needs. – Children and young people who live in poverty. Evidence suggests that families that are most likely to be financially vulnerable are also more likely to have large numbers of children or be lone parents. – Children and young people who are victims of domestic violence and/or who are involved in child protection cases . – Children and young people from 'families with multiple complex needs, including lone-parent families, a significant proportion of whom require specialist or statutory services. Families with multiple complex needs are more likely to be from poorer socio-economic backgrounds. – Children in care who are more likely to be boys between 11 – 15 years. – Children and young people who affected by alcohol and/or substance misuse. – Children with mental health needs. – Young people (16-19 year olds) Not in Education, Employment or Training (NEET). These are more likely to be males than females. – Young people who generally lack confidence accessing sexual health advice, information and services. – Teenage girls (under 18 years) amongst whom rates of conception are higher than the England average. These are statistically more likely to be girls who are from deprived backgrounds. Limited data is available on the protected characteristics. Further work needs to be done to explore the relationships between each of the above factors of vulnerability/high risk and children's/young people's gender, disability, race, religion/belief and socio-economic factors accordingly. Another unexplored factor is vulnerability of LGBT young people (aged 16+). Wherever possible we will consider and address these gaps in the

Priorities	Likely impact on people with protected characteristics and other disadvantaged groups
	Health and Wellbeing Strategy Action Plans.
Reducing avoidable hospital admissions	Evidence suggests the Ambulatory Care Sensitive (ACS) admissions can be reduced by 20% and this priority will target and potentially benefit everyone whose hospital admission is viewed as 'avoidable'. Although this priority will target and potentially benefit everyone whose hospital admission is viewed as 'avoidable', older people, disabled people and/or people with long-term illnesses are most likely to be subject to hospital (re-)admission. An increasing proportion of older people live alone, many carers are themselves frail older people, and fewer older people can rely on the support of an extended family living nearby. Socially isolated individuals are at risk of depression, self neglect and functional decline which can predispose to a physical health crisis and unplanned hospital admission. The primary reasons for (re-)admission of older people are: Chronic obstructive pulmonary disease (COPD), heart failure and angina, Gastroenteritis and association dehydration, preventable conditions due to the lack of immunisation and other interventions. Children are also more likely to be (re-)admitted to hospital compared to other age groups due to acute conditions or other preventable conditions, where immunisation and other interventions can prevent illness. Both children and older people can benefit from the protection afforded by immunisation. People with different types of disabilities and long-term illnesses (e.g. dementia, cancer) are also very likely to be subject to hospital admission and re-admission due to absence of a more appropriate, community-based, model of care. No strong evidence is suggesting that there is a relationship between hospital (re-)admissions and protected characteristics such as sexual orientation, transgender or religion.
Improving the quality of health services to ensure that patient experience and long-term health outcomes are the best they can be	Targets set shed light on groups that are likely to be impacted by this priority. This priority concerns service improvement and therefore positive impact is expected for all groups, particularly those most in need. Significant positive impact would be expected for pregnancy and maternity service users as a result of targets around improving service quality and patient safety in maternity services at Queens Hospital. Insignificant data was available to deduce whether there was any relationship between the evidence driving the need for this specific service improvement and other protected characteristics such as ethnicity, sexual orientation, transgender or religion. Actions around improving primary medical care in nursing homes and quality of care in community residential settings will positively impact older people accessing these services. Unfortunately insufficient data is available

Priorities	Likely impact on people with protected characteristics and other disadvantaged groups
	to show the ethnic distribution of the populations using these services. Commissioning of Healthwatch, the organisation that will serve as the voice of local patients of health and social care services and the wider community, will facilitate robust performance management of our providers and safe guard all populations, including the protected characteristics. Healthwatch will work to be inclusive across all 9 equality strands and ensure historically underrepresented groups views are considered and fed back into the needs assessment process. A positive impact on hard to reach groups that have historically not been as widely consulted on patient experience will therefore be possible.

6. What is the likely impact on arrangements for safeguarding children and/or safeguarding vulnerable adults?

6 (a) Vulnerable children

Please refer to table 2 above.

6 (b) Vulnerable adults

Please refer to Table 2 above.

PREVENTING DISCRIMINATION

7. If any negative impact is identified, is there a way of eliminating or minimising it to reasonable level? If not, how can the negative impact be justified?

7 (a) Staff

Staff involved in the implementation of the Health and Wellbeing Strategy and corresponding Action Plans will be fully versed on the objectives and expected outcomes of the strategy. They will also be required to:

- be aware of and comply with our duties under the Equality Act 2010 and other relevant legislation
- be sensitive to the different needs and experiences of the communities
- treat people with dignity and respect at all times
- report any discriminatory or inappropriate behaviour and escalate any concerns to their manager or another senior officer, following corporate policies and processes.

For staff members who are local residents, please refer to 7(b).

7 (b) Community

The Health and Wellbeing Strategy is an overarching and strategic document the aim of which is to ensure the health of all residents improves and those with the worst health benefit the most. We do not anticipate any direct negative impact arising from this document but recognise that there are gaps that need to be addressed (refer to Table 2) and, wherever possible, will address these gaps in the corresponding Action Plans.

PROMOTING EQUALITY

8. How will the activity help the Council fulfil its legal duty to advance equality of opportunity in the way services are provided?

8 (a) Staff

Under the Equality Act 2010 the Council has a legal duty (Public Sector Equality Duty) to: eliminate unlawful discrimination, harassment and victimisation; advance equality of opportunity; and promote good community relationships.

When carrying out their functions and services, members of staff involved in the implementation of the Health and Wellbeing Strategy and Action Plans are required to pay due regard to the Public Sector Equality Duty and consider the impact on all protected equality groups. This approach will not only ensure compliance with legislation but will also improve health outcomes and quality of life of local residents, particularly those who are vulnerable and at high risk, and equality groups who are historically more likely to face barriers when accessing services and/or information about services.

For staff members who are local residents, please refer to 8(b).

8 (b) Community

The Health and Wellbeing Strategy focuses on two key themes:

- Keeping people healthy: early identification of people at risk and early intervention to maintain and improve wellbeing (Prevention)
- Supporting those most at risk

The first theme is about ensuring that people in Havering are as healthy and independent as possible for as long as possible. We will identify key points in the life course when timely intervention can help our residents on to a healthier track, thereby improving outcomes and reducing the likelihood that they will need more intensive support from the health and social care system at a later date.

The second theme is about better targeting and coordinating the support of health and social care services on those protected groups within the population

who would benefit most from that input either because they are at very high risk or already have the poorest health and wellbeing. High quality, timely, effective, integrated care will improve outcomes and patient experience and maximise value for money.

Cross-cutting themes:

A number of common themes run through all aspects of the strategy:

- Improving the quality of care people receive and their experience of that care
- Being outcome focused and ensuring that improvements in the process of care translate into quantifiable improvements in health and wellbeing outcomes for local residents
- Working to reduce the health inequalities gap between local communities.

The main objectives of the Health and Wellbeing Strategy are:

- Raising public awareness and understanding of health and risks to health
- Reducing health inequalities, and
- Improving health outcomes and quality of life.

Our plans will ensure that the health of all residents improves and those with the worst health benefit the most. We will proactively target, communicate with and engage vulnerable people and those at high risk, and equality groups who are historically more likely to face barriers when accessing services and/or information about services.

By addressing health and wellbeing inequalities and improving people's health outcomes and quality of life, the Health and Wellbeing Strategy will ensure that Council is proactively fulfilling its Public Sector Equality Duty.

SPECIFIC NEEDS

9. What actions will you be taking in order to maximise positive impact and minimise negative impact from the activity?

9 (a) Staff

Please refer to 7(a) and 7(b)

For staff members who are local residents, please refer to 9(b).

9 (b) Community

Our plans will ensure that the health of all residents, including employees living in Havering, improves and those with the worst health benefit the most. We will proactively target, communicate with and engage vulnerable people and those at high risk, and equality groups who are historically more likely to face barriers when accessing services and/or information about services.

MONITORING AND REVIEW

10. Once implemented, how often do you intend to monitor the actual impact of the activity?

10 (a) Staff

The Health and Wellbeing Board, made up of GPs, local councillors, and healthcare professionals, as well as other commissioners of health services and patient involvement networks, will oversee the delivery of the strategy. Within the strategy are our priorities for action and each has a jointly agreed plan for how we will deliver improved outcomes for local people. The strategy will be delivered by partners of the Health and Wellbeing Board (see Appendix A for membership details of the Board). The Board is committed to ensuring that health and social care services in Havering are effective and cost-effective. Plans will be continually reviewed against the best available evidence and amended, where necessary, to ensure that the best possible outcomes are achieved within the resources available.

The metrics we will use to monitor progress regarding each of our priorities have been selected from the national NHS, social care and public health outcomes frameworks where these contain an indicator pertinent to our local priorities. In some instances, where this is not the case or where the national indicator is still in development, a local indicator has been specified. For each indicator, thresholds for adequate, good and excellent progress have been suggested to help the Health and Wellbeing Board and local residents judge performance over time.

Performance against the key actions and indicators set out in this strategy will be monitored and published every six months by the Health and Wellbeing Board, and the strategy will be critically reviewed and revised at the end of the two-year period.

10 (b) Community

Results from the 2011 ‘Your Council, Your Say’ residents survey, carried out by the Council identified health services as the top priority for local people in making the borough a good place to live. It also found that 25.3% of residents class themselves as having a ‘long standing illness or disability’.

SIGN OFF AND PUBLICATION

11. When completed, the Equality Analysis needs to be signed off by the Head of Service. Once signed off, it should be forwarded to the Directorate Equality Analysis Web administrator to publish it on the council's website.

HEAD OF SERVICE **Name:**

Date: **Signature:**

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Havering
LONDON BOROUGH

CABINET

21 November 2012

Subject Heading:	Public Health Transition to Havering Council
Cabinet Member:	Councillor Steven Kelly, Lead Member for Individuals and Deputy Leader
CMT Lead:	Lorna Payne, Group Director, Adult & Health
Report Author and contact details:	David Jones and Julie Brown
Policy context:	The Health and Social Care Act 2012 requires the transfer of most public health functions to upper tier / unitary local authorities. This is part of a number of major changes mainly affecting the NHS but which will have a significant impact on local government.
Financial summary:	An indicative baseline spending estimate was announced in February 2012, based on the 2010/11 spend. On this basis, the allocation will be one of the lowest in London. A formal announcement on the 2013/14 ring fenced grant allocation is expected during December 2012. It is anticipated that the grant will fund the transferring responsibilities and there will not be a call on any corporate budgets.
Is this a Key Decision?	Yes
Is this a Strategic Decision?	Yes
When should this matter be reviewed?	12-18 months (Sept 2013 – March 2014)
Reviewing OSC:	Individuals and Health

The subject matter of this report deals with the following Council Objectives

Ensuring a clean, safe and green borough	X
Championing education and learning for all	[]
Providing economic, social and cultural activity in thriving towns and villages	[]
Valuing and enhancing the lives of our residents	X
Delivering high customer satisfaction and a stable council tax	X

SUMMARY

1.1. From April 2013, it is anticipated that most public health responsibilities will transfer from the Department of Health to local government. Local authorities will have a duty to promote the health of their population and will also take on key functions to ensure that robust plans are in place to protect local populations and provide public health advice to NHS commissioners.

1.2. There will be a ring-fenced public health grant to support local authorities in undertaking these functions. Although the 2010/11 baseline spend estimate has been announced, the final grant figure will not be known until December 2012.

1.3. This report informs Cabinet of the new responsibilities, including the employment of a specialist Director of Public Health, together with the opportunities and risks. It draws on the work of PHAST (Public Health Action Support Team) which was commissioned to review the options. The report seeks approval for the work being undertaken and the initial plans to take on public health functions.

RECOMMENDATIONS

2.1 Note the content of the report including the work that has been undertaken on the transfer of the public health responsibilities and the opportunities and risks this presents, particularly financial risks.

2.2 Agree that when the public health services functions transfer, the Council will, in principle, take over the existing managerial structure, personnel and contracts pending further work on future options.

2.3 Note that the Constitution will need to be amended to provide for the creation of a chief officer level post of the Director of Public Health, but to authorise the immediate commencement of a recruitment process for that prospective post.

2.4 Agree to establish a specialist Director of Public Health for Havering at chief officer level from 1st April 2013 and to commence the recruitment process immediately.

2.5 Note that further work will be undertaken to explore shared functions and joint working with neighbouring boroughs.

REPORT DETAIL

3 Background

3.1 It is anticipated that the Health and Social Care Act 2012 will transfer public health responsibilities from the Department of Health to local government from 1st April 2013. Local authorities will have a duty to improve the health of their population and will also take on key functions to ensure that robust plans are in place to protect local populations and provide public health advice to NHS commissioners.

3.2 These responsibilities were with local government until 1974 so the 'return home' has been broadly welcomed as an opportunity to combine services and expertise to tackle the determinants of ill health and challenges such as the increase in obesity. It is also designed to support the strategic responsibilities vested in the Health and Wellbeing Boards which are anticipated to become council committees from April 2013.

3.3 "Local authorities already make a difference to health and wellbeing through their emphasis on people, places and empowerment. They are well-placed to tackle the wider determinants of health and to promote better health and wellbeing across the life course, for example through early years services, education, culture, sports and leisure, spatial planning, transport, housing, economic development and regeneration." (Improvement and Development Agency).

3.4 The generally accepted definition of Public Health is:

'The science and art of promoting and protecting health and wellbeing, preventing ill health and prolonging life through the organised efforts of society' (Faculty of Public Health)"

3.5 There are three domains of Public Health:

- Health improvement (including people's lifestyles as well as inequalities in health and the wider social influences of health)
- Health protection (including infectious diseases, environmental hazards and emergency preparedness)
- Healthcare public health advice to support commissioning (relating to service planning, efficiency, audit and evaluation)

3.6 From April 2013, local authorities will have statutory responsibility for leading on local health improvement and prevention activity.

3.7 Public Health will be expected to continue to make a valuable contribution to the continuing development of the Joint Strategic Needs Assessment and delivery of the priorities of the local Joint Health and Wellbeing Strategy summarised below:

Themes	Priorities for Action
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
Better 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. Improve the quality of health services to ensure that patient experience and long-term health outcomes are the best they can be

3.8 It will be essential to adequately resource work on these priorities together with the statutory requirements detailed in paragraph 3.13 below; therefore other work may need to be reduced or discontinued if it is not mandatory or statutory. Currently Havering funds DAAT services which are not mandatory under statute.

3.9 The future arrangements are not as simple as Public Health transferring to local councils 'as is'. Some functions such as health protection and screening and immunisations, terminations and sterilisations will in future be the responsibility of other organisations such as the NHS Commissioning Board (NCB) and Public Health England (PHE). However, local authorities will take over access to services such as genitourinary medicine (GUM), sexual and reproductive health (SRH), Chlamydia, contraception, psychosexual counselling, and young people's services.

3.10 From April 2013, whilst responsibility for public health commissioning for adults transfers to Local Authorities, the responsibility for children's commissioning follows a different timetable. Responsibility for 5–19 year olds will transfer from the NHS to local authorities from April 2013 but responsibility for public health commissioning for 0–5s will not transfer to local authorities until 2015. Until this time, it will be the responsibility of the NCB.

Therefore, the responsibility for some care pathways will be split between different organisations.

3.11 The Director of Public Health will be expected to hold PHE and the NCB to account for some functions so will need a relationship with them together with the CCG via its Commissioning Support Service (CSS). The impact in terms of local posts is covered later in this report. Some of the relationships require further clarification and the new organisations are still developing their structures / recruiting staff who will interpret them.

3.12 There will be a requirement to provide public health advice to NHS commissioners – domain 3 (see paragraph 3.5) - for example on assessing needs, reviewing service provision, advice to assist on deciding priorities, planning capacity and demand management and monitoring and evaluation). Discussions are underway with Havering CCG on their needs and expectations. A draft Memorandum of Agreement (MoU) has been prepared and work is scheduled to finalise this by the end of 2012. The CCG is fully involved in the transition planning so is aware of the expected funding limitations.

3.13 In summary, as from April 2013, it is anticipated that regulations and guidance will make it **mandatory** for the London Borough of Havering to ensure:

- Appropriate access to sexual health services
- Steps are taken to protect the health of the population, in particular, giving the local authority a duty to ensure there are plans in place to protect the health of the population
- NHS commissioners receive the public health advice they need, such as health needs assessments and evaluating evidence to support the process of clinical prioritisation for populations, individuals and new drugs and technologies – this advice is referred to as the “Core Offer” from Public Health to a CCG
- The NHS Health Checks Programme for people 40–74 is delivered
- The National Child Measurement Programme is delivered.

4 The Director of Public Health’s role and responsibilities

4.1 Each local area is required to appoint an individual who will be responsible for the local authority's new public health functions. That individual will be an officer of the local authority, and known as the Director of Public Health. The role and responsibilities of that post have been set out in guidance which makes it clear that there can be local variation in a number of ways of appointing that individual, but that the appointment is a joint one by the local authority and the Secretary of State (in practice Public Health England), although their subsequent employment relationship is with the local authority exclusively.

4.2 The Department of Health expects that a Director of Public Health will be directly accountable to a local authority chief executive for the exercise of each local authority's public health responsibilities, as set out in the Act and associated Guidance, and that they will have direct access to elected members. The Director of Public Health will be the person elected members and other senior officers will consult on a broad range of health issues including health improvement of the population of the borough and concerns around access to local health services.

4.3 The Act requires Directors of Public Health to be members of the Health and Wellbeing Board, and have responsibility for all public health functions which are the responsibility of local government. Section 30 of the Act defines the responsibilities of Directors of Public Health, as, broadly, to implement all the health improvement and public health duties of local authorities conferred by the Act, including any conferred on local authorities by regulation under subordinate legislation.

4.4 An amendment to Section 2 of the Local Government and Housing Act 1989 will add the Director of Public Health to the list of statutory chief officers of Local Authorities giving them status equivalent to Directors of Children's Services and Directors of Adult Social Services.

4.5 The PHAST (Public Health Action Support Team) has reviewed emerging arrangements elsewhere and the options available to Havering. This has included different organisational options, the scope of the role, and whether there should be a dedicated or shared Director of Public Health. This has had to take account of developments and decisions taken in adjacent boroughs. The conclusions of the PHAST report on the employment of a Director of Public Health are supported.

4.6 The recommended option is to appoint a dedicated Director of Public Health for Havering at chief officer level, reporting direct to the Chief Executive. The funding and health challenges facing Havering require strong and effective leadership from a public health professional in order to make the best of the available resources and to improve outcomes for local residents.

4.7 Further work is to be undertaken on the scope of the role to maximise the benefits of the post and, in acknowledgement of the competitive environment highlighted in the PHAST report, to make it attractive to prospective applicants.

4.8 As the post is to be at chief officer level, Cabinet approval is required. The intention would be to commence the recruitment process as soon as approval has been given. This will be more complicated than with other posts (see 4.1 above) and requires following Faculty of Public Health guidelines and complying with the duty to act jointly with the Secretary of State. The plan would, therefore, be to have a Director of Public Health in post by 1st April 2013 to coincide with the anticipated transfer of the funding to the council.

4.9 It will also be necessary to amend the council's constitution to reflect the new statutory responsibilities.

5 Transition planning

5.1 The transition to the Council is being tightly project managed. The transition plan is regularly reviewed and a risk register and communications plans are in place to support the work.

5.2 There are monthly meetings of the Transition Steering Group, consisting of senior officers from the council and the NHS, including the CCG, which is chaired by the Group Director, Adults and Health.

5.3 There are five topic-specific sub groups: finance, workforce, ICT, commissioning and governance / legal, which report to the Transition Steering Group and progress the detailed work required to achieve transition.

5.4 There is a memorandum of understanding (MoU) between the council and the PCT, signed by Chief Executives of both organisations, which was sent to NHS London in April 2012. This was prepared in consultation with London Councils and local government members of the Public Health Transition Delivery Board. This provides a level of consistency and assists NHS London in providing reassurance back to the Department of Health of the robustness of the planning arrangements. The MoU also provides a method to ensure that the critical components necessary for successful shadow working are in place.

5.5 Regular assurance reports to NHS London and local government leaders are being submitted, ensuring that issues are raised and cooperation developed across the agencies and ultimately that timescales are met. There is close working with the other neighbouring boroughs; Barking and Dagenham, Redbridge and Waltham Forest. However clarity is still required on a number of issues and future funding continues to be uncertain until the announcement of the ring-fenced grant expected in December 2012.

6 Budget

6.1 The Public Health 2010/11 baseline spend estimate issued in February 2012 was £6.9m.

6.2 A further reconciliation exercise in July increased this to £8.2m (see financial implications section). The grant Havering will receive from April 2013 will be subject to 13/14 uplift as well as adjustments applied to calculate the final allocation. The baseline spend data is based on a range of public health responsibilities that may not all fall to Local Authorities, so funding would be adjusted in line with the responsibilities that transfer. Based on the initial £6.9m baseline, the bulk of the spend (£4.5m) is on services commissioned at Cluster level; the largest items are sexual health (approximately £2m, mostly with BHRUT, the Acute provider), drug services (very little spent on alcohol services) and children's and families services such as school nursing.

6.3 Based on the increased figure of £8.2m, given that an amount of £5.7m relates to existing commissioned services including sexual health which is mandatory, the actual amount expected is between £6.9m and £8.2m (a reasonable uplift to reflect 2013/14 prices should be applied).

6.4 Spending on drugs and alcohol misuse services is currently from a number of different sources. Work is being undertaken on the amount which will be part of the Public Health ring fenced budget from April 2013.

6.5 The London pattern is that around 35% of the overall total spend on public health in 2010/11 was on sexual health services and around 12% was on drug and alcohol misuse services. Clarity is also being sought on whether the Cluster level procurement staffing costs have been appropriately disaggregated.

6.6 Initially, the intention was to top slice 3% of the funding allocated to London for the London Health Improvement Board (LHIB). The identified priorities are: addressing the impact of alcohol, childhood obesity, prevention and early diagnosis of cancers and information transparency to drive improvement and choice. However, when the Leaders' Committee met on 16 October, members were not willing to give an in principle agreement at that stage to the funding of LHIB projects in 2013/14. They asked for this issue to be brought back to Leaders' Committee at a later date with fuller information about the planned outputs and outcomes for the projects that they were being asked to consider funding.

6.7 It proved a major challenge to identify public health expenditure within the NHS as these budgets have often been used to cover overspends. The indicative allocation was announced in February at £6.9m for 2012/13. Havering is the second lowest in London, which is problematic and disadvantages the area as it is the only one under the capitation amount (i.e. funding per head of population) in London.

6.8 Various representations have been made including providing evidence to London Councils which commissioned research on the baseline spending allocation in order to make the case for a more acceptable level of funding.

6.9 Figures have also been submitted as part of the lobbying for financial support to assist with transition costs. A sum of £84k has recently been allocated to Havering.

6.10 During the summer, the Department of Health published an update giving next steps on moving from the estimated baseline spending published in February 2012 to the actual allocations for 2013-14 which are expected to be published by the end of 2012. This announcement also included conditions on the ring fenced Public Health Grant together with proposed financial reporting requirements. There remain concerns about the likely amount and the final announcement may necessitate revising plans and structures.

7 Current services

7.1 As previously highlighted, the bulk of current spending is on services commissioned at Cluster level by the Primary Care Trust. Therefore, high priority has been given to gaining an understanding of each service and the options through a review and due diligence process that has been examining the specifications, performance monitoring information and outturn figures. There are various periods for notice of termination or variation but most will novate to the Council. Much of the expenditure is on mandatory services essential to meet performance targets.

7.2 A particular risk is that some services, including the most costly, sexual health, are statutory open access on demand services with some cross charging occurring. The main sexual health contract, mainly providing services to residents of Havering, Barking and Dagenham and Redbridge, is with BHRUT (value is £1.8m per year) and is a Service Level Agreement as part of a larger acute health contract.

7.3 The due diligence work is being shared amongst the Cluster councils to make best use of local expertise and avoid unnecessary duplication. The processes being followed comply with the council's usual contract procedure rules but it is being made clear the award is subject to formalisation of the transfer. Work so far provides reassurance that the vast majority of the contracts are delivering essential services and achieving value for money.

7.4 Rolling forward most contracts is seen as the most pragmatic response and this will give more time to assess performance and the potential for improvement as well as the possibility of any shared arrangements such as contact monitoring with neighbouring councils.

7.5 The authority for the Council to commission services for functions in respect of which it does not currently have statutory powers is found in its general powers of competency in section 2 Local Government Act 2000 and section 1 Localism Act 2011. It is considered reasonable and appropriate to exercise these powers because legislation is already in place to transfer the relevant functions to the local authority and it is anticipated that these will come into force from 1 April 2013.

8 Workforce

8.1 The summary shows that the full, direct staffing establishment costs amount to £1.3m. Whilst the current staffing structure consists of 27 established posts, only 16 staff, costing approximately £830k, are in post, and some of these staff are on secondment, acting-up or on maternity leave. It is expected that any vacant established posts as at 31 March 2013 would become established as Local Authority posts under Local Authority terms and conditions but not subject to any transfer arrangements. There are 2 substantive senior members of staff, the Associate Director of Health Care Improvement and the Associate Director of Health Improvement. Some of the staff in acting-up positions have been doing so for over 3 years and some have never formally occupied their substantive post.

8.2 As Public Health England will have the lead for screening, one of the established posts is expected to transfer to Public Health England rather than to the council.

8.3 The team are structured into three sections; Health and Wellbeing, Health Protection and Health Care Improvement.

8.4 In May 2012, it was announced that a Transfer Order (similar to TUPE) will apply protecting the terms and conditions of employed public health staff who are transferred. They will retain their NHS pensions; clarity is awaited on the pension arrangements for staff that change jobs following transfer. The NHS will be responsible for any redundancies until 31 March 2013 and possibly, in certain circumstance, during 2013/14.

8.5 The current acting up arrangements have been extended by the PCT until the end of March 2013. Staff will transfer on their substantive post. The council will review each previous acting up arrangement on a case-by-case basis to consider whether service continuity requires the acting up to resume for a specified period following transfer.

9 Organisational proposals

9.1 There are number of uncertainties, including those related to funding which all Unitary / Upper tier local authorities face. Therefore similar to many other councils, it is recommended that the local public health team should be transferred as it is; this is being termed as a “lift and shift / drop” approach.

9.2 The consultancy commissioned from the Public Health Action Support Team (PHAST) has been exploring options including the opportunity to work with the other Cluster boroughs in providing some services. For example, it will be essential that there is sufficient capacity and technical skills to undertake the procurement functions carried out at Cluster level; it may not be practical or cost effective to locate them in each council. Further work will be undertaken to explore shared functions and joint working with neighbouring boroughs.

.

REASONS AND OPTIONS

Reasons for the decision:

It is anticipated that the Health and Social Care Act 2012 will transfer public health responsibilities from the Department of Health (DH) to local government from April 2013. This legislation necessitates the work summarised in the report and requires various decisions relating to implementation.

The 'lift and shift/drop' proposal is considered the most prudent because there continue to be a number of uncertainties, especially with regard to future funding and as proposals for transfer have to be finalised by 1st December 2012, more time is required to consider longer term proposals once final budgets are known later in December 2012.

The reasons for recommending a dedicated Director of Public Health for Havering are covered in section 4 of this report.

Other options considered:

Changes to the existing structure would be difficult as the Public Health Grant announcement is still awaited and decisions have to be confirmed over which staff will transfer to Public Health England rather than to the local authority.

The consultancy from the Public Health Action Support Team (PHAST) has explored different models including the opportunity to work with the other Cluster boroughs in providing some services.

There will be a statutory requirement to have a Director of Public Health. The PHAST report considered the different options (see section 4); the supported option is being recommended.

IMPLICATIONS AND RISKS

Financial implications and risks:

Public Health baseline spending estimates were issued in February 2012, as a result of a PCT data collection exercise carried out in September 2011. These figures gave the first indication of how Public Health resources could be distributed across Local Authorities. Havering's 2012/13 allocation was **£6.912m**. This equates to **£29** spend per head, the joint second lowest spend in London, compared to the average spend per head of £60.

Havering responded to this announcement by raising various concerns:

- The allocation is based on 10/11 spend. Therefore variations to budget and areas of budgetary pressure are not reflected.
- There were one off savings made to contribute toward the acute debt in 10/11, these totalled some £567k and are not considered.
- Some £500k funding for health checks is not reflected as Havering did not receive this in 10/11 as GP's were not ready at that point to implement.
- Demographics are not reflected.
- The baseline does not include monies to address key local priorities and unmet need.
- The treatment of overheads is not transparent.

London Councils have also lobbied Department of Health with various concerns, as have other Local Authorities.

In July a reconciliation of planned spend exercise was completed, whereby PCTs submitted a further return to the Department of Health to look to reflect any agreed adjustments. Havering's reconciliation is as below:

Adjustments	**£'000**
2010/11 Baseline	6,912
Adjustment for Sexual Health	292
DAAT funding change	185
DIP Funding from DH	106
Non-recurrent underspend	23
PCT underspend on DAAT	118
Mainstream PCT Substance Misuse spend	605
Total Public Health Expenditure	**8,241**

As can be seen, this acknowledges some amendments to the baseline. The adjustment for sexual health, DAAT funding change and the DIP funding adjustment were mandatory fields within the reconciliation, with the remaining adjustments being specific to the Local Authority. The purpose of this reconciliation was to pick up changes to the grant baseline and to consider any information that was not known at the time of the original data capture.

As the bulk of these adjustments are related to commissioned services, it is thought that these should be reflected within the grant allocation. The actual baseline figure to be applied is therefore expected to be somewhere between £6.912m and £8.241m.

Department of Health issued an update on Public Health funding on 14 June. This reported that the Advisory Committee on Resource Allocation (ACRA) had made some interim recommendations. ACRA is an independent committee of GPs, public health experts, NHS managers and academics who make recommendations on the relative distribution of resources to the Secretary of State for Health.

ACRA recommends that:

- A formula based on a measure of population health best meets the resource allocation criteria
- Standardised mortality ratio (SMR) is proposed as an indicator. SMR is a measure of how many more or fewer deaths there are in an area compared with the national average.
- An adjustment for unavoidable differences in the costs of delivering services due to location alone should be considered (an area cost adjustment).
- The ONS projected resident population for 2012 be used as the population base.

There will be a 'health premium' to set incentives for local delivery and performance related payments, which will apply only after mandatory services have been satisfactorily delivered.

It is not yet known what gradient would be applied to move towards a formula based allocation system as recommended by ACRA. Department of Health have committed that no Local Authority will be worse off in real terms in 2013/14, so formula changes to initial allocations could take some time to be applied, so as not to change allocations by untenable amounts in any one year (it is expected some form of cap would need to be applied).

London Councils anticipate these proposed changes would mean London as a whole would lose significant amounts of funding. A briefing issued on 18 June indicated that Havering's funding would increase under the ACRA proposed method, to £9.160m. However no assumptions on the ACRA method can be made at this stage.

The funding will be passed to Local Authorities from April 2013 in the form of a ring fenced grant. The exact allocation is expected to be announced by the end of December 2012. As demonstrated at 6.3, the majority of the budget is spent on commissioning arrangements; some £1.3m is related to the staffing establishment. The majority of the commissioned spend is related to sexual health and drug misuse services. These are demand led services that carry related financial risks. As contracts move to the Council the arrangements will need to be brought in line with our procurement framework.

As referred to in 6.6, there is a possible "top slice" to London for the London Health Improvement Board.

Local Authorities will be responsible for supporting Clinical Commissioning Groups. In terms of resources, it is not yet known what exactly this will mean in budgetary terms.

Department of Health has announced transition funding to support Local Authorities with costs incurred as a result of the transfer. Havering was awarded £84k as a one off grant, which will contribute towards one-off transition costs but is not expected to fully meet them. The transition costs include expenditure on consultancy, agency staff and ICT expenditure. Department of Health have indicated types of transition expenditure they expect the grant to fund.

Internally the transition process is being managed as detailed within this report by an overarching Transition Steering Group and sub groups that sit beneath this. There is a finance group which links in with the other groups, most notably commissioning given the size of the commissioning spend and potential contractual issues that could arise. There is also a finance group comprising the finance leads from the four ONEL boroughs (Redbridge, Waltham Forest, Barking & Dagenham and Havering) who meet monthly, then collectively meet with the ONEL non-acute Director of Finance.

The finance team will be responsible for ensuring public health is reflected within the Council's general ledger by April 2013. Accountancy wise, how Public Health is to be presented within the Councils' accounts is to be advised. It is anticipated that any post transfer accounting or debt management issues that relate to prior years will fall to the Cluster PCT to resolve.

The Council currently funds 50% of a Joint Director of Public Health post. From April 2013 the Director of Public Health will be funded via the specific grant, assuming there is sufficient capacity within the allocation. The Council may still need to bear some of the cost if the grant can not fully meet this. As recruitment will take place prior to 2013/14, related costs will need to be funded by the Council during the current financial year.

Financial Risks

The main risk is that the Council will not receive sufficient funding to carry out Public Health functions, which could result in budgetary pressure that is not accounted for. We do not presently have enough information to properly evaluate and quantify this potential risk. Work is ongoing to quantify and plan for this potential issue by obtaining as much pre-transfer information on potential commitments as possible. This has proved somewhat problematical due to the present integrated nature of some of the Health contracts.

The scope and implications of the "Health Premium" performance related payments, which will be targeted towards areas with the worst health outcomes and most need, are not yet known. Currently, it is proposed that any incentive scheme would apply from 2015/16.There have been concerns expressed over the precise working of such a scheme, which would apply to non mandatory services.

There are commissioning risks as the commissioning function could be quite different once responsibilities fall to local Authorities. The only resources transferring to the authority to carry out the commissioning function are those within the staffing resources. The Council would have the option to ask the Commission Support Service to continue to manage Public Health contracts, for which a fee would be payable.

Some economies of scale and the ability to manage large contracts across multiple boroughs could be lost once contracts transfer to local authorities. Demand led pressures in one area can presently be offset by underspends in another area, under the new arrangements we do not anticipate this will be the case. For some services, such as sexual health and smoking cessation where currently one contract covers many boroughs, there may be the option to consider "risk share"

arrangements to seek to manage demand across geographical boundaries and early discussions have taken place on this.

Overheads have been reflected within Havering's return as 27% pay and 10% non-pay expenditure. This is a notional figure. There is therefore the risk that funding will not adequately capture the true cost of necessary overheads.

Further analysis of financial statements and contractual information is on-going, and will continue as further information becomes available.

The impact of the staffing transfer on the pension fund is not yet quantified.

As Health staff are undergoing a restructure process, expertise may not be available for Local Authorities to draw upon post April 2013. This could result in resource implications, as well as possible operational issues.

Legal implications and risks:

Section 12 Health and Social Care Act 2012 will amend section 2 National Health Service Act 2006 and will impose a new duty under Section 2B as follows:

"Each local authority must take such steps as it considers appropriate for improving the health of the people in its area."

Whilst no date for implementation of this section has yet been formally set, it is widely anticipated that this will be 1 April 2013.

The steps that may be taken under this duty include:

(a) providing information and advice;

(b) providing services or facilities designed to promote healthy living

(whether by helping individuals to address behaviour that is detrimental to health or in any other way);

(c) providing services or facilities for the prevention, diagnosis or treatment of illness;

(d) providing financial incentives to encourage individuals to adopt healthier lifestyles;

(e) providing assistance (including financial assistance) to help individuals to minimise any risks to health arising from their accommodation or environment;

(f) providing or participating in the provision of training for persons working or seeking to work in the field of health improvement;

(g) making available the services of any person or any facilities.

Detailed legal advice will need to be provided in relation to the legal agreements required for the transfer of staff, novation of contracts as appropriate and transfer of functions in due course.

The Local Authority has to make firm plans for the transfer of functions in order to ensure that the risk of failing to comply with the new statutory duties is minimised.

Human Resources implications and risks:

The Council will assume full employment responsibility for any Public Health NELC PCT employees who transfer in on 1 April 2013. The Transfer Order that will govern the transfer of these employees to the Council has been agreed with NHS Trade Unions and confers 'TUPE-like' features to the process that will be undertaken, though the TUPE Regulations do not apply in this transfer. Under this Transfer Order, the Council will be expected to protect the NHS terms and conditions of the transferring Public Health employees and to provide them with access to the NHS Pension Scheme post transfer.

As the proposal is the transfer of these employees in 'as is' in terms of their substantive roles and responsibilities, the Council will be required to enter into a consultation process with the transferring employees and their Trade Unions when it has confirmed its position on a new structure for the Public Health Services as it will sit within the Council's establishment. This will be done in line with the relevant organisational change policy applicable to the NHS staff transferring in on 1 April 2013. This approach poses significant risks for the Council with regard to retention of key staff who have essential skills and experience to maintain service continuity in this transition period.

Specialist Public Health professionals may constitute a 'hard to recruit' group in the NHS labour market and this is likely to impact on the progress and outcome of the recruitment exercise around the Director of Public Health post that will be added to the Council's establishment in order to lead the new service. The Council will need to develop and apply a robust resourcing strategy to enable a successful appointment to this senior post to take place and to ensure that the Public Health service is able to respond to demands both in the lead up to the transfer date and beyond. This will require the collective input from Council Members, the Council's senior management and HR staff, NELC PCT and relevant regional/Public Health England (PHE) advisers.

Equalities implications and risks:

The Public Health Transition Steering Group will ensure that all transition projects will be subject to robust Equality Analysis. Any related new and existing services, contracts, strategies, projects and functions coming from the transition and for which the Council is to be responsible will be equality impact assessed. This includes (non-exhaustive list), for example the Joint Health and Wellbeing Strategy, the Joint Strategic Needs Assessments and any significant changes in health services provision, particularly changes due to reduced funding. The robust Equality Analysis approach will ensure a seamless transition and that any identified differential equality impact (both negative and positive) on both employees and service users will be carefully considered and appropriately mitigated (respectively, negative impact will be eliminated/minimised and positive impact will be optimised. Further, any actual or potential impact of reduced funding will also be Impact Assessed. Currently a draft analysis is being prepared at PCT Cluster level; this will form the basis of the local work.

BACKGROUND PAPERS

- *The Public Health Outcomes Framework for England, 2013-2016; DH, January 2012*
- *Public Health Advice to NHS Commissioners; DH, December 2011*
- *Transition accountability statement between Local Government & the Department of Health; LGA, 31st May 2012*
- *Update on Public Health Funding; London Councils, 18th June 2012*
- *Havering Public Health Transition Plan; 6th July 2012*
- *The Role of the Director of Public Health in local government; DH, October 2012*
- *Havering Public Health Function Options; PHAST; October 2012*

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