Public Document Pack

# HEALTH & WELLBEING BOARD

## AGENDA

**Wednesday, 11th February, 2015**
**1.30 - 3.30 pm**

**Committee Room 2 - Town Hall**

**Members**

| | |
|---|---|
| Councillor Steven Kelly (Chair) | |
| Councillor Meg Davis | |
| Councillor Wendy Brice-Thompson | |
| Anne-Marie Dean | Havering Healthwatch |
| Dr Atul Aggerwal | NELFT |
| Conor Burke | NELFT |
| Dr Gurdev Saini | NELFT |
| John Atherton | NHS London |
| Alan Steward | NHS England |

**Officers**

| | |
|---|---|
| Cheryl Coppell | Chief Executive |
| Andrew Blake-Herbert | Group Director |
| Joy Hollister | Group Director Children's, Adults & Housing |
| Mark Ansell | Director of Public Health |

1. CHAIRMAN'S ANNOUNCEMENTS

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

2. APOLOGIES FOR ABSENCE

(If any) – receive

3. DISCLOSURE OF PECUNIARY INTERESTS

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

*Members may still disclose any pecuniary interest in any item at any time*

*prior to the consideration of the matter.*

4. MINUTES (Pages 1 - 8)

   To approve as a correct record the minutes of the Committee held on 14th January 2015 and to authorise the Chairman to sign them.

5. MATTERS ARISING

   To consider the Board's Action Log

6. WINTER COMMUNICATION PLANNING

   Report by Alan Steward and Joy Hollister

7. COMPLEX CARE UPDATE

   Report by Conor Burke

8. CHILDREN'S SERVICES SELF-ASSESSMENT

   Report by Joy Hollister

9. DOMESTIC VIOLENCE STRATEGY (VAWG) (Pages 9 - 38)

   Report by Diane Egan

10. PRIMARY CARE STRATEGIC COMMISSIONING FRAMEWORK

    Report by Sarah See & Gemma Gilbert

11. HEALTH AND WELLBEING STRATEGY FOR APPROVAL (Pages 39 - 90)

    Please note decisions will be made with no further consultation of the strategy so please ensure you have read it thoroughly.

12. ORCHARD VILLAGE GP

    Report by NHS England

13. HOSPITAL PERFORMANCE IN A&E, AND BOROUGH RESPONSES

    Report by Joy Hollister

14. REPORTS FOR INFORMATION

Better Care Fund (Quarterly Update from Joy Hollister)
Falls Programme

15. ANY OTHER BUSINESS

16. DATE OF NEXT MEETING

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**MINUTES OF A MEETING OF THE**
**HEALTH & WELLBEING BOARD**
**Committee Room 2 - Town Hall**
**14 January 2015**

## Present

Cllr. Steven Kelly (Chairman)
Dr. Atul Aggarwal, Chair, Havering CCG
Cllr. Wendy Brice-Thompson, Cabinet Member for Health
Cheryl Coppell, Chief Executive, LBH
Anne-Marie Dean, Chair, Healthwatch
Joy Hollister, Group Director for Children, Adults and Housing, LBH
Alan Steward, Chief Operating Officer, Havering CCG

## In Attendance

Phillipa Brent-Isherwood, Head of Business and Performance, LBH
Mary Pattinson, Head of Children's Services, LBH
Claire Still, Communications Officer, LBH
Vicky Parish, Committee Officer, LBH (Minutes)

### 73 CHAIRMAN'S ANNOUNCEMENTS

The Chairman advised those present of the arrangements in case of fire or other event that may require the evacuation of the meeting room.

The chairman advised some amendments to the agenda, that items 6 and 8 were to be merged and presented by Diane Egan, and item 12 was removed due to Kathy Bundred's absence.

### 74 APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Meg Davis, Andrew Blake-Herbert and John Atherton.

### 75 DISCLOSURE OF PECUNIARY INTERESTS

No disclosures of pecuniary interest were made.

### 76 MINUTES

The minutes of the meeting held on 10th December 2014 were agreed as a correct record and signed by the Chairman.

## 77 MATTERS ARISING

From the previous minutes (10 December 2014), the matters arising were:

- **BHRUT**: The key members of the board were to visit to try to help provide feedback and develop further outcomes

- **Children's Health**- The board considered that the board did not provide as much support as they would like. Within the revised strategy some weaker items had been removed and some more critical items were supplemented in order to provide a better service. **The chairman confirmed that the strategy was authorised**.

- **Dementia Strategy**- Progress was slightly slower than expected, but moving along.

- **DOH underfunding**- To clarify the 'underfunding' was not in reference to a lack of funding, it referred to monies coming from a variety of sources but not reaching the services expected quickly. It was felt that the only way to cure A&E problems would be to provide more staff. The Chairman recommended following Dr Aggarwal's suggestion that A&E staff do not have to be A&E trained- and that specialist practitioners could be used for their specialist area within the context of A&E.

- The **Better Care Act** was accepted. The feedback provided was highly complimentary to Havering and the services provided within.

- **GP Opening Hours**- The service had been extended to seven days per week. This was crucial as it was one of the key solutions to reducing the impact on A&E facilities. More information needed to be communicated regarding the Primary Care options including the extended GP surgery hours and walk-in centres in order to make the residents of the borough more aware of their options and critically that their GP would always be the first point of support and help. Initial communication efforts of the board were agreed to focus attention on those most likely to go to GP surgeries. This was to be raised as an agenda item at the following meeting. The Director of Planning and Governance from Queens Hospital would be in attendance from the following meeting.

- A meeting had taken place with the pharmacies in December. The savings that could be made with full follow through over the following months were potentially enormous.

- The second anniversary of the establishment of the CCG had brought confirmation that the contracts were under control. Maturation of the partnership gave control of the services to the board. Reviews of any item of health care were able to be conducted easily.

## 78 SERIOUS YOUTH VIOLENCE STRATEGY

Crime within Havering was at the national average, in line with the Outer London boroughs. The main volume of crime within the borough was serious acquisitive crime such as burglary, car theft etc.

In 2011, 33 boroughs were identified as having crime issues. Havering was not amongst the number. In 2012, an additional number of boroughs were identified after further review. Havering was still not included.

There was a potential change due to the general movement of residents from inner to outer London Boroughs dispersing issues including crime. More residents would have resulted in more crime; more homes would have resulted in more residential burglary. Havering was on a property increase with rising property prices and rental values, with the number of unemployed residents above the national average, and increased numbers of complex families.

Within Havering there were links with 16 gangs across other boroughs. Operation Trident within the Police had profiled a matrix of gangs. Most of the work carried out was preventative not reflexive; including ensuring preventative action for at-risk individuals and their siblings and friends from becoming involved in crime.

Developments noted had been positive. An area that required improvement locally was the leadership.

It was identified that further work with schools was required in order to increase awareness to children and parents.

There was one small gang in the borough that met the definition of a ‘gang’. The National Crime Agency was mapping drugs lines out of London and there were possible connections.

The board agreed that it would sign off the updated drugs strategy at the following meeting.

It was agreed that the approach was to give focussed attention to groups rather than a global approach, as long term middle-aged drug users were considered less pressing than young people devolving into crime from drug use. It was also agreed that the strategy needed to incorporate repetition of location, timing and type of person aimed at, in order to establish the ideas in the general populace.

**Responding in Partnership**

Good relationships had been fostered with schools, and awareness-raising had highlighted the high risk schools. Many were identified as gang-naïve.

The work in MASH and sharing with individuals had been positive. There had been anonymised sharing of A&E data used. More detailed information needed to be gathered. An agreement was made to share this information within the organisations to aid the growth of the services and joined up working.

Information from Sixth Form Colleges was difficult to extract as they did not have named contacts as schools did, and did not seem to gather as much information overall. Information sharing with prisons was an issue that was identified. Perpetrators of gang activity often ended up becoming victims, and this cycle was identified as an issue.

**Next steps**
The new Community Safety Policy would inform years two and three of the plan. Cross-borough working informed the drugs strategy.

Havering had not reviewed community service leavers; however the rehabilitation service MTC Novo was required to monitor those on community orders of less than 12 months from 1st April 2015.

A budget report to cabinet had been issued which consolidated the consultation. The three main areas of focus were:

- The level of concern youth services and how an increase in the numbers of troubled young people would affect it
- The growing number of Looked After Children
- Peer reviews were doing well. Support and mentoring service proposals were considered to be brought back. Excellent work was done on a very small budget.

The Chairman considered that the lack of advertising of what the board and Health Services did was an impediment. The Chairman extended thanks to Diane Egan and the team for all of their hard work and the outcomes that had been achieved.

79 **HEALTH IN YOUNG OFFENDERS INSTITUTIONS**

There were no immediate problems within Young Offenders institutions. The Youth Offending Service attended meetings to discuss any potential issues that arose

Very few young people had custodial sentences imposed within the borough; only two had been within the last two years. Within Havering the rate of custodial sentencing was so low that little could be done to reduce the frequency or to consider this as a concern.

The reason for such low number of young offenders not receiving custodial sentencing was that issues were addressed at earlier stages. Custodial sentencing was a last resort.

The team were happy to give a fuller report to a future meeting if it were required.

## 80 HEALTH AND WELLBEING STRATEGY PROGRESS UPDATE

The Health & Wellbeing Strategy had expired in 2014. It was a statutory duty to keep it maintained. The priorities within the strategy were broadly accurate, however some items had progressed, and some aspects had been reviewed.

Further discussions regarding the future of the Health & Wellbeing Strategy were arranged. The first new priority to be included was Mental Health. Whilst Mental Health was not a big concern overall, dementia was a priority and had to be covered within the strategy. Those with dementia or learning disabilities were to be addressed within the Healthwatch report.

As a change from the preceding strategy, specific items intended to support vulnerable people, children and young people and their families would be included (?).
The Health & Wellbeing strategy had to include Wellbeing, by ward and by long term condition across the borough.

The new strategy could be ratified at the next meeting. All attendees were requested to read the details of the strategy in the meantime

The transfer of Overview and Scrutiny to one board required a joint action plan to be delivered by NELFT and the CCG.

There was a national focus on mental health. In particular the local Health & Wellbeing Boards were focussing on dementia and learning difficulties. The approach to long term conditions supported the Prime Minister's Challenge Fund. Fragility and vulnerability were bringing people together regarding integrated care. There was a long-term potential change to staff and patients

Within the area of health improvement activity, the board suggested a close analysis of early years health issues should be included in the strategy.

## 81 PRIMARY CARE CO-COMMISSIONING

Following the last elections, the new government had re-planned the NHS communal budget split, including allocating 6% to clinical commissioning.
Primary medical, pharmacy, and other areas received a combined 30%, and 10% went to Local Government for initiatives such as sexual health.

Over the course of the past two years, government had realised that this split is not working and decided to move the budgets back to the local community groups. The Clinical Commissioning Groups were required to reapply, and demonstrate their capability in order to be confirmed to

continue to provide the services. The arrangements would not include community pharmacy, dentistry or optometry at this stage. They would be required to commission a whole pathway

The CCG were proactive within the new requirements as they did not provide standalone services. Instead they provided care as a pathway.

They took advantage of the Prime Ministers Challenge Fund within this, as they received £5million - the largest allocation nationally due to the well organised and thorough planning.

Improving technology and information systems within Access to Primary Care, GPs, Complex Care etc were progressing to plan. Three hubs were open. "Health 1000" had opened (via NHS England). If it was successful, from 1st April more formal governance was required, and an account was required back to the board.

This was unlikely to result in more money for the health care services, but was likely to drive important modernisation.

82 **REPORTS FOR INFORMATION**

In April, the Carers Rights Act was due to become law. A briefing on 5th February had been arranged for all stakeholders.

National publicity would be outlining what was happening in the future, but boroughs were not expected to deliver on the promises for a few years. If this was not clear locally, Havering wanted to be clear about it in line with the national publicity.

NHS England and Public Health were working together on a national campaign. Some communications aspects had been considered, including the production of leaflets, radio production and newspaper advertising, and information being sent to 7,000 homes in the borough. National branding would be on the information, including the new 'Care and Support' logo.

A comprehensive training programme was designed between JAD and Barking & Dagenham. Regulations and guidance looked at cross-mapping in December 2014.

Before submission could be completed, the chairman requested revised targets to be submitted to the board for approval.
A Cabinet report was due for submission the following week. Havering would be the host for the funding.

A leaflet-drop was recommended in of the national set up, including providing detailed information to the call centre to ensure no one received a lack of information once the national information was sent out.

It was felt that the national advertising campaign would have affected the customer satisfaction levels if the Board had not pre-emptively addressed the expectations of the community in order to prevent issues arising.

83 **ANY OTHER BUSINESS**

A joint meeting with chairmen of other HWB boards had been arranged.

Potential agenda items raised at this meeting for it included:

- Children's services
- Reinforcement of JAD
- Primary Care

Joy Hollister & Alan Steward would present to the board. Conor Burke would provide report information as updates.

Start of another good year. Thank you to everyone for coming.

84 **DATE OF NEXT MEETING**

The next meeting was arranged for Wednesday 11th February, Havering Town Hall, RM1 3BD.

**Chairman**

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# Havering Violence against Women & Girls Strategy

V0.3

# Document Control

Document details

| | |
|---|---|
| **Name** | *Havering Violence against Women & Girls Strategy* |
| **Version number** | *V0.3* |
| **Status** | *Draft* |
| **Author** | *Iain Agar, Community Safety Partnership Analyst* |
| **Lead officer** | *Diane Egan, Community Safety Team Leader* |
| **Approved by** | *Havering Community Safety Partnership* |
| **Review date** | *2017-18* |

| | |
|---|---|
| **Supersedes** | *N/A* |
| **Target audience** | *All staff and partner agencies* |
| **Related to** | *See **Appendix 3** for full list of related documentation* |

Version history

| Version | Status | Date | Dissemination/Change |
|---|---|---|---|
| **V0.1** | *Initial Draft* | *Sep-14* | *Internal* |
| **V0.2** | *Second Draft* | *Nov-14* | *Internal* |
| **V0.3** | *Third Draft* | *Jan-15* | *Internal – action plan added* |

Approval history

| Version | Status | Date | Approved by |
|---|---|---|---|
| *V0.3* | *Initial* | *Sep-14* | |

Equality Impact Assessment record

| Date | Completed by | Review date |
|---|---|---|
| 31/01/2014 | Iain Agar – HCSP EIA | 31/03/2015 |

# Contents

# Foreword

Thank you for reading the Violence against Women and Girls Strategy for the London Borough of Havering.

This Violence against Women and Girls Strategy has been produced by the Community Safety Team on behalf of the Havering Community Safety Partnership. It sets out the plans and actions that the partnership aspires to as a result of this year's Violence against Women and Girls problem profile and related Joint Strategic Needs Assessment chapters for domestic violence and sexual violence. These documents are an analysis of the risk, prevalence and harm of violence against women and girls in Havering.

The partnerships local intelligence shows that this is a significant issue for Havering, with growing volumes of victims coming to our attention. This strategy is the result of the focused analysis which sets out actions and recommendations for various partnership groups in respect of prevention, provision and protection.

The Community Safety Partnership welcomes the support from the London Crime Reduction Board and the Mayor's Office for Policing and Crime (MOPAC), which sees tackling violence against women and girls as a key priority within the Police and Crime Plan launched in 2013.

We look forward to working in conjunction with the Mayor's Office for Policing and Crime to ensure this strategy is achieved.

**Cheryl Coppell**
**Chief Executive**
**London Borough of Havering**
**Chair of the HCSP**

**Jason Gwillim**
**Borough Commander**
**Havering Police**
**Vice Chair of the HCSP**

# Executive summary

In the London Police and Crime plan, launched in March 2013, the Mayor set out his mission and priorities for policing and crime reduction in London over the next four years. Tackling violence against women and girls (VAWG) is a key priority within that plan. The Havering Community Safety Partnership (HCSP) strategic assessment recommended that VAWG be one of three key strategic priorities locally.

VAWG accounts for the greatest socio-economic cost to community safety partnership services in Havering. Domestic violence also accounts for a third of all physical violence reported to agencies, even despite high levels of underreporting. Calls to police alone occur at a rate of 1 every 87 minutes in Havering. The last Crime Survey for England and Wales found that 31% of all women *(and 18% of all men)* had reported experiencing domestic abuse which means there are potentially 30,000 survivors of domestic abuse currently residing in Havering.

According to the 2011 British Crime Survey Havering responses, one in five residents worried about being attacked in the home, although the proportion is higher when considering females alone. This concern was consistent across all geographical areas of the borough and socio-economic groups.

Currently Havering delivers a number of initiatives and services to address VAWG using four strands – Prevention, Provision, Protection and Partnership. The strategic vision is to prevent and eliminate all forms of violence against women and girls through the development of policies and procedures to address violence, develop programmes of preventative work, provide high quality service provision which responds to local needs, and ensure that robust enforcement action is taken against perpetrators.

Havering has aligned it aims with those set out in the Mayoral Violence against Women and Girls Strategy for London, and has set the following aims:

- Prevention and early identification of violence against women and girls
- Provide intervention services to support all those experiencing violence and abuse
- Protect and take enforcement action against perpetrators

The Violence against Women and Girls Strategy is to be delivered over a four-year period. The action plan will be refreshed annually. This strategy will be implemented and monitored by the VAWG Strategic Group which reports directly to the Havering Community Safety Partnership. The strategic group will also have oversight of the Multi-Agency Risk Assessment Conference.

# Introduction

In the London Police and Crime plan, launched in March 2013, the Mayor set out his mission and priorities for policing and crime reduction in London over the next four years. Tackling violence against women and girls (VAWG) is a key priority within that plan. The Havering Community Safety Partnership (HCSP) strategic assessment recommended that VAWG be one of three key strategic priorities locally.

VAWG can include different types of abuse, including psychological, physical, sexual and emotional; and can take a number of forms, including domestic violence, female genital mutilation, forced marriage and honour based violence (please refer to ***Appendix 3*** – *What do we mean by violence against women and girls?*).

VAWG accounts for the greatest socio-economic cost to community safety partnership services in Havering (*estimated at £24million per annum across all services, not including human and emotional costs to victims*[1]). Domestic violence accounts for a third of all physical violence reported to agencies, even despite high levels of underreporting. Calls to police alone occur at a rate of 1 every 87 minutes in Havering. The last Crime Survey for England and Wales found that 31% of all women *(and 18% of all men)* had reported experiencing domestic abuse which means there are potentially 30,000 survivors of domestic abuse currently residing in Havering.

According to the 2011 British Crime Survey Havering responses, one in five residents worried about being attacked in the home, although the proportion is higher when considering females alone. This concern was consistent across all geographical areas of the borough and socio-economic groups.

VAWG is a public health and safeguarding issue. More than 50% of female mental health service users have experienced domestic violence[2] whilst more than 35% of abused women experience depression and anxiety disorders[3]. VAWG also commonly results in self-harm and attempted suicide. Locally the impact on young people is also significant with almost 50% of child protection plans currently in place affecting children in households suffering domestic abuse[4]. Whilst physical injuries from violence are the most obvious impact, other health related issues can include gynaecological disorders, cardiovascular disease, adverse pregnancy outcomes and sexually transmitted infections[5].

[1] Havering Community Safety Partnership Strategic Assessment 2013
[2] Department of Health 2003
[3] Astbury, 1999; O'Keane, 2000; Humphreys, 2003; Humphreys and Thiara, 2003; Vidgeon, 2003
[4] Havering Violence Against Women & Girls Strategic Problem Profile 2013
[5] Adverse Health Conditions and Health Risk Behaviors Associated with Intimate Partner Violence, US Department of Health 2008

Violence can have direct consequences for health, and it can increase the risk of future ill health. Additionally, VAWG is a commonly cited precursor and contributory factor to offending by prisoners in the United Kingdom[6]. Almost 30% of men serving custodial sentences reported emotional, physical or sexual abuse and 41% observed domestic violence in the home, in their early years[7].

Currently Havering delivers a number of initiatives and services to address VAWG using four strands – Prevention, Provision, Protection and Partnership.

- Campaigns and communications messages are used to prevent violence by challenging attitudes and behaviours and providing information on where to seek support sooner rather than later.
- Provision of support for those experiencing violence is delivered through a number of agencies including Victim Support London, Havering Women's Aid, East London Rape Crisis Centre, Relate North East London and Women's Trust East London.
- Action taken to reduce the risk to women includes provision refuge accommodation, independent domestic violence advocacy and the multi-agency risk assessment conference.
- Key stakeholders are involved in a local strategic group to monitor the work being done as well as identify and address problems or issues.

The Violence against Women and Girls Strategic Problem Profile 2013 (*see* ***Appendix 2***), identifies key areas for development in Havering to continue to address VAWG and these are reflected in a comprehensive action plan.

Through this strategy we will work within the VAWG Strategic Group to ensure we deliver an effective co-ordinated multi-agency response to tackle violence against women and girls, which will be evidence based and measurable in its success.

## Vision

The strategic vision is to prevent and eliminate all forms of violence against women and girls through the development of policies and procedures to address violence, develop programmes of preventative work, provide high quality service provision which responds to local needs, and ensure that robust enforcement action is taken against perpetrators.

[6] Prisoners' childhood and family backgrounds, results from the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners, Ministry of Justice 2013
[7] Ibid

## Aims, objectives and outcome

Havering has aligned it aims with those set out in the Mayoral Violence against Women and Girls Strategy for London, and has set the following aims:

- Prevention and early identification of violence against women and girls
- Provide intervention services to support all those experiencing violence and abuse
- Protect and take enforcement action against perpetrators

Performance measures will be agreed annually by the Havering Community Safety Partnership.

## Timescales

The Violence against Women and Girls Strategy is to be delivered over a three-year period. The action plan will be refreshed annually.

## Related documents

Please refer to **Appendix 5** for key documents and strategies related to this document.

## Consultation

Development of this strategy has involved consultation with all member agencies of the Havering Community Safety Partnership. Representatives from all of these areas are present within the VAWG strategic group.

# Authorisation and communication

The strategy will be authorised by the Havering Community Safety Partnership.

The stakeholders of this strategy are as follows:

- Havering Council
- Havering Local Safeguarding Children's Board
- Havering Safeguarding Adults Board
- Havering Women's Aid
- London Fire Brigade
- Havering Police
- Havering CCG
- National Probation Service
- Havering Community Rehabilitation Company
- Public Health
- Registered Social Landlords
- Voluntary Sector
- Victim Support

# Implementation and monitoring

This strategy will be implemented and monitored by the VAWG Strategic Group which reports directly to the Havering Community Safety Partnership. The strategic group will also have oversight of the Multi-Agency Risk Assessment Conference.

## Action plan and performance measures

An Action Plan and performance measures are included at the end of this strategy document. The Action Plan will be delivered through the Violence Against Women & Girls Strategic Group which meets quarterly.

# Evaluation and review

The VAWG strategic group will produce quarterly reports to the HCSP against progress and performance. The action plan will be refreshed annually. The strategy will be reviewed in January 2018.

# Further information

Please contact Community Safety on 01708 432927

# Appendix 1: Equality Impact Assessment

HCSP Equality Impact Assessment.p

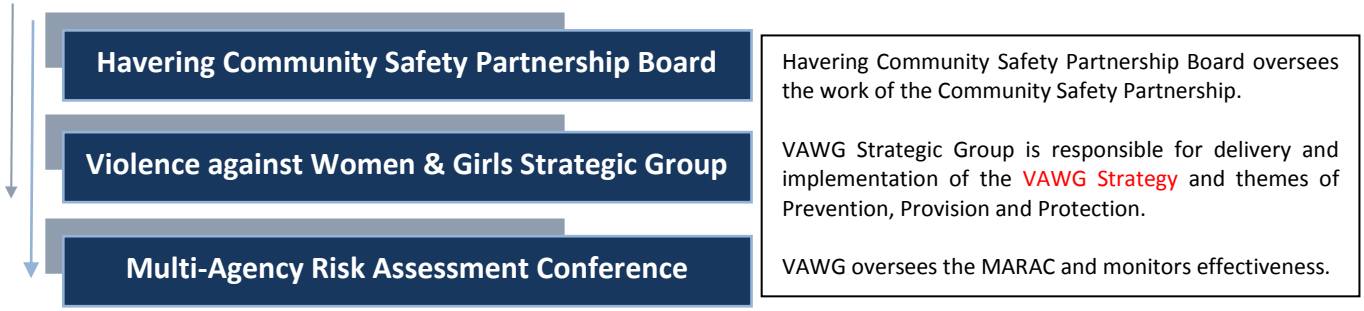
# Appendix 2: Violence against Women and Girls Strategic Problem Profile

VAWG Strategic Problem Profile.pdf

# Appendix 3: What do we mean by violence against women and girls?

VAWG Definitions.pdf

# Appendix 4: Governance



# Appendix 5: Related documents and strategies

**Locally:**

- Havering Joint Strategic Needs Assessment
- London Borough of Havering Corporate Plan 2014-15
- London Borough of Havering Community Safety Partnership Plan 2014-17
- London Borough of Havering Health & Wellbeing Strategy
- London Borough of Havering Service Plans
    - Learning & Achievement
    - Children's Services
    - Homes & Housing

**Regionally:**

- London Child Protection Procedures 2013
- London Crime Reduction Board Anti-Gangs Strategy
- Mayoral Strategy on Violence Against Women & Girls 2013-17
- Metropolitan Police Policy on Domestic Violence
- Metropolitan Police Child Sexual Exploitation Policy

**Nationally:**

- Borders, Citizenship and Immigration Act 2009
- Child Abduction and Custody Act 1985
- Children Act 2004
- Children & Young Persons Act 2008
- Children, Schools, Families Act 2010
- Civil Partnership Act 2004
- Crime and Disorder Act 1998
- Domestic Violence, Crime and Victims Act 2004
- Education Act 2011
- Equality Act 2010
- Every Child Matters 203
- Family Law Act 1996
- Female Genital Mutilation Act 2003
- Forced Marriage (civil protection) Act 2007
- Health & Social Care Act 2012
- Housing Act 2004
- Modern Slavery Bill 2014
- National Action Plan to Tackle Child Abuse Linked to Faith or Belief 2012
- Policing & Crime Act 2009
- Protection from Harassment Act 1997
- Protection of Freedoms Act 2012
- Safeguarding Vulnerable Groups Act 2006
- Serious Crime Act 2007
- Serious Organised Crime and Police Act 2005
- Sexual Offences Act 2003

**Globally:**

- Human Rights Act 1998
- United Nations Convention on the Rights of the Child
- United Nations Trafficking Protocol

# Action plan

| Corporate goal and strategic outcome | Strategy Objective | Project/Action | Outcomes | Resources | Timescale | Lead Agency / Individual | Impact on other Services and Organisation |
|---|---|---|---|---|---|---|---|
| 1 – 1.2 | Prevention and early identification | Co-ordination of the Violence Against Women & Girls Strategic Group.<br><br>1) To implement the VAWG Strategy Action Plan.<br><br>2) To monitor progress and hold the group to account. | Improved multi-agency response to violence against women and girls. | Staff | Ongoing | Community Safety Partnership | Increased awareness of the prevalence of VAWG in Havering. |
| 1 – 1.2<br>3 – 3.1<br>5 – 5.1, | | Increase awareness of VAWG among agencies and residents through communications.<br><br>1) Develop and deliver a VAWG communications plan.<br><br>2) Publication of VAWG resource guide and information cards.<br><br>3) Develop a web-page one stop shop.<br><br>4) Ensure work includes targeting of under-represented groups (BME, LGBT, and Disability). | Improved awareness amongst professionals and public of all forms of VAWG (inc. stalking, HBV, FGM, trafficking, CSE and prostitution).<br><br>Improved confidence amongst victims who are encouraged to report abuse to services.<br><br>Improved access to information about services available.<br><br>Increased reporting to and uptake of VAWG services within the borough.<br><br>Support delivery and implementation using annual conference, regular social media messages, newsletter and workshops. | Staff | April 2015 onwards | Community Safety Partnership<br><br>Corporate Communications | Increased awareness of the prevalence of VAWG in Havering and improved referral pathways for victims will lead to increase in victims accessing multi-agency services (statutory and non-statutory). |
| 1 – 1.2<br>2 – 2.2<br>4 – 4.1, | | Safeguard the needs of young people and vulnerable adults. | Early identification to ensure that victims and their children are supported and | LSCB | April 2015 onwards | LSCB Training Officer | Early identification will lead to improved service provision and |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 4.2, 4.4, 4.5<br>5 – 5.5 | | 1) Delivery of VAWG training through the Local Safeguarding Children's Board.<br><br>2) Delivery of VAWG training through the Safeguarding Adults Board. | safeguarded appropriately.<br><br>Increase in staff confidence when responding to disclosures of VAWG. | | | | better outcomes for victims.<br><br>Increased and confident use of safeguarding procedures to protect adults and children. |
| 1 – 1.2<br>2 – 2.2<br>4 – 4.1, 4.2, 4.4, 4.5<br>5 – 5.5 | | Ensure effective interventions at the earliest opportunity.<br><br>1) Provision of education workshops in primary and secondary schools to raise awareness of VAWG. | Young people are better informed about VAWG.<br><br>Young people are aware of services available for their families.<br><br>Negative attitudes to women and girls are challenged. | Staff | April 2015 onwards | Education<br><br>Mary Pattinson | Increased uptake of services by 16-18 year olds.<br><br>Increased numbers of victims identified. |
| 1 – 1.2<br>4 – 4.1, 4.4<br>5 – 5.5 | | Integrate VAWG into all relevant service areas and ensure effective inter-agency co-ordination.<br><br>1) Training of Domestic Abuse Champions based in local authority departments, statutory partnership agencies and local private/voluntary sector services. | Professionals have improved access to advice via a single point of contact within their agency.<br><br>Improved multi-agency response.<br><br>Victims have fewer contacts before accessing meaningful support. | Staff<br><br>MOPAC funding | March 2015 | Community Safety Partnership<br><br>Jasbir Kaur | Early identification will lead to improved service provision and better outcomes for victims.<br><br>Increased and confident use of referral procedures. |
| 1 – 1.2<br>4 – 4.1, 4.4<br>5 – 5.5 | Provision of intervention services | Continue to improve the efficiency and effectiveness of the MARAC.<br><br>1) Develop an extended Information Sharing Protocol for the MARAC so that police are able to share domestic abuse crime reports and DASH risk assessments (HMIC Recommendation for MPS).<br><br>2) Ensure referral routes into the MARAC are understood and promoted across all agencies (include in communications plan). | High risk and repeat victims of domestic violence identified will receive a multi-agency response that involves safeguarding, whole family interventions and addressing perpetrator behaviour.<br><br>Reduction in repeat victimisation.<br><br>Reduced risk of domestic homicide.<br><br>Increased confidence in reporting crime. | Staff | Ongoing | Community Safety Partnership, LCSB<br><br>MPS MARAC Lead (TBC)<br><br>Jasbir Kaur, Alice Peatling | Increased number of referrals and increased uptake of services. |

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| Page 22 | | 3) Develop locally agreed threshold for automatic referral to MARAC of identifiable repeat victims to improve their access to services.<br><br>4) Development of an induction pack to agencies coming to the MARAC. This should consider inclusion of details on information sharing, referral procedures, local thresholds and risk assessments, action and safety planning, monitoring of cases, pre-meeting research.<br><br>5) Offer of MARAC training to front line services.<br><br>6) Monitor core agency attendance.<br><br>7) Improved referral to the Domestic Violence Disclosure Scheme.<br><br>8) Audit of MARAC cases. | Better outcomes for victims and their children.<br><br>Action point 7 - Victims and potential victims have a formal mechanism for making enquiries about a current partner to reduce harm and increase victim safety. | | | | |
| 1 – 1.2<br>3 – 3.1<br>4 – 4.1, 4.2, 4.4<br>5 – 5.5 | | Domestic Violence caseworker and Independent Domestic Violence Advocate to identify and support VAWG cases from early identification to the MARAC process.<br><br>1) All agencies aware of DV caseworker and IDVA to sign post victims<br><br>2) Expand IDVA support into key areas (i.e. considering within maternity and police CSU) pending allocation of resources outlined in the MOPAC Pan-London manifesto | Early intervention and support to reduce risk from escalating. | MOPAC £20,000 DV caseworker within in Early Help service<br><br>MOPAC £20,000 for Victim Support caseworker | March 2015 | Victim Support<br><br>Jan Scott | |

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| | | to maintaining domestic violence services across London. | | | | | |
| 1 – 1.2<br>4 – 4.2,<br>4.4, 4.5<br>5 – 5.5 | | Phoenix Counselling to provide information on young people (boys, girls, pregnant clients) who are experiencing domestic abuse. | Early intervention and support to reduce risk from escalating. | | From April 2015 | Phoenix Counselling<br><br>Lesley Kelsey | Increased uptake of services and referrals. |
| 1 – 1.2<br>4 – 4.4<br>5 – 5.5 | | Deliver an effective Criminal Justice System service for victims.<br><br>1) Support victims through the criminal justice process.<br><br>2) Monitor CPS conviction rates at Magistrate and Crown Courts.<br><br>3) Promote and encourage use of Victim Impact Statements in court to influence sentencing.<br><br>4) Work with CPS to ensure court is suitably resourced.<br><br>4) Consider potential for court observers panel to scrutinise trials locally | Independent Domestic Violence Advocate to work with victims to achieve the best possible outcomes at court.<br><br>Monitor court attrition rates to determine reasons for collapsed trials.<br><br>Make victims feel that they are part of the criminal justice process and not disempowered. | MOPAC £18,000 | March 2015 | Victim Support<br><br>Jan Scott | Reduction in repeat victims of abuse. |
| 1 – 1.2<br>4 – 4.4<br>5 – 5.5 | | Commissioning of evidence led services for adults and children fleeing VAWG.<br><br>1) Review of JSNA to ensure service provision is adequate to need.<br><br>2) Commissioning of advocacy services, support groups and rape crisis interventions. | Victims and children have access to a wider variety of support services.<br><br>Services will reduce inequalities associated with VAWG. | Staff<br><br>MOPAC funding<br><br>£14,798 for advocacy<br>£6,540 support groups<br>£20,000 rape crisis funding top sliced by MOPAC | March 2016 | Community Safety Partnership<br><br>Diane Egan | Increased uptake of services, and improved outcomes for service users. |
| 1 – 1.2<br>3 – 3.3<br>4 – 4.2,<br>4.4 | | Offer safe and secure housing options for families affected by VAWG.<br><br>1) Review of refuge provision. | Reduction in further risk of harm and repeat victimisation.<br><br>Reduction in families | Staff | Ongoing | Community Safety Partnership<br><br>Teresa Munro, | Improved outcomes for service users.<br><br>Demand greater than available resource. |

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| | | 2) Review of housing options for victims.<br><br>3) Review provision of community alarms and target hardened properties.<br><br>4) Consider potential options to house perpetrators to prevent them coming back to victim address. | presenting as homeless.<br><br>Access to emergency refuge accommodation and floating support.<br><br>Housing providers are able to support victims by evicting perpetrators.<br><br>Neighbourhood Officers better able to identify tenants at-risk of homelessness resulting from VAWG.<br><br>Vulnerable properties are secured. | | | Michelle Brown | |
| 1 – 1.2<br>2 – 2.2<br>4 – 4.1, 4.2, 4.4, 5 – 5.5 | | Identification of early child protection referrals where VAWG is a factor by Local Safeguarding Children's Board.<br><br>1) Ensuring identification of VAWG is clearly recorded at triage and assessment.<br><br>2) Ensure staff are aware of services available and referral procedures. | Children coming to notice of Children Social Care, Early Help Services and Troubled Families are safeguarded from further harm, and vulnerable victims protected. | Staff | Ongoing | LCSB, Troubled Families<br><br>Carol Carruthers, Sarah Thomas | Increased caseload identified and referred to services for appropriate intervention.<br><br>Improved outcomes for service users. |
| 1 – 1.2<br>2 – 2.5<br>4 – 4.1, 4.4 | | Develop work to address the health, social and economic consequences of VAWG.<br><br>1) Production of VAWG training package for emergency department doctors and nurses.<br><br>2) Develop a pathway of management of domestic abuse identified in emergency departments.<br><br>3) Sexual health services develop a referral pathway for domestic abuse and female | Early identification of VAWG by A&E health care professionals and supervisors.<br><br>Victims who access sexual health-based services are able to access immediate and appropriate VAWG support. | Staff | From April 2015 | NHS England<br><br>Stephen Hynes, Martin Gardner | Increased caseload identified and referred to services for appropriate intervention.<br><br>Improved outcomes for service users. |

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| | | genital mutilation. | | | | | |
| 1 – 1.2<br>4 – 4.1,<br>4.4 | | Empowering female offenders experiencing VAWG.<br><br>1) Delivery of Women's Empowerment Programme | Reduction in inequality and social exclusion of marginalised women. | MOPAC £1,050 | March 2015 | Community Safety Partnership<br><br>Chris Stannett | |
| 1 – 1.2<br>2 – 2.5<br>4 – 4.1,<br>4.4<br>5 – 5.1 | | Facilitate access to specialist support for women and girls involved in prostitution.<br><br>1) Develop referral pathways for those involved in prostitution with substance misuse needs.<br><br>2) Develop referral pathways to access specialist health care provision relating to sexual health.<br><br>3) Awareness campaign on sexual exploitation to be included in communications plan.<br><br>4) Develop training programme on sexual exploitation for practitioners. | Reduce social inequality faced by marginalised women by removing barriers. | London Council's Grant Funded | March 2015 | LSCB, NHS England, Community Safety Partnership<br><br>Lyndsey Buckles, Martin Gardner, Diane Egan | |
| 1 – 1.2<br>2 – 2.2<br>4 – 4.1,<br>4.2, 4.4<br>5 – 5.1 | | Develop specialist support for women and girls affected by gangs and sexual exploitation linked to criminal networks.<br><br>1) Young people's services to receive training on identification of those at-risk of gang activity and how to safeguard/sign post.<br><br>2) Mentoring and outreach programme for those involved or at-risk of gang involvement.<br><br>3) Integration of VAWG strategic group and services with the Multi-Agency Sexual Exploitation (MASE) group to | Improved identification of victims and referrals to appropriate services / interventions. | MOPAC | March 2015 | Community Safety Partnership<br><br>Chris Stannett | Increased caseload identified and referred to services for appropriate intervention.<br><br>Improved outcomes for service users. |

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| | | manage relevant cases. | | | | | |
| 1 – 1.2 | | Improve women's safety on public transport.<br><br>1) Explore potential to utilise central resources and existing campaigns (Project Guardian) through partnership working. | Increase confidence in using trains and buses without fear of harm or abuse. | Staff | From April 2015 | Metropolitan Police, Transport for London, British Transport Police<br><br>David Partridge | |
| 1 – 1.2 | Protect victims and take enforcement against perpetrators | National Probation Service and Community Rehabilitation Company to manage perpetrators effectively.<br><br>1) Ensure that strict licence and order conditions are in place to protect victims.<br><br>2) Identify suitable programmes for offenders based on their needs (i.e. Domestic Abuse perpetrator programmes, alcohol and drug treatment referrals).<br><br>3) Monitor the completion of programmes and compliance with licence. | Improved management of offenders.<br><br>Increased victim safety and reduction in further harm and repeat victimisation.<br><br>Reduction in repeat perpetrators.<br><br>Challenging negative views held by perpetrators about victims (i.e. male attitudes to women). | Staff | Ongoing | National Probation Service and Community Rehabilitation Company<br><br>Lucy Satchell-Day | Reduction in repeat victims accessing services and reduction in repeat perpetrators requiring intervention and enforcement. |
| 1 – 1.2 | | Havering Police take steps to ensure that recommendations made by the HMIC for the Metropolitan Police to improve their response to domestic abuse, are implemented at a local level where relevant.<br><br>1) Training of response officers to increase awareness of less obvious forms of domestic abuse.<br><br>2) Training of response officers to understand the impact of taking positive action for a victim. | Increased victim safety and reduction in further harm and repeat victimisation.<br><br>Improved access to services for victims.<br><br>Improved understanding of domestic abuse and local interventions and services among police response teams.<br><br>Improved contingency so that the level of response is maintained. | Staff | Ongoing | Community Safety Partnership<br><br>Jason Gwillim | Improved outcomes for service users, reduction in repeat victimisation and repeat perpetrators. |

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| | | 3) Integrate Neighbourhood Policing Teams into safeguarding of victims and managing perpetrators in their wards (information briefings on addresses / perpetrators).<br><br>4) Continue to utilise the MARAC to help victims support locally available support services. | | | | | |
| 1 – 1.2 | | Provision of front line services to be available where possible, and appropriately trained (understanding of VAWG) and equipped (i.e. body cameras), during peak periods – 70% of VAWG takes place between 12pm-Midnight with Fri, Sat and Sun being the highest days. | Increased victim safety and reduction in further harm and repeat victimisation.<br><br>Improved access to services for victims. | Staff | Ongoing | Community Safety Partnership | Improved outcomes for service users, reduction in repeat victimisation and repeat perpetrators. |
| 1 – 1.2<br>3 – 3.1<br>4 – 4.4<br>5 – 5.1 | | Engage General Practitioners in the co-ordinated response to VAWG<br>1) Improve practices to understand and identify VAWG.<br><br>2) Improve confidence in consulting with patients.<br><br>3) Improve primary care response to patients experiencing VAWG. | Increased victim safety and reduction in further harm and repeat victimisation. | CCG | From April 2015 | CCG? | Increased caseload identified and referred to services for appropriate intervention.<br><br>Improved outcomes for service users. |
| 1 – 1.2<br>5 – 5.5 | | Utilise the Integrated Offender Management Panel to target / manage domestic abuse offenders who are engaged in other types of crime.<br><br>1) Ensure the work of IOM is linked in with the wider work of the MPS CSU and MARAC. | Offenders can be dealt with through alternative means whereby victims do not have the confidence to substantiate allegations. | Staff | From April 2015 | Community Safety Partnership<br><br>Chris Stannett | Reduction in repeat victims accessing services. |
| 1 – 1.2 | | Improve the ability to achieve victimless prosecutions.<br><br>1) Protocol agreed and adhered | Offenders can be dealt with through alternative means whereby victims do not have the confidence to | Staff | From April 2015 | Havering Magistrates Court, Havering Crown Court, | |

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| | | to by CPS and MPS.<br><br>2) Increased deployment of body worn cameras, and prioritisation for VAWG incidents where possible. | substantiate allegations. | | | Metropolitan Police<br><br>Jason Gwillim | |
| 1 – 1.2 | | Provide access alcohol and drug intervention treatment programmes for victims and perpetrators. | Reduce the harm and risk of VAWG which is heightened as a result of substance misuse. | | | | |
| 1 – 1.2<br>5 – 5.5 | Intelligence and Information | Ensure that all work to address VAWG is informed by information and intelligence.<br><br>1) Strategic Problem Profiles of VAWG to be completed and refreshed annually.<br><br>2) Joint Strategic Needs Assessment chapter for VAWG to be created (replacing the expired DV chapter from 2011).<br><br>3) Develop the intelligence picture on the nature, extent and impact of gang violence on girls in Havering. | Help partners and decision makers understand levels of local prevalence, vulnerable and at-risk groups, gaps in service provision and information.<br><br>Help senior decision makers allocate resources and inform policy.<br><br>Improve local understanding of VAWG. | Staff | Ongoing | Community Safety Partnership, Public Health<br><br>Iain Agar, Ade Abitoye | Assist in allocation of scarce resources more efficiently and provide an evidence base to support funding opportunities and commissioning of services. |
| 1 – 1.2<br>5 – 5.5 | | Implement the Information Sharing to Tackle Violence (ISTV) legislation within Havering.<br><br>1) A&E Departments to provide depersonalised database on violence related injuries to the Community Safety Partnership with additional information<br>• Time and date of incident<br>• Specific locations of violent incident<br>• Primary means of assault (i.e. weapon, knife, blunt force) | Help partners and decision makers understand levels of local prevalence, vulnerable and at-risk groups, gaps in service provision and information.<br><br>Improve local understanding of VAWG. | Staff | From April 2015 | Public Health<br><br>Ade Abitoye | Assist in allocation of scarce resources more efficiently and provide an evidence base to support funding opportunities and commissioning of services. |

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| 1 – 1.2<br>5 – 5.5 | | Obtain local data from the Crown Prosecution Service on outcomes.<br><br>1) Work with Havering Magistrates Court to improve information sharing, tracking of cases and results. | Understand what reasons lead to unsuccessful prosecutions and how they can be avoided (poor practice, gaps in service provision) | Staff | Ongoing | CPS | Assist in allocation of scarce resources more efficiently and provide an evidence base to support funding opportunities and commissioning of services. |
| 1 – 1.2<br>5 – 5.5 | | Improve locally available information regarding less understood areas of VAWG.<br><br>1) Services to improve recording of incidents identified as concerning Forced Marriage, Honour Based Violence, Female Genital Mutilation, Faith Based Abuse, Trafficking and Sexual Exploitation). | Improve local understanding of VAWG and identify any gaps in service provision. | Staff | Ongoing | Community Safety Partnership | Assist in allocation of scarce resources more efficiently and provide an evidence base to support funding opportunities and commissioning of services. |
| 1 – 1.2<br>5 – 5.1 5.5 | | Map out all service provision to address VAWG within the London Borough of Havering.<br><br>1) Include details of all services situated locally.<br><br>2) Include details of all services available to local residents but not situated locally. | Improve access to information for victims, residents and practitioners seeking services, and increasing understanding and awareness of what is available. | Staff | From April 2015 | Community Safety Partnership | |



| Ref. | Description | 2013/14 Outturn (End-of-year) | 2014/15 Target | Link to Corporate goal and Strategic outcome |
|---|---|---|---|---|
| *Identify the measures that will be used to assess progress and success; often these will take the form of performance indicators, but could also be significant outputs or benefits to be realised, etc.* | | | | |
| Met Police | Repeat victimisation rate | | | |
| Met Police | % of Identified repeat victims referred to MARAC | | | |
| MARAC | Number of cases referred to MARAC | | | |

For info – these above are just examples of what we could include. Could just input the ones relevant to MOPAC projects (DV Repeats) and Corporate Plan (repeat cases at MARAC) – want to decide as part of VAWG what these should be?

Havering
LONDON BOROUGH

# HEALTH & WELLBEING BOARD

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| **Subject Heading:** | Domestic Violence |
| **Board Lead:** | Joy Hollister (Group Director – Children, Adults and Housing) London Borough of Havering |
| **Report Author and contact details:** | Diane Egan (Team Leader - Community Safety) London Borough of Havering<br>diane.egan@havering.gov.uk<br>01708 432927 |

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

- ☒ Priority 1: Early help for vulnerable people
- ☐ Priority 2: Improved identification and support for people with dementia
- ☐ Priority 3: Earlier detection of cancer
- ☐ Priority 4: Tackling obesity
- ☐ Priority 5: Better integrated care for the 'frail elderly' population
- ☒ Priority 6: Better integrated care for vulnerable children
- ☐ Priority 7: Reducing avoidable hospital admissions
- ☐ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

## SUMMARY

This report presents the first Violence against Women and Girls Strategy for Havering for consultation.

## RECOMMENDATIONS

1. That the Board members review the content of the strategy and provide comments to Community Safety via diane.egan@havering.gov.uk by 28th of February 2015

## REPORT DETAIL

## 1. Background

Domestic Violence ( Home Office 2013) is defined as

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."*

*This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

In 2011/12, 7.3% women (1.2 million) and 5% men (800,000) in the UK reported having experienced domestic abuse (ONS 2013). An analysis of 10 separate domestic violence prevalence studies found consistent findings that 1 in 4 women experience domestic violence over their lifetimes and between 6-10% of women suffer domestic violence in a given year (Council of Europe, 2002). On average, two women a week are killed by a violent partner or ex-partner. This constitutes nearly 40% of all female homicide victims. (Povey, (ed.), 2005; Home Office, 1999; Department of Health, 2005.)

Abused women are more likely to suffer from depression, anxiety, eating problems and sexual dysfunction. Violence may also affect their reproductive health (WHO 2000). It is estimated that 30% of domestic violence starts in pregnancy and domestic violence has been identified as a prime cause of miscarriage or still-birth and of maternal deaths during childbirth (Lewis and Drife, 2001). Many women use alcohol or drugs as a response to and a way of dealing with abuse. Women experiencing domestic violence are up to fifteen times more likely to misuse alcohol and nine times more likely to misuse other drugs than women generally.

Children who live with domestic violence are at increased risk of behavioural problems and emotional trauma, and mental health difficulties in adult life. (Hester et al 2007). The term 'toxic trio' is used to describe the comorbidity of domestic abuse, mental ill-health and substance misuse. National level biennial reports reviewing the learning from serious case reviews (SCRs) note the prevalence of domestic violence, misuse of alcohol and/or drugs, and parental mental health problems in the lives of the families at the centre of SCRs. The last biannual report, drawn

from 139 overview reports, finds 'evidence that about two-thirds of cases featured domestic violence, and mental ill health of one or both parents was identified in nearly 60% of the families. A wealth of research has been conducted in this field and more background information is available in Appendix 1

## 2. Domestic Abuse in Havering

Domestic violence (DV) is rising in the borough and we know that it has a significant impact on the health and wellbeing of victims and their children.

The total number of reported and recorded Violence against Women & Girls incidents and offences has increased by 861 offences in the current financial year to date (to December 2014), representing a rise of 20.4%. This has been driven by a notable rise in the volume of both Domestic Offences and Domestic Incidents.

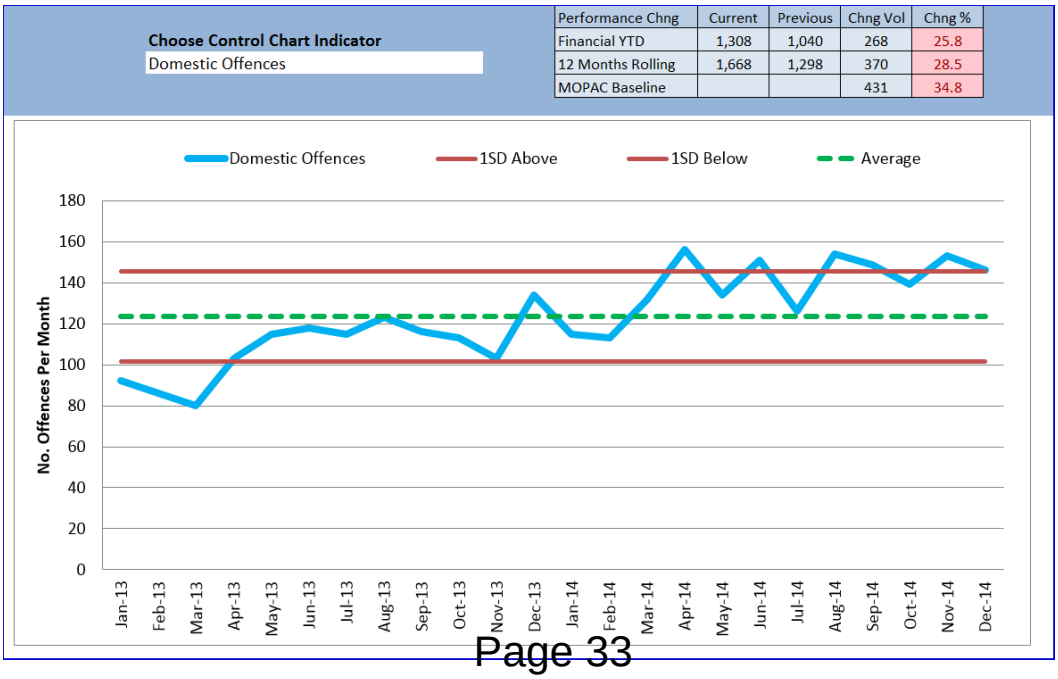
The increase in DV Offences is at present currently above the regional average, showing a 27% increase compared to a 22% increase across London. Where DV Violence with Injury is concerned, Havering has the 9th highest numerical increase and the 7th highest percentage increase.

| Official Performance Data Metropolitan Police | | | | |
|---|---|---|---|---|
| Offence | Offences Current FYTD | Offences Previous FYTD | Change No. | Change % |
| DV Violence with Injury | 453 | 367 | +86 | +23.4 |
| DV Offences | 1,319 | 1,040 | +279 | +26.8 |
| DV Incidents | 3,128 | 2,688 | +440 | +16.4 |
| Rape & Sexual Assault | 191 | 135 | +56 | +41.5 |
| Total Violence against Women & Girls | 5,091 | 4,230 | +861 | +20.4 |

*Source: MPS Met Stats Data to December 2014*

The rate of overall Domestic Abuse per 1,000 residents this financial year to date is 19.0, slightly behind the regional average of 20.0. This ranks Havering 17th of London's 32 boroughs, falling from 20th the previous year (where 32 is best).

The control chart below shows the rising levels of Domestic Abuse offences, with average monthly totals pre December 2013 being consistently below 120, whilst post March 2014 they have averaged in the region of 145.



A new repeat offender and victim data sheet has been produced by the Metropolitan Police, which allows for easier identification of repeat cases. This is currently a 6-month rolling perspective rather than 12-month rolling. During the last 6 months there were:

- 99 high harm victims identified in Havering who were victims in 331 records over the previous 6 months
- 40 of those victims (excludes victims who are also recorded as perpetrators) were victims 3 or more times in the previous 6 months (7 males and 33 females)

The number of repeat cases referred to the domestic violence Multi-Agency Risk Assessment Conference (MARAC) in Havering currently stands at 21% for the previous 12 months rolling (46 of 219 cases).

The table below shows a breakdown of all repeat domestic violence victims by borough at November 2014 (*Source: Metropolitan Police Repeat Victims Report*). Havering had 126, of which 11 reported victimisation between 7 and 15 times, and 34 between 3 and 6 times. The total percentage of victims in Havering who are repeat victims is 32.8%, the fifth highest of 32 London boroughs and highest of East London boroughs.

Currently, detections, arrest rates, charge rates and cautioning rates have all fallen in Havering. This is also true regionally. Havering is performing below the Metropolitan Police area average in all indicators with the exception of cautions.

| Sanctioned Detection (SD) Data Metropolitan Police | | | | |
|---|---|---|---|---|
| Offence | Havering Current FYTD | Havering Previous FYTD | Havering Direction of Travel current FYTD | MPS Current Average (Havering rank in MPS) |
| Domestic Violence – Violence with Injury (Sanctioned Detection) | 39.8 | 49.7 | ↓ | 44.6 (29) |
| Domestic Violence – Total Offences (Sanctioned Detection) | 36.2 | 44.9 | ↓ | 36.2 (21) |
| Domestic Violence – Arrest Rate | 69.6 | 79.3 | ↓ | 71.4 (24) |
| Domestic Violence – Charge Rate | 21.0 | 28.8 | ↓ | 22.0 (21) |
| Domestic Violence – Cautions | 15.2 | 16.2 | ↓ | 14.2 (14) |

*Source: MPS Met Stats data for FYTD to December 2014*

The number of referrals to MARAC has continued to increase, with 219 for the 12 months to December 2014. There has been a significant rise in the volume and percentage of referrals being made via Children's Social Care and the Early Help Team (from 14 to 38). Police referrals increased in the last 12 months from 42 to 57 whilst the Independent Domestic Violence Advocates (IDVAs) contributed to the highest number of referrals with 86.

With regard to the aforementioned repeats database of high harm victims and offenders, collated by the Metropolitan Police:

- Of the 40 high harm victims with 3 or more repeats in the last 6 months, 14 had been referred to the MARAC on at least one occasion. It is unknown whether the remaining 26 are known to services other than the MPS and whether or not they are accessing services.
- Of all cases discussed at MARAC in the previous 6 months, only 9 have appeared on the high harm repeat datasheet produced by the Metropolitan Police.
- The remaining 26 referrals by police colleagues were not identified as repeat victims (based on volume of reports to police)

- In the last 6 months police contributed to 35 of 88 individuals referred.
- Approximately 60% of those referred by other agencies had not reported incidents/crimes to police, and thus may have been unknown to police before the MARAC meeting.

Other MARAC data showed a decline in BME victims being referred (32 down to 23), an increase in male victims (6 up to 10), and an increase in victims with a disability (3 up to 5). There remain 0 referrals for LGBT cases and just 1 whereby the victim was aged 16-17.

**3. Why is this an issue for the Health and Well Being Board?**

In November 2013 the Mayor of London launched his second strategy on violence against women and girls (VAWG) with one of the key objectives being "addressing health, social and economic consequences of violence." Boroughs are being encouraged to develop a wider response to VAWG which includes domestic violence , rape and other sexual offences, female genital mutilation, forced marriage , honour-based violence and trafficking and prostitution

Domestic Abuse remains a high priority for the Havering Community Safety Partnership. However limited funding is available through the Mayor's Office for Policing and Crime (MOPAC) to develop responses to domestic violence and the wider VAWG agenda, with only £76,000 made available in 2014-15. Commissioning of services for victims of domestic abuse is therefore limited compared to other London Boroughs

- The Council current funds a full time independent domestic violence advocate (idva) based in Victim Support to support high risk victims of DV, commissioned by Community Safety .
- MOPAC is in the process of commissioning a Pan London DV IDVA service which will see an up-lift in provision of an additional 3.5 IDVAs.
- Domestic violence advocacy services are provided for 8-12 hours per week through Havering Women's Aid (HWA) funded through MOPAC grant funding. The Service Level Agreement (SLA) for this service is managed by Community Safety.
- Refuge provision in the Borough is again provided by HWA, commissioned by Homes and Housing, via two refuges within Havering. The three year contract is due to end October 2014 (with an option to extend for one year), and future funding will be reviewed in spring 2015.
- There are no specific services for children experiencing violence at home and limited funding is available to deliver prevention work with young people and perpetrators. However for 2014-15 the Early Help team has seconded a DV specialist worker to support staff in early help settings to support families with children experiencing DV.

A DV JSNA chapter was completed by Health in 2012 which made a number of key recommendations for decision makers and commissioners - many of which have not been taken forward due to the changes in Health care provision locally and nationally. These have been incorporated into the new VAWG strategy.

Referrals to the Multi-Agency Safeguarding Hub (MASH) have seen an increase in families where comorbidity of domestic abuse, mental ill-health and substance misuse is an issue.

Areas of consideration by Health providers include

**Prevention**

- Consider the introduction of the Identification and Referral to Improve Safety system (IRIS). IRIS is a general practice-based domestic violence and abuse (DVA) training support and referral programme that have been evaluated in a randomised controlled trial showing reductions in repeat victimisation. Core areas of the programme are training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services. The target patient population is women who are experiencing DV from a current partner, ex-partner or adult family member. IRIS also provides information and signposting for male victims and for perpetrators.

**Provision**

- Consider how Havering can enhance alcohol, substance misuse and mental health services for victims/survivors of DV/VAWG
- Consider how Havering can enhance services for people from minority groups, children and young people

**Protection**

- Improve levels of general practitioner referrals to MARAC (just 24% of GPs said they were prepared to make appropriate referrals for victims – Royal College of General Practitioners 2012)

## IMPLICATIONS AND RISKS

### Financial implications and risks:

Failure to identify funding to tackle the issues raised in this report may impact on the Council's and other partners' ability to respond to a trend of rising domestic abuse within Havering.
The services already provided for domestic violence victims are funded from existing resource and, in the case of the Women's Aid advocacy service, via a grant from MOPAC.
Failure to comply with terms and conditions of the grant agreement, which does not allow any flexibility in spend, may result in funding for future years being withdrawn

### Legal implications and risks:

The Council and other statutory partners including Health have a responsibility under the Crime and Disorder Act 1998 to address crime and disorder within the borough.
Although the funding available to the Havering Community Safety Partnership (HCSP) is consistent with previous years , we no longer have the flexibility of how we spend the funds which will impact on the Partnership's ability to respond to emerging crime trends over the coming year.
Failure to comply with terms and conditions of the grant agreement may result in funding for future years being withdrawn.

### Human Resources implications and risks:

The Domestic Violence IDVA is employed by Victim Support London on an annual contract and therefore there are no HR implications for the Council if future funding is not secured.

### Equalities implications and risks:

Equalities implications run throughout each of the strands of the MOPAC VAWG strategy and analysis of data in relation to the demographics of victims and offenders must be used to develop future services to address violence against women and girls.
Data will continue to be collected and reviewed to ensure services are delivered appropriately and that the needs of the changing communities in Havering are accommodated.
All commissioned services must ensure as part of our contractual arrangements and corporate procurement processes that they are compliant with the Equality Act 2010 and in particular the Public Sector Equality Duty. This will be monitored through the equalities monitoring of those who access the services

## BACKGROUND PAPERS

**Appendix 1 Draft Havering Violence against Women and Girls Strategy 2015-2018**

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# Havering's Health and Wellbeing Strategy

## 2015 – 2018

## Contents

## Executive Summary

Our strategy has been developed by Havering's Health and Wellbeing Board and it is the overarching plan to improve the health and wellbeing of children and adults in our borough.

The vision of the Havering Health and Wellbeing Board remains *"For the people of Havering to live long and healthy lives, and to have access to the best possible health and care services."*

Informed by the Joint Strategic Needs Assessment and other needs analysis, we have identified the most pressing health and social care issues in the borough. By working collectively as a strategic partnership, we have prioritised the actions we need to take to deliver our vision and improve outcomes for local people. These are set out clearly in this Health and Wellbeing Strategy, which focuses on three overarching themes and eight priorities for action:

| **Overarching Themes** | **Priorities** |
|---|---|
| **Theme A: Preventing, reducing and delaying the need for care and support through effective demand management strategies** | Priority 1: Provide effective support for people with long term conditions and their carers so that they can live independently for longer<br><br>Priority 2: Improve identification and support for people with dementia and learning disabilities and their carers<br><br>Priority 3: Reduce obesity<br><br>Priority 4: Reduce premature deaths from cancer and cardiovascular disease. |
| **Theme B: Better integrated support for people most at risk** | Priority 5: Better integrated care for the "frail elderly" population<br><br>Priority 6: Improve integrated care for children, young people and families most at risk<br><br>Priority 7: Reduce avoidable hospital and long term care home admissions |
| **Theme C: Quality of services and patient experience** | Priority 8: Improve the quality of services to ensure that patient experiences and long term health outcomes are the best they can be |

All member agencies of the Health and Wellbeing Board are facing significant budget pressures while operating in an environment where demand for higher quality services is increasing.

Havering operates within a challenged health economy where historically underdeveloped community based services have led to high numbers of frail community members receiving sub-optimal care. The Health and Wellbeing Board's strategy is consequently focused, at least in the short to medium term, on improving health and social care services for this frail group but will in future turn its attention to the wider prevention agenda and strategies to assist people to understand how to age better and prevent the onset of conditions that require substantial health and social care intervention.

All of the above will need to be supported and facilitated by the continued development and delivery of integrated commissioning strategies and activities across the organisations represented on the Board.

# Foreword

Welcome to Havering's second Health and Wellbeing Strategy.

Over the life of our first Health and Wellbeing Strategy, we have worked successfully together to give patients, service users and their carers better care and support. Patients now recover more quickly and are pleased to be able to benefit from home-based services that allow them to remain in or return to their own homes and communities.

This second strategy sets out how, over the next three years, we will build on the successes of our first Health and Wellbeing Strategy and how, by working in partnership with each other and the community, we will improve the health and wellbeing of local people and improve the quality of, and access to, local healthcare services.

We believe that everyone in Havering has the right to enjoy good health and wellbeing. We have a lot to be proud of in this borough. Life expectancy is high and overall the borough is quite healthy. There is a wealth of open parks and spaces, good transport links and high levels of employment. Residents feel that Havering offers a very good quality of life. However, we want to continue to do more. We want to help people to live healthier lives and we want to provide better quality of care and services.

We are in a period of great change and legislative reform that brings with it many opportunities but also many challenges. As well as the impacts arising from the Care Act, the Children and Families Act and Government austerity measures, rising demands and expectations from service users are all forcing significant changes to both the commissioning and direct provision of health and social care services.

But despite the challenging context we are working in, we believe the most vulnerable people must continue to be valued and protected. Havering has an increasing older population and we believe we can improve support for people with dementia and learning disabilities, and also help older people to remain independent for as long as possible. We understand how important carers are and we will continue to provide support for them in their crucial role. We will also continue our on-going work to improve the quality of our local hospitals and community care services.

We are clear that a "one size" approach will not fit all and that, in many cases, both the current performance data and the need to achieve more with our declining resources will mean that we will have to focus our efforts by targeting "hotspot" areas. Tackling health inequalities across the borough and improving life expectancy continue to remain priorities, particularly in the most deprived areas of Havering.

We know that it is only by working together can we create a borough where everyone can realise their potential and have the best life chances. To this end, we must ensure that everyone can access the support they need, but also empower communities to take responsibility for their own health and wellbeing and that of their families and loved ones.

Despite the challenging environment, we must be ambitious in our thinking and desire for change. Good health and wellbeing is everyone's responsibility and everyone must play their part.

By Cllr. Steven Kelly (Chair of the Havering Health and Wellbeing Board)

Dr. Atul Aggarwal (Chair of the Havering Clinical Commissioning Group)

# 1. Achieving our Vision

The vision of this strategy is:

*"For the people of Havering to live long and healthy lives, and have access to the best possible health and care services."*

To deliver this vision, we have identified the most pressing health and social care issues in the borough. Informed by the Joint Strategic Needs Assessment, we have identified the following three key themes:

Theme A: Preventing, reducing and delaying the need for care and support through effective demand management strategies

Theme B: Better integrated support for people most at risk

Theme C: Quality of services and patient experience

There are eight priorities for action to deliver these themes and each has a jointly agreed plan as to how improved outcomes for local people will be delivered. Partnership working, joint commissioning and integrated working are fundamental to the delivery of this strategy. Tables that set out the themes, priorities and key actions can be found at Appendix 4.

In accordance with the Council's obligations under the Public Sector Equality Duty, the strategy has been assessed for its equalities implications and the impact of the proposed actions on members of the population who possess protected characteristics. The Equality Impact Analysis is available on the Council's website. Individual schemes and initiatives arising from the Health and Wellbeing Strategy will also be subject to separate Equality Analyses which will likewise be published on the Council's website.

# 2. Scope and Purpose of the Strategy

The Health and Wellbeing Strategy sets out how we will work together as a strategic partnership, as well as with the local community, to improve the health and wellbeing of local people and to improve the quality of, and access to, local health and care services. It provides the overall direction for the commissioning of health and social care services across the borough.

This strategy replaces the Havering Health and Wellbeing Strategy 2012-2014.

The Strategy focuses predominantly on health and social care related factors that influence health and wellbeing. The wider determinants of health and wellbeing include factors such as housing, education and employment, and the environment. These are addressed through other key partnership strategic documents. A list of such documents can be found at Appendix 3.

# 3. Context

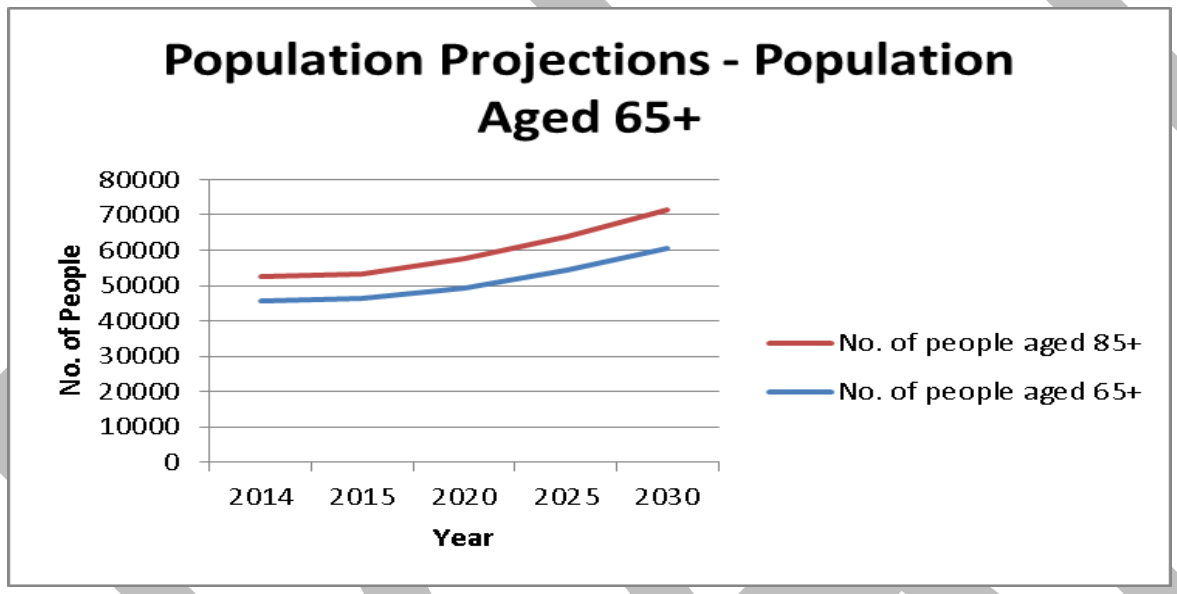
## 3.1 Our Population in Havering

The people of Havering are generally fairly healthy. Life expectancy is long and residents and visitors to the borough benefit from plenty of high quality parks and open spaces.

There are 237,232 people living in Havering and 256,731 people registered with a Havering GP. It is estimated that by 2016, Havering's population will have grown by 5.4% (12,699 people) and by 11.5% (27,095 people) by 2021, a faster rate of growth than the London average.

The life expectancy for people living in Havering is 78.6 years for men and 83 years for women. While life expectancy overall is above the England average, there is a 7.4 year gap in life expectancy for men and 4.6 years for women across Havering, with life expectancy particularly impacted by where people live and the circumstances of their upbringing.

Havering has one of the largest older populations in London, with more than 23% of residents (40,000) over the age of 65. Between the 2001 and 2011, growth in the 85+ age group saw the largest percentage increase (at 43%, which is higher than for both London and England), and the size of this age group is projected to continue to increase, by 20.3% by 2020.




This projected increase in the older people population is likely to result in increases in numbers of residents suffering from cardiovascular disease (CVD), cancer, respiratory illnesses (e.g. bronchitis and pneumonia), dementia, osteoporosis, incontinence and hearing impairments.

Simultaneously, however, the borough's large older population also offers many assets to the community. Their skills and experience can be – and are – harnessed to enrich community life. Older people are always very willing to offer their views in

response to surveys and other consultations and offer considerable resources and expertise for volunteering opportunities. Older people also offer the majority of informal care to their spouses and loved ones.

The borough has a large younger population too. It is estimated that around 23% (54,018) of the population in Havering is aged 0-19, similar to the England average of 24%. Future projections suggest that the 0-15 age group is estimated to grow by 8.2% by 2016 and 21.1% by 2026.

While the population is predominantly White British, it is becoming increasingly diverse. It is estimated that around 12% of Havering's working age population is of non-white ethnicity, however the school census reported that nearly 23% of school pupils in Havering were from non-white ethnic groups.

The borough is generally fairly affluent, being ranked 177th overall out of 326 local authorities for deprivation, but has pockets of deprivation. Two small areas of the borough (situated in Gooshays and South Hornchurch) fall into the 10% most deprived areas in England. When compared with other London boroughs, Havering has a relatively small proportion of children living in poverty, however this has risen in recent years (bucking the trend seen in most other London boroughs of declining levels of child poverty).

The results of the 2011 *Your Council, Your Say* survey indicated that health services are the top priority for local people in making the Borough a good place to live, followed by clean streets and the level of crime.

## 3.2 Key Achievements to Date

While we are aware that we still face significant challenges in addressing health inequalities and improving wellbeing, we are proud of the significant improvements that have been made during the life of the first Health and Wellbeing Strategy.

As we move into the next planning period, much good work has already started, giving the Board a strong foundation on which to build. As a partnership, we are particularly proud that:

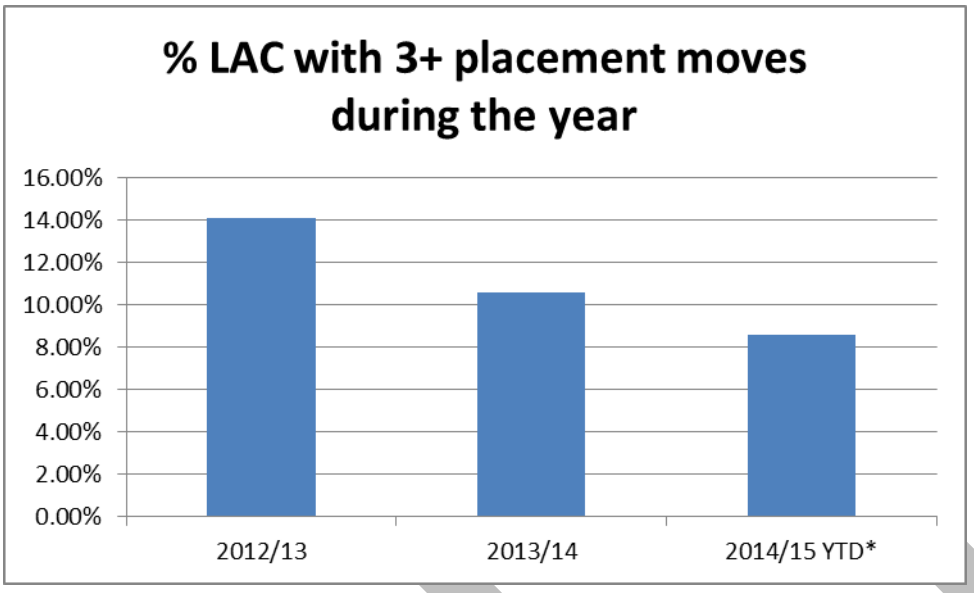
- Urgent Care Centres have been set up in the borough, with the aim of reducing A&E attendances and helping patient flow by seeing patients in the most appropriate setting. Hospital staff and local GPs can book non-urgent cases directly into these clinics.
- An Integrated Care Strategy is in place and being delivered, which is helping to shift activity away from acute settings towards community and locality settings. As part of this, Integrated Case Management across health and social care has already been introduced.
- Residents of the borough now benefit from a Joint Assessment and Discharge (JAD) team, operating seven days a week, which provides a more collaborative approach across health and social care to ensure that planning for discharge takes place closer to the point of admission. This has played a

large part in making Havering one of the best performing boroughs in London in terms of delayed transfers of care.

- In response to feedback from patients that they want to be supported closer to, or in, their own homes where possible, we have implemented Community Treatment Teams (CTTs) and the Intensive Rehabilitation at Home Service (IRS), and surveys indicate that most patients are very happy with these new models of care, with CTTs receiving a patient rating of 8.7 out of 10 and the IRS receiving a patient rating of 9 out of 10. In 2013/14, Havering's Intensive Rehabilitation Services received 159 referrals against a target of 69. During the same period, there were 1,576 referrals to the Queens Hospital hub of the new Community Treatment Team, 78% of which did not go on to be admitted to hospital. Within the community spoke of the CTT, 2,707 referrals were received during this time, 94% of whom were treated and maintained at home without the need for an acute admission. Without services such as these, many more patients would be presenting at already over-stretched A&E departments and required more help from their family and / or carers.
- A Frailty Academy was launched across Barking and Dagenham, Havering and Redbridge in February 2014, to ensure that the lessons of various approaches and initiatives are learned and used to inform the development of mainstream services. As at May 2014, 34 participants had enrolled in the Academy, representing a range of agencies including the London Ambulance Service, NELFT, BHRUT and the Havering Care Association.
- The first stage of the new Community Health and Social Care Service (CHSCS) went live on 28 April 2014, with the reconfiguration of community nursing, Integrated Case Management, therapies and mental health services into locality based teams. We are now working towards the integration of partners outside of NELFT (e.g. social care and others) into this model.
- In June 2014, Havering became the first borough in London, and one of the first in the country, to expand its Multi-Agency Safeguarding Hub (MASH) to identify adults as well as children at risk. Alongside this, the Council and its partners developed a Community Multi-Agency Risk Assessment Conference (Community MARAC), to provide a multi-agency problem solving forum in respect of adults who do not meet the threshold for statutory services but who nonetheless require a multi-agency response in order to maintain them safely in the community. An independent evaluation is now underway, but anecdotal evidence and performance data suggests that both these initiatives are adding value to the partnership's work to identify and support vulnerable people and families.
- Havering has performed particularly well in the national Troubled Families programme. As at March 2014, the borough's initial target of identifying 415 "troubled families" to work with had been exceeded, with over 500 families

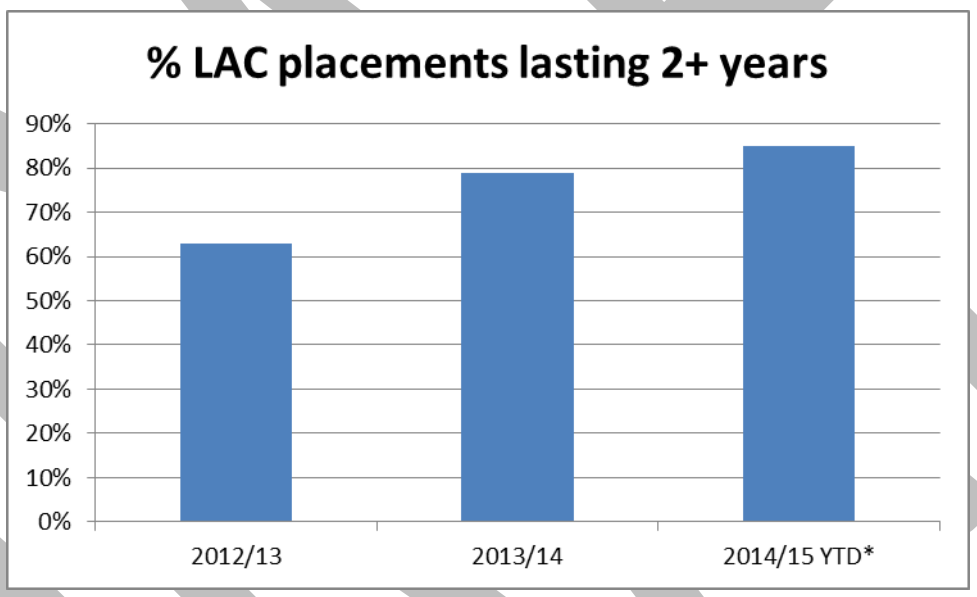
having been identified. Havering's Troubled Families team is now closely involved nationally in the development and roll out of Phase 2 of the programme.

- Havering was awarded Dementia Friendly Borough Status in 2014, making the borough only the second London borough to receive this status.
- The stability of care placements for children looked after by the local authority has improved, with the percentage of looked after children with three or more placements during the year reducing each year.




* As at end November 2014

- The percentage of LAC placements lasting two or more years has also steadily improved.




*As at end November 2014

- Going forward, the recent successful bid to the Prime Minister's Challenge Fund will facilitate further improvements to the quality of and access to primary care services across the Clinical Commissioning Group by investing in improvements to complex care and facilitating access to services between 8am and 10pm seven days a week, as well as enabling technology to facilitate better information and data sharing.

## 3.3 The National Context

### The Care Act 2014

The Care Act is the most important and far reaching piece of legislation impacting on adult social care since the NHS Community Care Act 1990. The Care Act combines many different laws regarding care and support into one piece of legislation that creates a range of duties and responsibilities.

Key areas of change to be implemented from April 2015 include:

- Greater responsibilities on local authorities, including to promote people's wellbeing, focusing on prevention and providing information and advice (including to self-funders);
- The introduction of a consistent, national eligibility criteria;
- New rights to support for carers, on an equivalent basis to the people they care for;
- A legal right to receive a personal budget and direct payment;
- A requirement to ensure more holistic and integrated provision of services across both statutory and non-statutory organisations;
- New guarantees of continuity of care when service users move between areas;
- The extension of local authority adult social care responsibilities to include prisons, and
- New responsibilities around transitions, provider failure, supporting people who move between local authority areas and safeguarding.

Major reforms to the way that social care is funded will be effective from April 2016, including:

- A lifetime 'cap' of no more than £72,000 for individuals on reasonable care costs to meet their eligible needs, and
- An increase in the capital threshold for people in residential care who own their own home.

**Better Care Fund**

The Better Care Fund (BCF) supports the transformation and integration of health and social care services to ensure local people receive better care. The BCF is a pooled budget that shifts resources into social care and community services for the benefit of the NHS and local government.

The key objectives of the BCF (which will be linked to a payment by results mechanism) are to:

- Ensure more joined up and effective commissioning, including the procurement, specification and contracting of health and social care services;
- Deliver more integrated solutions for residents and service users, at the lowest and most appropriate level possible, and
- Avoid hospital and long term care home admissions by ensuring improved management of high cost resources through targeted locality interventions.

The Better Care Fund is not new money that we can invest in the local health economy, but does provide an opportunity for partners to accelerate established plans to deliver greater benefits and improved outcomes to local people by combining budgets and working in a more integrated manner. Partners represented on the Health and Wellbeing Board will work together to deliver the specific schemes highlighted in the borough's BCF Plan, which in turn contribute to the achievement of our Health and Wellbeing Strategy.

**The Children and Families Act 2014**

The Children and Families Act draws together the support a child or young person aged 0-25 with special educational needs (SEN) requires across education, health and social care into a single Education, Health and Care (EHC) Plan which will replace the current statementing system. These will be gradually implemented over a two to three year period from September 2014 and will require plans to be outcomes, rather than outputs, focussed as well as requiring a co-ordinated, multi-agency assessment process. The Act introduces a new legal requirement for the local authority to work with health to integrate services, as well as a requirement for joint commissioning arrangements across education, health and social care, and a mechanism to agree the levels of service required.

The Act also strengthens the rights of young carers to an assessment of needs for support. It is believed that the number of young carers in the borough is currently under identified and likely to increase. This in turn will increase the demand for assessments and services. This is recognised in the borough's BCF plan.

The Act also requires children, young people and their parents or carers to be offered personal budgets to meet their care needs. This will require increased transparency,

signposting and market development of “the Local Offer” within an increasingly competitive health and social care economy.

**The Marmot Review 2010**

The Marmot Review 2010, *Fair Society, Healthy Lives*, proposed evidence based strategies for reducing health inequalities including addressing the social determinants of health. It concluded that a good start in life, a decent home, good nutrition, a quality education, sufficient income, healthy habits, a safe neighbourhood, a sense of community and citizenship are fundamentals for improving quality of life and reducing health inequalities. We are aware that, to reduce health inequalities and improve wellbeing, we must focus our efforts on those who are experiencing poverty and deprivation and must support our communities to lead healthy lives and to make healthy choices.

## 3.4 The Local Context and Delivery Arrangements

### 3.4.1 The Havering Health and Wellbeing Board

The Health and Wellbeing Board is the forum through which key leaders from health and social care work together in partnership to improve the health and wellbeing of the people of Havering and to reduce health inequalities across the borough. The Board is committed to ensuring that health and social care services in the borough are operationally and cost effective and oversees the implementation of the wider change agenda across the local health and social care economy. The Board will hold commissioners in the borough accountable for delivering the priorities and actions outlined in this strategy and its accompanying action plan.

Membership of the Havering Health and Wellbeing Board is set out at Appendix 1.

The Governance Structure (also attached at Appendix 1) illustrates how the Health and Wellbeing Board fits into the wider health and social care system and the other local governance structures which, whilst not all directly accountable to the Health and Wellbeing Board, provide the mechanisms through which the Board can receive assurance on progress against the priorities identified within this strategy.

### 3.4.2 Havering’s Joint Strategic Needs Assessment (JSNA)

The JSNA identifies and assesses the health and wellbeing needs of the local population. It is carried out by analysing a range of data and intelligence from various sources, including feedback from local people. It identifies where our health and social care services perform well compared with others and where we need to improve. The JSNA is regularly updated and available to view on the Havering data intelligence hub at: www.haveringdata.net/research/jsna.htm.

### 3.4.3 The Financial Landscape

Both the local NHS and the Council are facing a highly challenging financial position for at least the short to medium term. The total forecast financial gap by 2018/19 for the major providers in Barking, Havering and Redbridge is £260m. The borough's acute trust (BHRUT) accounts for £150m of this – which compounds the current issues concerning service quality, performance and productivity. For the CCGs, the forecast gap is £128m, with the Havering CCG having a gap of £48m. Meanwhile there is a need for the local authority to reduce its budget by £60m over the four years from 2015/16. All of these budget reductions will be extremely challenging to achieve given the levels of population growth being experienced in the borough and the changing care needs and increasing acuity that are presenting in the local population. The implementation of the Care Act 2014 and the Children and Families Act 2014 will also put further financial pressures on the Council and its partners. All key partners are therefore facing significant budget pressures while operating in an environment where demand for higher quality services is increasing.

In such a challenging financial context, it is crucial to ensure that projects and resources are managed diligently in order to maximise the return on investment; ensure a sustainable financial position and, even more critically, to improve the health and wellbeing of local residents.

## 3.5 Action Plan

This Strategy sets out the Health and Wellbeing Board's eight priorities, and each has a jointly agreed action plan as to how improved outcomes for local people will be delivered. The Action Plan accompanying the Strategy is set out at Appendix 4. This includes a variety of interventions including individual, targeted and population-wide initiatives. Each intervention seeks to provide the most beneficial outcome for individuals, whilst being achievable within the constraints of health and social care budgets.

## 3.6 Monitoring and Review Arrangements

It is the responsibility of the Health and Wellbeing Board to oversee the delivery of the strategy. Performance against the key actions and indicators set out in this Strategy will be monitored on a quarterly basis by the Board.

The strategy will be critically reviewed and refreshed as necessary at the end of the three year period. In the meantime, plans will be continually reviewed in light of the best available evidence and amended, where necessary, to ensure that the best possible outcomes are achieved within the resources available.

# 4. Health and Wellbeing Themes and Priorities

## Theme A: Preventing, reducing and delaying the need for care and support through effective demand management strategies

People with the most complex needs pose the greatest challenge to health and social care providers. Older people, especially those with **long-term conditions**[1], are the most intensive and costly users of health and social care services. In response to the 2011 *Your Council, Your Say* survey, more than a quarter (25.3%) of residents identified themselves as having a long standing illness or disability.

As well as treating the symptoms of these conditions, we need to address some of the lifestyle choices and factors that contribute to them. For example, one in five adults smoke and the alcohol consumption of one in five is at a harmful or increased level. By focusing on prevention and early intervention, we aim to help manage demand on services and enable more people to be healthier and to live independently and safely in their own homes for as long as possible. Our continued focus on reablement and rehabilitation services for those recovering from a period of illness, alongside support to help older and vulnerable people manage long-term conditions and to lead healthier lifestyles, will help more people to maintain independent living for longer. However, given the broad range of factors that impact on the health and wellbeing of the local community, our prevention initiatives will not simply be restricted to those provided by health and social care services. Other services that are delivered or commissioned right across the partnership, such as leisure and cultural services, will also have a key role to play in tackling root causes of ill health and health inequalities. Particularly in the current economic climate, we will also need to consider how we can get the most health gain from universal services by identifying the prevention opportunities that we may be able to build into all mainstream services rather than necessarily commissioning bespoke services to respond to each and every presenting need.

Overall, the level of mental health difficulties in Havering is comparatively low, but it remains an issue for the local population and for the Health and Wellbeing Board as there are significant inequalities in the distribution of risk factors and the prevalence of mental illnesses across the borough, with evidence showing that people who live in the most deprived wards such as Gooshays and Heaton are much more likely to suffer from a mental illness than those who live in the least deprived parts of the borough such as Upminster and Cranham. However, whilst Havering has a significantly lower prevalence of patients recorded with a diagnosis of mental illness overall, **dementia** is a particularly pertinent issue in Havering due to its large and growing older population. Dementia is a particularly distressing illness for both the sufferers themselves and their friends and family and others who care for them.

[1] Defined as one or more of the following: Asthma, Cancer, Coronary Heart Disease, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Dementia, Depression, Diabetes, Epilepsy, Hypertension, Heart Failure, Learning Disability, Stroke and those receiving end of life services

Supporting people with dementia is a high priority both nationally and locally and, whilst clinical diagnosis of dementia is predominantly a matter for the NHS, access to post-diagnostic support (for both the patient and their family and carers) is a matter for all members of the Health and Wellbeing Board.

Research carried out to inform the Joint Strategic Needs Assessment (JSNA) chapter on mental health also found that people with **learning disabilities** in the borough have significant unmet needs, and also identified links between learning disabilities and depression, anxiety and other mental disorders. In particular it was noted that clients with a LD can particularly struggle with grief following a bereavement (often of a parent).

In February and March 2014, Healthwatch Havering facilitated a series of workshops, attended by service users and carers as well as representatives from the voluntary and community sector, NHS organisations and the Council, to investigate what services were available in the borough for people with dementia or learning disabilities and what could be done to secure improvements. The findings of the resulting report are addressed in our Action Plan attached at Appendix 4.

**Obesity** increases the likelihood of the development of a range of health conditions, with the most important of these in terms of the burden on health services being type II diabetes, cardiovascular diseases and several types of cancer. It increases the risk of morbidity, disability and premature mortality. Being obese also restricts mobility, can lead to poor mental health and reduce life quality. Obesity in pregnancy increases the risk of complications both for the mother and the child. These effects can last throughout childhood and into adulthood, with babies born to obese women facing increased risk of foetal death, stillbirth, congenital abnormality, shoulder dystocia, macrosomia and subsequent obesity. Type II diabetes has increased in overweight children. Other risks associated with childhood obesity include early puberty, eating disorders, skin infections, asthma and other respiratory problems.

Obesity further costs society through the loss of disability-free life years, additional pension payments due to early retirement through ill health, increased absenteeism and / or reduced productivity at work due to ill health. There have also been links made between obesity and various emotional and psychological effects such as anxiety and depression. In children, this can have a knock-on effect on educational attainment. Once established, obesity is difficult and costly to treat, so prevention and early intervention are paramount. By promoting healthier lifestyles, increasing levels of physical activity and commissioning appropriate support services, the Havering Health and Wellbeing Board aims to help residents maintain healthy weight.

Partly linked to this, a greater proportion of people in Havering than in England and other statistically similar local authorities die prematurely from heart disease and strokes. The expected increase in the number of elderly residents in Havering is

predicted to increase still further the numbers of residents experiencing cardiovascular diseases (CVD) and cancer, as well as respiratory illnesses (e.g. bronchitis and pneumonia), osteoporosis (and fractures due to falls), incontinence and hearing impairment. This emphasises the need to reduce the prevalence of **cardiovascular disease** through primary prevention.

Meanwhile **cancer** is one of the top for priorities for outcomes improvement across London and one of the top three causes of premature mortality across the Barking and Dagenham, Havering and Redbridge (BHR) Clinical Commissioning Group (CCG) and therefore warrants our continued attention.

**What we want to see**

- Earlier identification and diagnosis of dementia in order to improve treatment
- Earlier diagnosis and treatment of cancer
- Improved quality of life for those with one or more long term conditions
- Individuals feeling in control of their care, and empowered and enabled to live well.
- Reduced harm caused by modifiable risk factors
- Better co-ordination of end of life care.

Our four priorities are to…….

Priority 1: Provide effective support for people with long term conditions and their carers, so that they can live independently for longer

Priority 2: Improve identification and support for people with dementia and learning disabilities and their carers

Priority 3: Reduce obesity

Priority 4: Reduce premature deaths from cancer and cardiovascular disease

## Priority 1: Provide effective support for people with long term conditions and their carers so that they can live independently for longer

**What we know about Havering**

- As at 19 September 2014, the number of people who were both registered with a Havering GP and resident in Havering with long-term conditions was as follows:

| No. of long-term conditions | No. of people aged 18-64 | No. of people aged 65-74 | No. of people aged 75+ | TOTAL |
|---|---|---|---|---|
| **1** | 27,822 | 7,999 | 6,256 | **42,077** |
| **2** | 6,612 | 4,493 | 5,783 | **16,888** |
| **3** | 1,445 | 1,720 | 3,501 | **6,666** |
| **4+** | 413 | 773 | 2,424 | **3,610** |

- As at 19 September 2014, 32,949 Havering residents aged 65 or over have a limiting long term illness.

- 17.3% of the population of Havering say that their day to day activities are limited due to their health, compared to 14.2% for London and 17.6% for England.

- As at 31 March 2014, there were 530 people with learning disabilities and 3,615 people with physical and sensory impairments receiving social care support in Havering. A further 1,765 older people were believed to be directly purchasing and funding their own care.

- In 2013/14, there were 378 people aged 65 years or over with a physical disability who were receiving residential / nursing care; 766 receiving domiciliary care; 804 in receipt of equipment and / or assistive technology; 377 in receipt of direct payments and 121 receiving reablement services.

- There are 1,200 older people in the borough that have particularly complex health and social care needs.

- People aged 85+ have the most complex health and social care needs, with approximately 900 of them accounting for 38% of all emergency beds.

- 45.2% (2,656) of adult social care clients receive some form of self-directed support. During 2013/14, 975 adult social care clients received a personal budget, which is above both the London and England averages.

- 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. This is slightly lower than the figure for the whole of England (55%) but in line with the London-wide figure (52%)

**Case Study**

Mr OB is a 57 year old man who suffered a brain injury six years ago. When he was discharged from hospital Mr OB went into rehabilitation. He suffered severe bouts of depression and he and his family believed that he would always need some form of residential care. When he was ready to leave rehabilitation, Mr OB and his wife made clear that he really wanted was to go home to be with his family.

A personal budget was arranged with Mr OB and his wife, so they could be confident that when he returned home on a permanent basis, the work of the rehab unit could be continued. As his wife was his main carer, this would also ensure she had some time to herself so she could continue to provide the support he needed

In Spring 2014, Mr OB left the rehab unit and moved home. He uses his personal budget to purchase support from carers who have specialist training in working alongside people who have a brain injury. They go to his home to support him providing a structured day and trips to the gym to continue the physiotherapy programme started in rehabilitation. He also spends two days a week in a physical disability specialist unit where he participates in many different activities and discussion groups. Most importantly for Mr OB and his wife, the flexible personal budget has given them the opportunity to have a quality home life together; something that neither of them had believed would be possible again.

**What we plan to do**

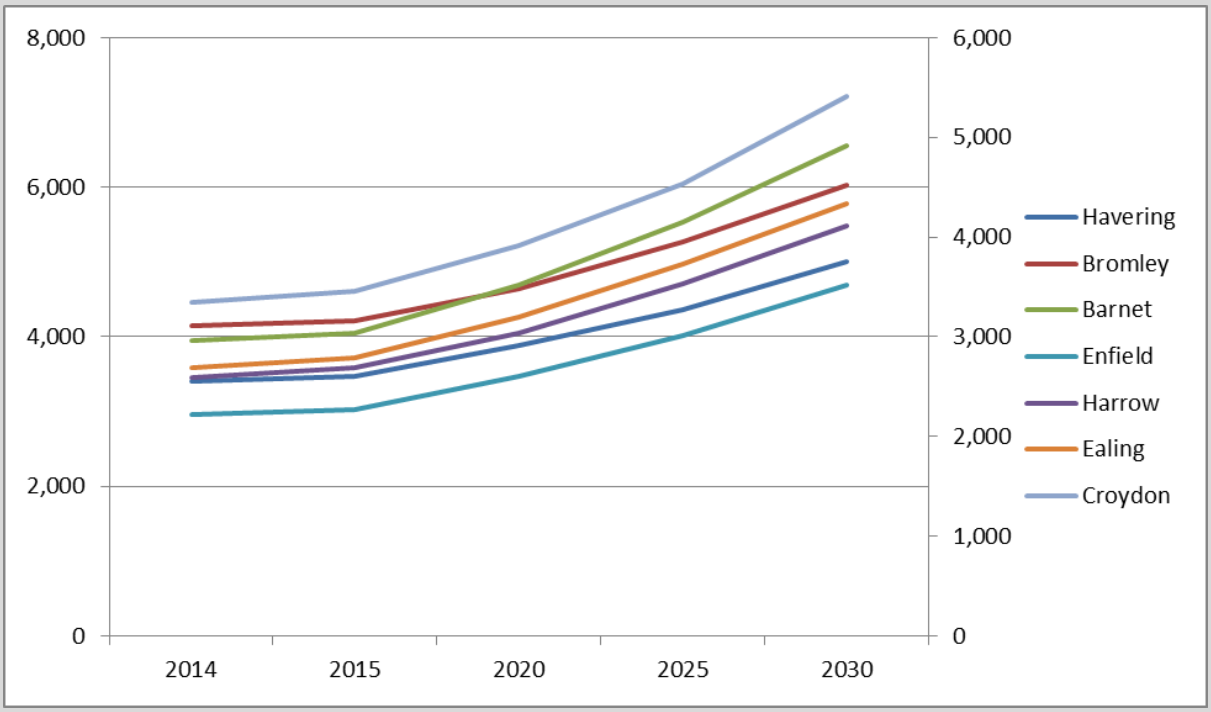
- Work as a partnership to improve residents' choice and control over the health and social care services they receive.
- Provide co-ordinated health and social care services in individuals' own homes, or as close to where they live as possible
- Work with the voluntary and community sector to support vulnerable people in the community, including providing respite care and support schemes for people who have just left hospital and their carers.
- Build community resilience and support people to manage their own conditions through initiatives such as peer support, mentoring and time-banking.
- Strengthen the co-ordination of complex care and end of life services across health and social care.

## Priority 2: Improve identification and support for people with dementia and learning disabilities and their carers

**What we know about Havering**

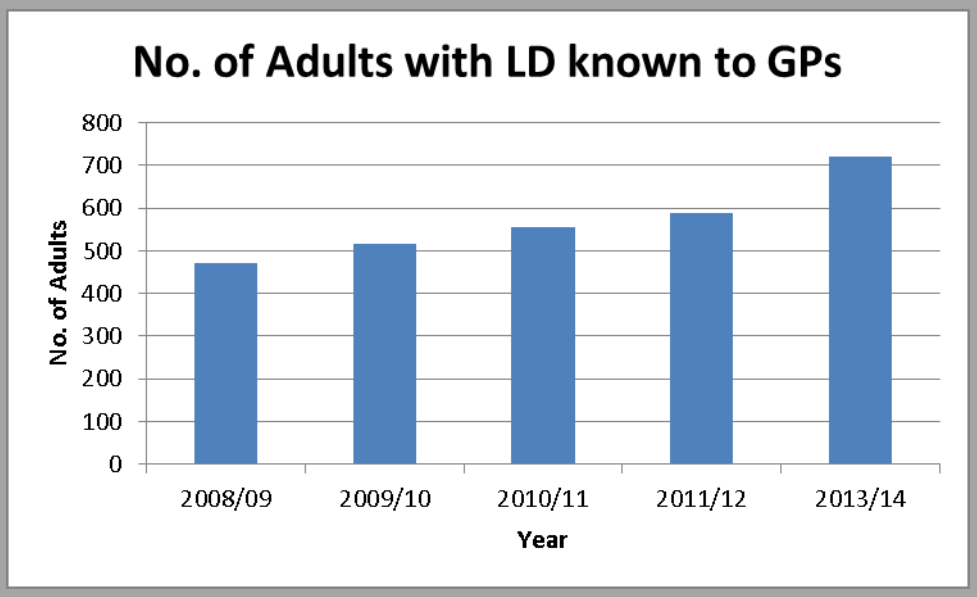
- It is estimated that, in 2014, Havering had over 3,000 people aged 65+ with dementia. This is predicted to rise to 3,794 by 2020 and to 5,005 by 2030, with Havering being home to the sixth highest number of residents with dementia in London

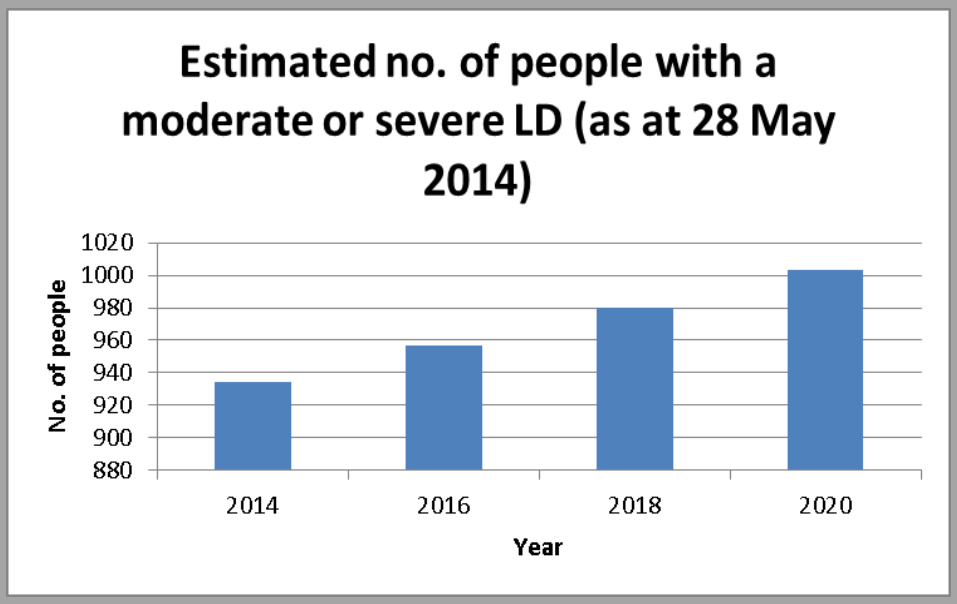
**People aged 65 and over predicted to have dementia projected to 2030 in the top seven boroughs (POPPI) 2014**




- As at December 2014, the dementia diagnosis rate for Havering had increased from 39% to 48.4%. However this remains considerably lower than the 55% national diagnosis rate and the 67% national target diagnosis rate. The Memory Service would need to see at least another 500 people to reach the national target.
- The recorded number of people with dementia in Havering is significantly lower than the expected number (given the borough's demographics), suggesting that more than 2,000 local people are living with undiagnosed dementia and, therefore, are not benefiting from treatments that could slow its progression and improve their wellbeing.
- Around 60 people aged 30-64 in Havering are estimated to be affected by early onset dementia

- It is estimated that around 63% of those with late onset dementia live in private homes in the community, and around 37% live in care homes
- Evidence suggests that the majority of people with dementia in Havering are white, aged 70+, and that there are considerably more female dementia cases than male.
- A large proportion of care for people suffering from dementia (particularly the undiagnosed) is provided by family and friends.
- The borough is a "net-importer" of people with learning disabilities, due to the large and growing number of supported living schemes in the borough, which mean that other borough place people in Havering. Due to ordinary residence rules, these individuals become the responsibility of the local authority and primary care services within Havering.
- As at 31 March 2014, there were 530 people with learning disabilities receiving adult social care support in Havering. Of these, around 9% are aged 65 plus. The number of new LD service users requiring assessments has increased substantially in recent years, which has also resulted in an increase in the number of carers of people with LD requiring an assessment or review.
- In Havering, we are expecting an increase of 10% in people aged over 65 with a learning disability to 2020, and an increase in 5% in the number of people aged 18 – 64 with a learning disability.
- The average age of adult social care service users with a learning disability has reduced from 29 in 2012/13 to 26 in 2013/14, whilst the average age of carers has remained consistent at approximately 60 years old.
- As at 28 October 2013, there were just 72 children registered with a Havering GP who were recorded as having a learning disability. This suggests substantial under-recording of learning disabilities.
- Comparisons of the number of adults with learning disabilities known to GPs (see below) or social care and the estimated numbers of adults with learning disabilities in Havering (also shown below) suggests that – as for dementia - a large proportion of people with learning disabilities are still being solely supported by their own families.


No. of Adults with LD known to GPs
800
700
600
500
400
300
200
100
0
No. of Adults
2008/09
2009/10
2010/11
2011/12
2013/14
Year


Estimated no. of people with a moderate or severe LD (as at 28 May 2014)
1020
1000
980
960
940
920
900
880
No. of people
2014
2016
2018
2020
Year

**What we plan to do**

- Aid prevention through early identification of risk factors.
- Increase referral and diagnosis rates for dementia.
- Improve the level of local detail about learning disabilities and dementia within the Joint Strategic Needs Assessment (JSNA), thus providing a better opportunity to plan and design care for the longer term.
- Ensure that people with dementia and learning disabilities and their carers are effectively supported by health and care services and the community to live as well and as independently as possible with their condition(s).

## Priority 3: Reduce obesity

**What we know about Havering**

- In 2012, 41% of people were overweight and 22.3% were obese in Havering
- Obesity rates in reception year children appear to be increasing over time**.** Just over one in ten (10.7 %) of reception year children in Havering are obese, whilst almost one in five (19.3%) year six children are obese. For children aged 4 – 11, there are correlations in Havering's Middle Layer Super Output Areas (MSOAs) between obesity and income deprivation and between obesity.
- At 27.3%, the proportion of adults in Havering who are obese is the second highest in London and also higher than both the England average of 24.2% and the London average of 20.7%
- In Havering, the proportion of patients who are obese (with a BMI of 30 – 34.9) is significantly greater in patients with a diagnosis of depression than in those without.
- Pockets of high obesity prevalence across the Borough tend to be clustered in the less affluent wards of Gooshays, Heaton and South Hornchurch.
- Although a low number of Havering residents aged 16+ (17.5%) reported that they took part in the recommended 3x30 minutes of physical activity (which is lower than previously and below both London and England participation rates), Sport England's Active People Survey 2009/10 showed that almost 50% (54% men / 43% women) of borough residents took part in sport or active recreation at least once in the four weeks prior to the survey. In addition, the 2010/11 survey showed that 21% of the borough's residents were members of sports clubs, 13% had received sports tuition in the last 12 months and 13% had taken part in organised competition in the last 12 months. However data also suggests that 51.8% of adults in Havering do no physical activity at all.

**What we plan to do**

- Increase physical activity levels amongst residents in the borough
- Assist residents (particularly in the most deprived areas of the borough) to maintain healthy weight
- Continue to invest in the assessment, treatment and prevention of childhood obesity, especially for under 5s
- Capitalise on opportunities presented through the National Child Measurement Programme to identify overweight and obese children, and signpost them to services

## Priority 4: Reduce premature deaths from cancer and cardiovascular disease

**What we know about Havering**

- The premature mortality rate (all causes) for Havering is 90.5 (1,684) for people aged under 65 and 92.1(3,327) for people aged under 75, compared to the England ratio of 100.

- Levels of smoking are high in the borough. 20% of adults smoke, which is worse than the London average, and the borough also has the highest rate of smoking during pregnancy in London. The proportion of women who smoke in maternity almost doubled between 2005/06 and 2013/14. Nationally, people with mental health difficulties are more likely to smoke, and this is also reflected in the Havering population. There are around 400 smoking related deaths per annum in the borough.

- High numbers of Havering residents are diagnosed with and die from cancer each year; due in part to the large older population. This will increase even further as the population continues to get older.

- Cancer survival rates are not improving and are worse than the national average

- Breast, bowel, and lung cancer are the most common cancers in women in Havering, while prostate, lung and bowel cancer are most common in men

- Around a third of deaths in Havering are caused by Cardiovascular Disease (CVD), a large proportion of which are deaths from Coronary Heart Disease and Strokes. However, overall, mortality from CVD in Havering is lower than the England average, but above the London average

- There are nearly twice as many male deaths from CVD in Havering as in women (which is also the case in London and England).

- Those who live in the less affluent areas of Havering are more likely to die from CVD, and those registered at GP practices in the most “deprived” areas of the borough a 55% more likely to have hypertension, 36% more likely to have congestive heart failure and 70% more likely to have coronary artery disease than those registered at GP practices in the least “deprived” areas.

**What we plan to do**

- Improve support and care coordination for people living with and beyond cancer.
- Maximise participation in screening programmes and health checks by identifying communities with low participation rates and taking targeted action in those communities
- Commission well-evidenced prevention programmes to tackle modifiable risk factors such as smoking, unhealthy diets and alcohol consumption

## Theme B: Better integrated support for people most at risk

Havering has large and growing population of vulnerable people and older people. As our older people population continues to grow, and so does the number of **"frail elderly"** residents in the borough, we are facing increasing demands on services. By better integrating services across the health and social care sectors, as well as the voluntary and community sector, we can improve service user experiences and outcomes and also secure better value for money.

**Vulnerable children**, such as those in care or with disabilities, also face particularly complex challenges. Physical and psychological ill-health tends to be more prevalent amongst looked after children and care leavers compared with their peers. It is therefore essential that all looked after children receive a comprehensive and holistic health assessment and annual reviews, and that looked after children and their carers are supported to lead healthy lives.

In January 2014, the Government confirmed that the Healthy Child Programme (HCP) (Universal / Universal Plus) for 0-5 year olds, which includes the commissioning of health visiting and family nurse partnership services, will transfer from NHS England to local government on 1 October 2015. This transfer marks the final park of the overall public health transfer (which saw wider public health functions transfer to local government from Primary Care Trusts in 2013) and will join up commissioning arrangements for 0-19 year olds (and up to 25 years for young people with Special Educational Needs and Disabilities). The transfer represents a unique opportunity to transform and integrate health, education, social care and wider Council led services in pursuit of improving outcomes for children and young people. The Health and Wellbeing Board will need to maintain a strategic overview of the transfer; ensure that there are appropriate governance and communications arrangements in place, and plan how best to meet the needs of the local population. Unlike the previous public health transfer, in this case it is only the commissioning responsibility that will transfer; not the workforce. Health visitors and family nurses will continue to be employed by their provider organisations however, across the partnership, we will need to consider the workforce profile and the skills mix needed to support the programme.

Having successfully reduced the incidence of delayed transfers of care, more work now needs to be done across the whole system to **reduce the number of admissions and the average length of stay in hospital**. 60% of deaths in the borough occur in hospital, often following unplanned and prolonged hospital admissions. Hospital admissions are costly to the health service and disrupt the lives of those affected, including family and friends. Long and frequent hospital stays also reduce people's confidence to manage at home in the future. Emergency admissions account for nearly two thirds of hospital bed days in England and are costly compared to other types of care. Some of these admissions could be avoided. The Havering Health and Wellbeing Board is therefore keen to reduce unnecessary

and unplanned hospital admissions, particularly where these relate to ill health or injury that could have been avoided, and / or individuals who are admitted to hospital on a frequent basis.

The Havering Health and Wellbeing Board's vision for whole system integrated care is based on what individuals, communities of interest and local organisations have told us is most important to them. Our aim is to provide people with new ways to access primary care, and to offer other innovative services which are designed around the needs of the patient in order to reduce acute admission and A&E attendance and also to improve the patient experience.

**What we want to see**

- Seamless, integrated and people-centred health and social care services delivered to Havering residents.
- Greater co-commissioning across the CCG and local authority, and also across Havering, Barking and Dagenham and Redbridge where appropriate.
- Effective co-commissioning and delivery of early years services, from pre-birth
- The introduction of joint assessments of health and social care needs; interoperability between health and social care systems and the holding of single case records across the health and social care sectors
- A vibrant primary care model
- Services shifted out of secondary care and into the community and primary care
- A reduction in avoidable time spent in hospital
- A higher proportion of older people living independently following discharge
- Improved physical, social and psychological health across the looked after children population

Our three priorities are to…….

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

Priority 6: Improve integrated care for children, young people and families most at risk

Priority 7: Reduce avoidable hospital and long term care home admissions

## Priority 5: Better integrated care for the "frail elderly" population

**What we know about Havering**

- There are 1,200 older people in the borough that have particularly complex health and social care needs.
- Approximately 19,500 Havering residents aged 65 or older have a limiting long term illness
- 17,277 older people were estimated to be living alone in 2014 and this is predicted to rise to 20,590 by 2020.
- Havering experiences the second highest number of excess winter deaths in London. Between 2006 and 2009, there were an average of 137 winter deaths per annum involving a person aged 85+ in Havering and these deaths are expected to increase along with the age of the population.
- In 2014, 15,784 older people aged over 65 were estimated to be unable to manage at least one self care task on their own, and 19,248 were estimated to be unable to manage at least one domestic task (e.g. shopping, washing etc) on their own.

**What we plan to do**

- Work as a strategic partnership to design and deliver seamless, integrated and efficient care pathways for "frail elderly" people with care needs
- Maintain our collective commitment to the Frailty Academy.
- Enhance the independence and capability of individuals to manage their conditions at home
- Provide support within the community to people who have recently been discharged from hospital or who are at risk of admission / readmission.

## Priority 6: Improve integrated care for children, young people and families most at risk

**What we know about Havering**

- Of just over 30,000 families in Havering, it is estimated that nearly 400 of them 'families with multiple complex needs' and over 2,000 are 'barely coping'.
- The level of child poverty in Havering is better than the England average with 19.1% of children in Havering living in poverty as at March 2014. However in some wards (e.g. Gooshays, at 35.2%) the percentage of children living in poverty is above both the London (28.8%) and England (18.2%) average, and the proportion of children living in poverty in the borough has bucked London-wide trends by increasing over recent years. Havering is one of only two London boroughs in which the rate of child poverty has increased. This is a concern to the Health and Wellbeing Board as children in poverty are more likely to report a range of poor health outcomes.
- Between 1 April 2013 and 31 January 2014, domestic violence was a presenting factor in 10.9% of all initial contacts to children's social care and was the second highest reason for contacts progressing to a referral to children's social care (placed only behind physical abuse). Domestic violence also featured in 19.7% of Children in Need Plans and 16.4% of Child Protection Plans.
- As at the end of November 2014, there were 180 children from Havering on Child Protection Plans. This had increased from an average of 124 per month during 2013/14.
- As at the end of November 2014, there were 164 children on a Child in Need (CIN) Plan. This had reduced from a peak of 214 at the end of July 2014.
- As at the end of November 2014, there were 216 children looked after by the local authority. The numbers of LAC have been at their highest ever levels in the borough during 2014/15.
- At primary level, speech, language and communication difficulties are the most commonly identified type of special educational need (SEN), followed by moderate learning difficulties, then behaviour, emotional and social difficulties. At secondary level, moderate learning difficulties are more prevalent, followed by behaviour, emotional and social difficulties, then speech, language and communication needs. Special schools, meanwhile, have a very different profile, with most of their pupils having severe, moderate or profound and multiple learning difficulties.
- The number of children aged 5 – 10 with an emotional disorder is expected to rise by 26 between 2014 and 2017, split roughly equally between boys and girls.

**What we plan to do**

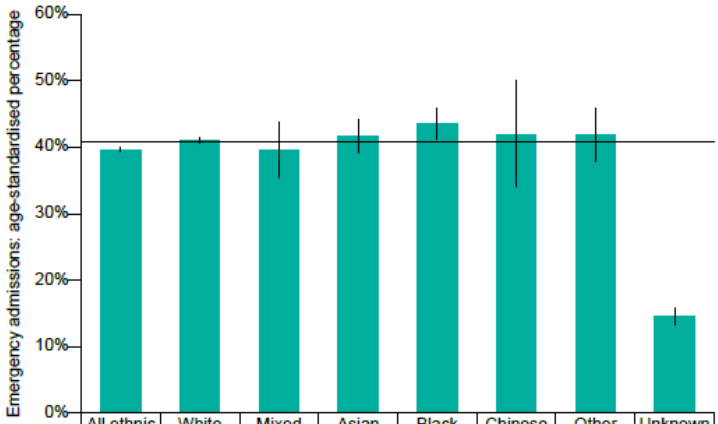
- Continue to provide intensive, bespoke support to families with multiple complex needs to avert the escalation of their difficulties.
- Reduce the numbers of children living in poverty in Havering
- Promote the physical, social and psychological health and wellbeing of children looked after by the local authority
- Work across the health and social care economy to put in place an effective Early Years Pathway from pre-birth
- Improve transitions from children's to adults' care packages for young people with disabilities.
- Improve access to high-quality therapies for children and young people.

## Priority 7: Reduce avoidable hospital and long term care home admissions

### What we know about Havering

- Approximately 60% of deaths in the Havering occur in hospital, often following unplanned and prolonged hospital admissions.
- Rates of emergency hospital admission in Havering are significantly lower than the average for England and London but are increasing. A&E attendance rates, meanwhile, have declined in recent years with a reduction of 12% overall between Q3 2012/13 and Q3 2013/14, due largely to the work of the Integrated Care Coalition.
- The main health conditions responsible for avoidable admissions in Havering are chronic obstructive pulmonary disease (16.5% of all avoidable admissions), influenza and pneumonia (15.1%) and dehydration and gastroenteritis (11.3%)
- There are pockets across the borough with particularly high rates of avoidable hospital admissions. 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
- There are wide variations between Havering GP practices in terms of avoidable hospital admissions, ranging from 7 per 1,000 population to 32 per 1,000 population
- Readmission rates in Havering have risen by more than 4% over the last 10 years, in line with national trends. However, when emergency readmissions are analysed by age, Havering has consistently had a significantly higher (worse) percentage of older people (aged 75+) who are readmitted to hospital in an emergency within 28 days of discharge, compared with England

Percentage of hospital admissions that were emergencies, by ethnic group




This chart shows the percentage of hospital admissions in 2012/13 that were emergencies for each ethnic group in this area. A high percentage of emergency admissions may reflect some patients not accessing or receiving the care most suited to managing their conditions. By comparing the percentage in each ethnic group in this area with that of the whole population of England (represented by the horizontal line) possible inequalities can be identified.

Havering

England average (all ethnic groups)

95% confidence interval

Figures based on small numbers of admissions have been suppressed to avoid any potential disclosure of information about individuals.

| All ethnic groups | White | Mixed | Asian | Black | Chinese | Other | Unknown | |
|---|---|---|---|---|---|---|---|---|
| 22,082 | 19,779 | 223 | 625 | 725 | 57 | 245 | 428 | Local number of emergency admissions |
| 39.7 | 41.0 | 39.5 | 41.6 | 43.5 | 41.9 | 41.8 | 14.5 | Local value |
| 40.8 | 41.3 | 40.8 | 45.4 | 45.0 | 37.0 | 46.5 | 30.3 | England value |

Havering Health Profile 2014

**What we are going to do**

- Continue to develop effective care pathways both in and out of hospital and primary care
- Improve access to primary care, including in community settings
- Continue to develop Intermediate Care services
- Develop an integrated health and social care commissioning function

## Theme C: Quality of services and patient experience

Ensuring that patients, 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. In Havering, we want all patients to have as positive an experience as possible from the health and social care services they receive. Services across the whole health and social care economy should be delivered efficiently, safely and sustainably.

The Havering Health and Wellbeing Board remains aware of the serious quality and patient safety concerns identified within some of the borough's providers. CQC reports identified specific concerns relating to BHRUT (the borough's major acute provider) and it was placed in special measures in December 2013. This meant that it had to make significant improvements in the way it provides patient care and operates as an organisation. The Trust now has a new leadership team in place and is working to a robust improvement plan – *Unlocking our Potential* - that members of the Health and Wellbeing Board were instrumental in developing. Patient satisfaction has improved, with the Trust's Friends and Family Test inpatient score for June 2014 reaching 69, compared with 43 in June 2013. But while improvements have been made since, there is still more that needs to be done, and the Health and Wellbeing Board continues to have a vital role in scrutinising, challenging and supporting BHRUT to continue to make progress and improvements to benefit patients and their families.

The Council commissions Healthwatch Havering to engage local people on the health issues that matter most to them and to ensure that the voices of local patients and residents are represented on the Health and Wellbeing Board, in order to inform the development and improvement of local health and social care services.

**What we want to see**

- Consistently high quality and safety of care in all health and social care services provided in the borough.
- CCG and social care commissioners commissioning and procuring jointly, with a focus on improving outcomes for individuals within our communities.
- Improved patient engagement
- Better communication of the activities of the Health and Wellbeing Board and its impact on local health and social care services

Our priority is to…….

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

## Priority 8: Improve the quality of services to ensure that patient experiences and long term health outcomes are the best they can be

**What we know about Havering**

- The borough has two major service providers, these being the Barking, Havering and Redbridge University Hospitals Trust (BHRUT) for acute hospital services and the North East London Foundation Trust (NELFT) for community services (such as district nursing and mental health services). Community and mental health services are provided in clinics and hospitals as well as in people's own homes.
- We are working in one of the eleven most challenged health economies in the country and with one of the most challenged hospital trusts in the country. While improvements have been made, there is still more needing to be done to improve quality of services.
- Havering's patient experience of primary care and out of hours services is in the bottom quartile of London CCGs, while our patient-to-GP ratio (the number of patients to every GP in the borough) is very high.
- GP practices in Havering generally see lower levels of patient satisfaction with their GP than in most other CCGs nationally, and issues of patient access persist in some practices.

**What we plan to do**

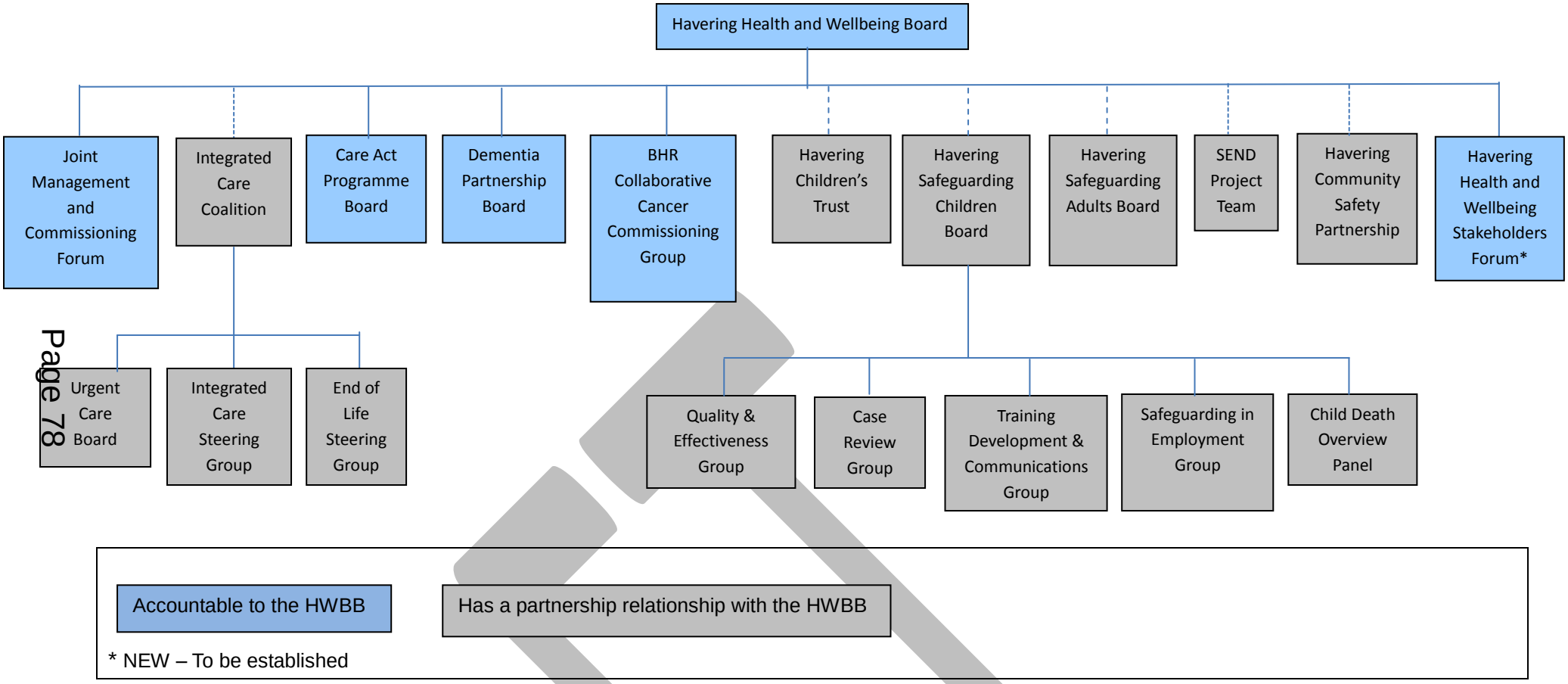
- Ensure that the CQC's findings and recommendations for improvements in the quality of care and patient safety at Queen's Hospital continue to be addressed.
- Work across the health and social care sectors to make the best use of our combined estates and assets.
- Ensure that patient and public engagement actively informs service improvement.
- Improve communication of the activities of the Health and Wellbeing Board and its impact on local health and social care services.

# Appendix 1: Membership and Governance of the Havering Health and Wellbeing Board

## Membership of the Health and Wellbeing Board

| Name | Designation | Organisation |
|---|---|---|
| Cllr. Steven Kelly (Chair) | Elected Member | London Borough of Havering |
| Cllr. Meg Davis | Cabinet Member for Children and Learning | London Borough of Havering |
| Cllr. Wendy Brice-Thompson | Cabinet Member for Health | London Borough Of Havering |
| Cheryl Coppell | Chief Executive | London Borough of Havering |
| Joy Hollister | Group Director (Children, Adults and Housing) | London Borough of Havering |
| Andrew Blake-Herbert | Group Director (Communities and Resources) | London Borough of Havering |
| Mark Ansell | Acting Director of Public Health | London Borough of Havering |
| Conor Burke | Chief Officer | Barking, Havering and Redbridge Clinical Commissioning Group |
| Dr. Atul Aggarwal | Chair | Havering Clinical Commissioning Group |
| Alan Steward | Chief Operating Officer | Havering Clinical Commissioning Group |
| Dr. Gurdev Saini | Clinical Director (Frail Elders) | Havering Clinical Commissioning Group |
| Anne-Marie Dean | Chair | Healthwatch Havering |
| John Atherton | Head of Assurance | NHS England |

# The Health and Wellbeing Board's Governance Structure



# Appendix 2: Glossary of Key Terms

Chronic Obstructive Pulmonary Disease (COPD) – A collection of lung diseases including chronic bronchitis, emphysema and Chronic Obstructive Airways Disease.

Community Health and Social Care Service (CHSCS) – A team developed through the reconfiguration of relevant NELFT services (community nursing, Integrated Case Management, therapies, and a mental health link worker) into locality based teams.

Community Learning Disabilities Team (CLDT) – An integrated team, historically governed through a Section 75 Agreement between the CCG, the local authority and NELFT, providing a range of care and support services. The NHS and local authority commission the CLDT, which in turn is responsible for commissioning services on behalf of the CCG and local authority to meet the needs of individuals (including services for informal carers).

Community Treatment Team (CTT) – An expanded service operating in Havering between 8am and 10pm, seven days a week. This aligns with peak attendances in A&E, in an effort to help relieve the pressure on accident and emergency units. The team provides short-term intensive care and support to individuals with a health and / or social care crisis to help support them at home rather than in hospital. The team includes both health and social care professionals, including doctors, nurses, occupational therapists, physiotherapists, social workers and support workers. The CTT aims to:

- Provide short term intensive care and support to people experiencing health and / or social care crisis, to help them to be cared for in their own home rather than in hospital;
- Support people to return home as soon as possible following an acute or community inpatient stay, where this is appropriate, and
- Provide a single point of access to intensive rehabilitation at home or in a bed in a community rehabilitation unit if necessary.

Frailty Academy – A virtual academy operating across Barking and Dagenham, Havering and Redbridge and comprising of clinicians and other staff from across health and social care as well as academics from University College London (UCL). Its aim is to ensure that the lessons of various approaches and initiatives are learned and used to inform the development of mainstream services.

Healthwatch Havering – The consumer local champion for health and social care services within the borough. It aims to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for individuals locally.

Healthy Child Programme (HCP) – A national public health programme based on best knowledge / evidence to achieve good outcomes for all children.

Integrated Care Coalition (ICC) – Brings together senior executive leaders within the Barking and Dagenham, Havering and Redbridge health and social care economy to support the

three Clinical Commissioning Groups and the three local authorities in commissioning integrated care and building a sustainable health and social care system. The ICC is responsible for developing recommendations for system wide integrated care for consideration by commissioners and the Health and Wellbeing Boards.

Integrated Care Steering Group (ICSG) – Co-ordinates (on behalf of the Integrated Care Coalition) the production of the five year strategic plan across the Barking, Havering and Redbridge health economy.

Integrated Case Management (ICM) – A model of practice which aims to ensure that patients with complex health and social care needs receive the right care, in the right place, at the right time. The ICM team in Havering includes a GP, a Community Matron, a District Nurse, a Social Care lead, a Care Liaison Officer and any other relevant staff needed in order to meet specific needs (e.g. from the mental health team).

Intensive Rehabilitation Service (IRS) – A team consisting of nurses, occupational therapy staff, physiotherapy staff and rehabilitation assistants, with access to a geriatrician as required via the Community Treatment Teams (see above). It aims to offer an alternative to admitting patients to an inpatient unit for rehabilitation by supporting people in their own homes where it is appropriate to do so. The in-home support provided is intensive and involves between one and four home visits each day, depending on the patient's needs. The service operates between 8am and 8om, seven days a week.

Joint Assessment and Discharge (JAD) team – Brings together the assessment and discharge teams across Barking and Dagenham, Havering and Redbridge into a single, integrated, ward based system, able to discharge to any of the three boroughs.

Multi-Agency Safeguarding Hub (MASH) – A co-located, multi-agency team working in a single, secure assessment and referral unit where protocols govern what information from each agency can be shared and how in order to ensure that the welfare of the individual is safeguarded and promoted. Information is gathered from a range of relevant agencies to inform the decision about what further action is required and which agency is best placed to lead this.

Nursing Home Scheme – A scheme designed to prevent unnecessary conveyances to hospital from nursing homes. As at May 2014, 31 nursing homes in Havering were signed up to the scheme.

Urgent Care Board (UCB) – Develops and delivers the improvement plan for urgent care

**Abbreviations**

A&E – Accident and Emergency Unit

BCF- Better Care Fund

BHRUT- Barking, Havering and Redbridge University Hospitals Trust

CAMHS- Child and Adolescent Mental Health Services

CCG- Clinical Commissioning Group

CHSCS – Community Health and Social Care Service

CIN – Child in Need

CLDT – Community Learning Disabilities Team

COPD – Chronic Obstructive Pulmonary Disease

CPP – Child Protection Plan

CQC- Care Quality Commission

CTT – Community Treatment Team

CVD- Cardiovascular Disease

DH – Department of Health

DTOC – Delayed transfers of care

FNP – Family Nurse Partnership

GP – General Practitioner

HCP – Healthy Child Programme

ICC – Integrated Care Coalition

ICM – Integrated Case Management

ICSG – Integrated Care Steering Group

IRS – Intensive Rehabilitation Service

JAD- Joint Assessment & Discharge Team

JCB – Joint Commissioning Board

JSNA- Joint Strategic Needs Assessment

LA – Local Authority

LAC – Looked After Child(ren)

LAS – London Ambulance Service

LBH – London Borough of Havering

LD – Learning Disability

LTC – Long Term Condition

MASH – Multi-Agency Safeguarding Hub

MARAC – Multi-Agency Risk Assessment Conference

NCMP – National Childhood Measurement Programme

NELFT- North East London Foundation Trust

NHS – National Health Service

NHSE – National Health Service England

PEF – Patient Engagement Forum

PHE – Public Health England

PPG – Practice Participation Group

SALT- Speech and language therapies

SEN – Special Education Need(s)

SEND – Special Educational Needs and Disabilities

UCB – Urgent Care Board

# Appendix 3: List of key partnership strategic documents

Havering Better Care Fund (BCF) Submission

Children and Young People's Plan 2014 - 2017

Havering Joint Dementia Strategy 2014 - 2017

Integrated Care Strategy

Child Poverty Strategy

London Borough of Havering's Corporate Plan

London Borough of Havering's DRAFT Corporate Parenting Strategy

London Borough of Havering's DRAFT Looked After Children (LAC) Strategy

London Borough of Havering's DRAFT Voluntary Sector Strategy

Havering Clinical Commissioning Group's Commissioning Strategic Plan 2014/15 – 2015/16

Barking and Dagenham, Havering and Redbridge Integrated Care Coalition Strategic Plan Final Submission (June 2014)

Unlocking our Potential (BHRUT's improvement plan)

Culture and Leisure Strategy

Arts Strategy

DRAFT Violence against Women and Girls Strategy

Community Safety Strategy

Housing Strategy

Joint Strategic Needs Assessment (JSNA)

## Appendix 4: Action Plan

TO BE INSERTED

Havering
LONDON BOROUGH

# HEALTH & WELLBEING BOARD

| | |
|---|---|
| **Subject Heading:** | Havering's Health and Wellbeing Strategy 2015 – 2018 |
| **Board Lead:** | Joy Hollister<br>Group Director – Children, Adults and Housing<br>London Borough Of Havering |
| **Report Author and contact details:** | Pippa Brent-Isherwood<br>Head of Policy and Performance<br>London Borough of Havering<br>phillipa.brent-isherwood@havering.gov.uk<br>01708 431950 |

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

- ☒ Priority 1: Early help for vulnerable people
- ☒ Priority 2: Improved identification and support for people with dementia
- ☒ Priority 3: Earlier detection of cancer
- ☒ Priority 4: Tackling obesity
- ☒ Priority 5: Better integrated care for the 'frail elderly' population
- ☒ Priority 6: Better integrated care for vulnerable children
- ☒ Priority 7: Reducing avoidable hospital admissions
- ☒ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

## SUMMARY

The Health and Wellbeing Board's first Health and Wellbeing Strategy expired in 2014. The Board has a statutory duty to produce and deliver a joint Health and Wellbeing Strategy and, as such, a new strategy is required to steer the work of the Board going forward.

An initial draft of the new strategy was considered by the Health and Wellbeing Board at its meeting in January 2015. Though the initial draft was broadly welcomed, members of the Board agreed to grant Board members an additional three weeks to review the draft strategy and make any further comments on it.

Further to discussion at the last Board meeting as well as additional feedback received since then, the final draft of the new strategy is now attached for the formal ratification of the Board at Appendix 1.

## RECOMMENDATIONS

1) That the Health and Wellbeing Board ratifies the draft Health and Wellbeing Strategy 2015 – 2018 (attached at Appendix 1).

2) That, subject to the approval of the draft strategy by the Board, members of the Health and Wellbeing Board work together outside of the meeting to finalise the associated action plan, in order that this may be approved at the March meeting of the Board.

## REPORT DETAIL

In light of discussions at the last Health and Wellbeing Board meeting, and additional feedback received since, the draft Health and Wellbeing Strategy 2015 – 2018 that was presented at that meeting has now been updated as follows:

- The focus on learning disabilities and dementia has been framed within the context of the wider mental health agenda, based on the findings of the JSNA Mental Health Chapter, which was recently approved for consultation. The links between mental health difficulties and other risk factors such as smoking and obesity have also been highlighted in the relevant sections of the strategy.

- Specific reference has been made to the transfer of the Health Child Programme (HCP) for 0-5 year olds from NHS England to local government from 1 October 2015.

- The document reflects the Health and Wellbeing Board's intention (expressed at its the last meeting) to maintain its commitment to the Frailty Academy.

- Data and needs analysis has been updated where more up-to-date data has become available. The Public Health service has indicated that it is able to provide further updates to some of the figures quoted in the draft strategy, and has undertaken to do so before the strategy is eventually published.

- A case study has been added to the document to demonstrate the benefits of integrated and personalised care in practice.

- The document is more explicit about why the strategy is currently focused more on care and support for frail elderly members of the community rather than on the wider prevention agenda. However, greater reference is also

made to the role of services outside of health and social care (for example, cultural and leisure services) in tackling the root causes of ill health and health inequalities.

- More detail has been added about the scale of the financial challenges facing the local health and social care economy.

The draft strategy attached for ratification at Appendix 1 reflects these changes.

A detailed action plan setting out exactly how the priorities and outcomes expressed in the strategy are to be achieved is currently in draft form but has some residual gaps to be filled in, in terms of lead officers, target timescales and performance targets etc. Subject to the approval of the draft Health and Wellbeing Strategy 2015 – 2018 (attached at Appendix 1), it is proposed to circulate the draft action plan to members of the Health and Wellbeing Board to finalise for approval at the March meeting of the Board.

## IMPLICATIONS AND RISKS

**Financial implications and risks:**

There are no direct financial implications or risks arising from this report. Implementation of the Health and Wellbeing Strategy will be funded from within existing resources.

There will be a performance by results mechanism linked to the metrics set out in the Better Care Fund.

As the Care Act represents such a fundamental reform to adult social care there will be financial implications to the local authority that are currently being modelled and are expected to be significant. The main areas of anticipated financial risk relate to self-funders, support to carers, income and young adults. There will also be significant infrastructure costs.

The Children and Families Act will also carry financial implications.

The Council's budgets are expected to reduce by up to £60m over four years from 2015/16. This is against a backdrop of increasing demand. As such, the Council's budget strategy plans to target services effectively to manage demand, with a strong focus on prevention and early intervention, in line with Government health and social care integration initiatives.

Implementation of the Care Act, Children and Families Act and BCF are being managed through work programmes in service areas, with appropriate governance in place. The outputs from the work streams are aligned with the overall budget strategy and the draft Health and Wellbeing Strategy attached at Appendix 1.

**Legal implications and risks:**

Health and Wellbeing Boards were established under the Health and Social Care Act 2012 to bring key leaders from the health and social care system together to improve the health and wellbeing of their local populations and to reduce health inequalities. The refreshed strategy attached at Appendix 1 reflects these aims, as well as a number of recent and future legislative changes impacting on the provision of health and social care services across the borough, most notably the Care Act 2014 and the Children and Families Act 2014.

**Human Resources implications and risks:**

The legislative changes and other reforms set out in the report and in the draft Health and Wellbeing Strategy will have significant implications for the shape of the health and social care workforce, due to a greater emphasis on working in a more integrated way to meet the needs of service users and their carers more effectively.

Strategic work is being undertaken by senior management, key advisors and HR staff to plan for any required programmes of change that may need to be put in place within the Council and / or its partners. Any future changes will be undertaken in line with the HR policies of the relevant organisations.

**Equalities implications and risks:**

The refresh of the Health and Wellbeing Strategy has been informed by the local population's needs as identified in the Joint Strategic Needs Analysis (JSNA) and will be supported by a revised Equality Impact Assessment. Individual schemes and initiatives arising from the Health and Wellbeing Strategy will be subject to separate Equality Impact Assessments and contract specifications will incorporate the relevant equality and diversity considerations and requirements that will be monitored on a regular basis, to ensure compliance with the Public Sector Equality Duty and the Equality Act 2010.

It is envisaged that the refreshed strategy and action plan, along with the proposed arrangements for monitoring the delivery of this, will result in the Health and Wellbeing Board delivering more effective ways of responding to future demographic challenges in the delivery of health and social care services across Havering, such as the significant growth of both children / young people and the 65+ population in the borough, as well as the increasing ethnic minority population.

**BACKGROUND PAPERS**

- Joint Strategic Needs Assessment (JSNA)
- Havering's Better Care Fund (BCF) submission
- Havering Clinical Commissioning Group Commissioning Strategic Plan 2014/15 – 2015/16

- Barking and Dagenham, Havering and Redbridge Integrated Care Coalition Strategic Plan (June 2014)
- Integrated Care Strategy
- Havering Joint Dementia Strategy 2014 - 2017
- Children and Young People's Plan 2014 - 2017

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