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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD
AGENDA

1.00 pm	Wednesday, 20 July 2016	Committee Room 3B - Town Hall

Members: 16, Quorum: 9

BOARD MEMBERS:

Elected Members:	Cllr Wendy Brice-Thompson (Chairman) Cllr Gillian Ford Cllr Roger Ramsey Cllr Robert Benham
Officers of the Council:	Dr Susan Milner, Interim Director of Public Health Andrew Blake-Herbert, Chief Executive Tim Aldridge, Director of Children's Services Barbara Nicholls, Director of Adult Services
Havering Clinical Commissioning Group:	Dr Atul Aggarwal, Chair, Havering Clinical Commissioning Group (CCG) Dr Gurdev Saini, Board Member Havering CCG Conor Burke, Accountable Officer,Barking & Dagenham, Havering and Redbridge CCGs Alan Steward, Chief Operating Officer, Havering CCG
Other Organisations:	Anne-Marie Dean, Healthwatch Havering Matthew Hopkins, BHRUT Ceri Jacobs, NHS England Jacqui Van Rossum, NELFT

For information about the meeting please contact:
Anthony Clements 01708 433065
anthony.clements@onesource.co.uk

What is the Health and Wellbeing Board?

Havering's Health and Wellbeing Board (HWB) is a Committee of the Council on which both the Council and local NHS and other bodies are represented. The Board works towards ensuring people in Havering have services of the highest quality which promote their health and wellbeing and to narrow inequalities and improve outcomes for local residents. It will achieve this by coordinating the local NHS, social care, children's services and public health to develop greater integrated working to make the best use of resources collectively available.

What does the Health and Wellbeing Board do?

As of April 2013, Havering's HWB is responsible for the following key functions:

- Championing the local vision for health improvement, prevention / early intervention, integration and system reform
- Tackling health inequalities
- Using the Joint Strategic Needs Assessment (JSNA)and other evidence to determine priorities
- Developing a Joint Health and Wellbeing Strategy (JHWS)
- Ensuring patients, service users and the public are engaged in improving health and wellbeing
- Monitoring the impact of its work on the local community by considering annual reports and performance information

1. WELCOME AND INTRODUCTIONS

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.

Councillor Brice-Thompson

Start time: 13.00

2. APOLOGIES FOR ABSENCE

(If any) – receive.

3. DISCLOSURE OF INTERESTS

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

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

4. MINUTES OF LAST MEETING AND MATTERS ARISING (NOT ON ACTION LOG OR AGENDA) (Pages 1 - 8)

To approve as a correct record the minutes of the Board held on 11 May 2016 (attached) and to authorise the Chairman to sign them. To also consider any matters arising not on action log or agenda.

Councillor Brice-Thompson.

Start time: 13.05

5. ACTION LOG (Pages 9 - 12)

To consider the Board's Action Log (attached).

Councillor Brice-Thompson.

Start time: 13.10

6. DELIVERING THE NHS FIVE YEAR FORWARD VIEW: DEVELOPMENT OF THE NORTH EAST LONDON SUSTAINABILITY AND TRANSFORMATION PLAN (Pages 13 - 24)

Report attached.

Conor Burke

Start time: 13.15

7. THE STRATEGIC OUTLINE CASE FOR THE ACO (Pages 25 - 34)

Report attached.

Conor Burke/Andrew Blake-Herbert

Start time: 13.30

8. JSNA PROGRAMME UPDATE (Pages 35 - 86)

Report attached.

Sue Milner

Start time: 13.50

9. DEMAND MANAGEMENT STRATEGY: CASE STUDY - SOCIAL ISOLATION (Pages 87 - 92)

Report attached.

John Green

Start time: 14.15

10. LAUNCH OF FACE TO FACE INTERVENTION (WORKING WITH CHILDREN IN SOCIAL CARE) (Pages 93 - 98)

Report attached.

Tim Aldridge

Start time: 14.30

11. FORWARD PLAN (to be tabled)

Sue Milner

Start time: 14.45

12. DATE OF NEXT HEALTH AND WELLBEING BOARD MEETING

21 September 2016

(Meeting close time – 15.00).

13.

MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD
Committee Room 3A - Town Hall
11 May 2016 (1.00 - 2.50 pm)

Present:

Board Members present:

Councillor Wendy Brice-Thompson, Cabinet Member, Adult Social Services and Health (Chair) **(WBT)**
Councillor Roger Ramsey, Leader of the Council **(RR)**
Councillor Gillian Ford (GF)
Isobel Cattermole, Deputy Chief Executive, Children's, Adults and Housing, LBH **(IC)**
Elaine Greenway, Acting Consultant in Public Health, LBH (substituting for Sue Milner) **(EG)**
Dr Gurdev Saini, Clinical Director, Havering CCG **(GS)**
Anne Marie Dean, Havering Healthwatch **(AMD)**
Tom Travers, Chief Financial Officer, BHR CCGs (substituting for Conor Burke) **(TT)**

Also Present:
Phillipa Brent-Isherwood, Head of Business and Performance **(PBI)**
Jacqui Lindo, Consultant in Public Health, LBH **(JL)** (part of meeting)
Barbara Nicholls, Assistant Director, Adult Services, LBH (BN)
Anthony Clements, Principal Committee Officer, LBH (minutes) **(AC)**

All decisions were taken with no votes against.

54 **WELCOME AND INTRODUCTIONS**

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

55 **APOLOGIES FOR ABSENCE**

Apologies were received from Cheryl Coppell and Sue Milner (Elaine Greenway, Acting Consultant in Public Health substituting) London Borough of Havering, Atul Aggarwal and Alan Steward, Havering CCG and Conor Burke, BHR CCGs (Tom Travers – Chief Finance Officer substituting).

56 **DISCLOSURE OF INTERESTS**

There were no disclosures of interest.

57 MINUTES OF LAST MEETING AND MATTERS ARISING (NOT ON ACTION LOG OR AGENDA)

The minutes of the meeting held on 23 March 2016 were agreed as a correct record and signed by the Chairman. There were no matters arising not covered in the action log or elsewhere on the agenda.

58 ACTION LOG

The Better Care Fund plan had now been e-mailed to Board members for comment.

An update on the outcome of the consultation on reconfiguration of sexual health services would be brought to the next meeting of the Board.

IC confirmed that good progress had been made on health assessments for Looked After Children. All annual reviews were now complete and the formal agreement between CCG and NELFT also included pre-adoption health assessments for all Looked After Children. It was believed that the formal agreement had yet to be signed and IC raised concerns if this had not been done. **ACTION:** TT would check if an agreement had now been signed and would forward a copy of the signed agreement to the Board as soon as possible.

59 DRAFT PRIMARY CARE HEALTH CARE STRATEGY

TT explained that the document had been developed by the Primary Care Transformation Board and focussed on provider development over the first year. The strategy would then move towards place-based commissioning.

The first phase of the strategy aimed to strengthen capability to respond to planned care issues. It was wished that primary care would be the foundation for a locality based model.

It was confirmed that a London-wide workforce stream was looking at issues of recruitment and retention. There were already cluster GP localities in Havering and some of these would be used to pilot the new structure. Some self-determination would be given under the new structure regarding the type of services offered in each locality. Positive levers would be used to show to GPs the benefits of working at cluster level.

Patients would still go to their existing GP surgery under the new model. Over time, estate issues could mean a need to co-locate surgeries but TT emphasised that consultation would be carried out in these instances. TT agreed that patients should be communicated with effectively. The strategy aimed to rebuild the capacity and robustness of primary care in order to

offer better alternatives to A & E. Councillor Ramsey suggested that the Council's e-mail list could be used to communicate details about alternatives to A & E.

It was noted that nearly 1,000 people had recently gone through the A & E units at Queen's and King George within a 24 hour period. IC felt that a culture change was needed in people's behaviour as well as a full communication re alternatives to A & E.

GS confirmed that the CCG would communicate if e.g. a practice was moving but felt it was also important not to overload the public. He felt that very simple language should be used in any communications. He added that GPs now had a culture of working with other practices and could see the advantages of e.g. offering minor surgery in a locality. He felt that there would be a move to larger, more locality based GP groups in the future.

Most GP IT systems were able to talk to each other but GS felt it was important that systems could also be linked to services such as end of life care and social care. Funding would be an issue with this work but care records could now be accessed by staff at the Hospital Trusts. TT added that IT was a common thread through the CCG transformation work and there had been investment in GP IT. It was believed that the bid for investment in IT via the Vanguard programme was not now likely to be successful.

AMD felt that the strategy was broad and that a detailed operational plan for Havering should be brought to the Board. Targets in the strategy also needed to be more robust. Healthwatch Havering had carried out a survey with residents which indicated that people did not know where to go for medical help when their GP was closed. GS felt it was important that any changes to services were in place before they were publicised.

GPs had been informed of the plans at the last CCG members' meeting and had been assured that single handed practices would not disappear under the proposals. The strategy would be piloted in two areas and TT felt it would take approximately two and a half years for the strategy to be fully implemented.

60 **HWB TERMS OF REFERENCE FOR SIGN OFF**

It was agreed that the words 'to build strong and effective partnerships' be added to the section on why the Board had been set up. It was also agreed

that consideration of housing be included. It was hoped that BHRUT and NELFT would be represented at the next meeting of the Board.

It was **AGREED** that, subject to the amendments shown above, the Chairman be authorised to sign off the Board's terms of reference.

PBI added that it was necessary to decide whether the Children's Trust was still needed. **ACTION:** PBI would discuss this with IC.

61 OUTLINE OF REFRESHED JHWS

EG summarised the proposals for the annual refresh of the JHWS, and confirmed that, once the strategy had been agreed, a detailed action plan and indicators would be developed. The strategy listed reframed priorities as being primary prevention, early identification and intervention,, that the right services were provided in the right place at the right time, and ensuring a good quality of service and user experience.

A number of workstreams had been identified as system enablers, including IT.. GF suggested that specific reference be made in the strategy to end of life care. Officers would also consider inclusion of self-care as an aspect of planned care.. TT would supply some wording on this issue.

It was suggested that reference should also be made to current financial challenges and the importance of demand management and getting best value for money..

It was **AGREED** that the amendments suggested above be made and that a final draft of the strategy be brought to the July meeting of the Board.

62 ASC LOCAL ACCOUNT

BN explained that the account showed the areas where Adult Social Care had achieved and where it was felt more work was needed. The final document would be published on the Council's website. It was noted that paragraph 1.1 should say 2013/14 rather than as stated.

There had been rising demand for adult social care services with increasing numbers of people in Havering aged over 65 and over 85. There were also major financial challenges for the Council and its partners with the Government funding formula not being advantageous to Havering. Members wished to retain front line services.

Examples of good practice included the integrated Multi-Agency Safeguarding Hub which had been nominated for a MJ Achievement Award and the work of the Dementia Action Alliance which was recognised as

good practice. The work of the Health and Wellbeing Board had also been shortlisted for the APSE awards. There was also now better communication with social care providers with the Council checking for example that providers were paying the national living wage to staff.

Challenges included the low take-up of direct payments and work was in progress concerning improving the information and advice offered. Safeguarding work was also a priority as was ensuring that accommodation was correct, for example the provision of extra care housing for older people. A new programme had also started to use community workers to address the triggers for social isolation.

The Board **NOTED** the ASC Local Account 2015 prior to publication.

63 PLACE OF SAFETY REPORT

BN explained that consultation was currently in progress on the place of safety issue which applied to people needing assessment and detention under the Mental Health Act 1983. It was wished to take people to a health based setting for this rather than to a police station.

A total of 107 people had been detained in Havering under the Act in 2015/16 although none had been detained in a police station in the last year. The length of stay in a place of safety often depended on the availability of doctors but could be up to 7-8 hours. The primary place of safety used was Goodmayes Hospital and no more than two people from Havering per week were expected to be detained there. The hospital had recently undergone an inspection. Alternative places of safety used were the A & E departments at Queen's and King George Hospitals. It was believed that young people presenting with mental health issues at A & E were taken to a side room of the main unit for assessment etc.

The Board **AGREED** that any further comments on the draft guidance should be forwarded to BN.

64 CLINICAL GOVERNANCE ASSURANCE REPORT

JL explained that most clinical governance work for public health in the last year had been around agreeing processes with providers of clinical services.There had not been any serious incidents in the last year.

It was clarified that, under paragraph 6.14 of the governance policy, information from the Care Quality Commission was also analysed and disseminated. In terms of monitoring of quality, staffing levels were considered in the policy but it was felt that staff turnover was an important key indicator.

The Board **NOTED** the report.

65 FORWARD PLAN

It was agreed that past meetings no longer needed to be shown on the Forward Plan.

It was expected that the ACO/STP update would be available for the July meeting of the Board. The item on demand management strategy would include a case study on social isolation and it was suggested that a second case study could also be presented on the MASH reconfiguration.

The draft STP business case would be e-mailed to the Board for comment. BN and Keith Cheeseman were happy to meet with members of the Board to discuss the plan in more detail.

The agendas for future meetings would be informed by the content of the confirmed Health and Wellbeing Board Strategy. The SEN needs assessment could also be brought to the July meeting.

The Board **AGREED** the forward plan.

66 URGENT BUSINESS

IC briefed the Board on the joint targeted area inspections of provision for young people with disabilities or special educational needs. These would include the Council, police, the probation service and health partners. Lead responsibility for the inspection would be taken by the three local CCGs.

Pilots for the inspections had now been completed. The inspection would be area-led and a stretching process where the perceptions of services held by the child and parents would be key. There was one week's notice given of an inspection and IC would circulate an extract of the inspection handbook.

67 **DATE OF NEXT MEETING**

The next meeting would be held on Wednesday 20 July at 1 pm at Havering Town Hall, committee room 3B.

Chairman

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Health and Wellbeing Board Action Log

No.	Date Raised	Board Member Action Owner	Non-Board Member Action Owner	Action	Date for completion	RAG rating	Comments
15.3	11-Nov-15	Alan Steward	Clare Burns	Alan to provide electronic copies of the CCG's commissioning Intentions for children and the children's equipment plan to Sue for circulation to the HWB.	Mar-16		Mar 16: completed but item to be left on action log
16.7	23 Mar 16	Isobel Cattermole	John Green	Update on progress of Transforming Care Partnership to be given to the Board	20 July 16		
16.9	23 Mar 16	Susan Milner		Havering Sexual Health Services reconfiguration: SM to prepare appropriate Executive Decision form for Councillor Brice-Thompson and bring an update on the outcomes of the consultation to future meetings of the Board.	20 July 16		
16.12	May 16	Alan Steward Susan Milner	Tom Travers	Check that the formal agreement between CCG and NELFT for health assessments for Looked After Children and pre-adoption has been signed by both parties. Thereafter, AS/TT to send a copy of the signed agreement to the Board as soon as possible via SM SM to forward to the Board.	ASAP (before July Board meeting)		

No.	Date Raised	Board Member Action Owner	Non-Board Member Action Owner	Action	Date for completion	RAG rating	Comments
16.13	May 16	Susan Milner		To prepare for Chairman's signature final version of the Terms of Reference that takes into account amendments agreed at May Board meeting.	31 May 16		
16.14	May 16	Isobel Cattermole	Pippa Brent-Isherwood	Following the agreed changes having been made to HWB Terms of Reference, to consider/recommend whether a Children's Trust is still needed.	20 July 16		
16.15	May 16	Susan Milner		To produce final draft of a refreshed Joint Health and Wellbeing Strategy, incorporating proposals presented to the May Board and additional content as agreed during meeting.	20 July 16		
16.16	May 16	All		All Board members to submit to Barbara Nicholls directly their comments on draft guidance relating to Place of Safety.	End May 16		

No.	Date Raised	Board Member Action Owner	Non-Board Member Action Owner	Action	Date for completion	RAG rating	Comments
16.17	May 16	Susan Milner All All	Barbara Nicholls / Keith Cheeseman	When available, the draft STP business case to be emailed to the Board for comment via SM. Timescales were not known at the time of the May meeting, although final submission needs to be made by 30 June. Therefore drafts will be provided to HWB members as soon as available. Board members to send comments direct to Barbara Nicholls. Board members wishing to discuss the plan in more detail to contact Barbara Nicholls/Keith Cheesman.	As soon as possible		

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	**Update on North East London Sustainability and Transformation Plan**
Board Lead:	**Conor Burke, Accountable Officer, Barking & Dagenham, Havering and Redbridge CCGs**
Report Author and contact details:	**Helena Pugh,** Local Authority Engagement Lead, NEL STP 020 3816 3813 nel.stp@towerhamletsccg.nhs.uk

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 provides an update to the Board on the development of the north east London Sustainability and Transformation Plan (known as the NEL STP). While the mandate for the STP development and sign off lies with health partners, we are working closely with local authorities to develop the approach to sustainability and transformation as we recognise that their involvement is central to the success of our ambitious plans to develop truly person-centred and integrated health and social care services. Appendix 1 provides an update on the plan's development including the draft vision, priorities and enablers which have been identified to support the work of the STP. As part of the STP development, several workshops are being held with key stakeholders to ensure their perspectives are reflected and woven into the STP.

A draft 'checkpoint' STP was submitted to NHS England on 30 June 2016, and further work is continuing to develop the plan in more detail. Additional updates will be presented to the Board as they become available.

For Barking & Dagenham, Havering and Redbridge, the detail of the local contribution to the Sustainability and Transformation Plan for north east London will be the propositions developed through the established programme to develop a business case for an Accountable Care Organisation.

N.B. On 30 June 2016 we submitted a draft STP to NHS England. Following further discussions with NHS England regarding our draft submission, due to take place on 14 July, we will be developing and sharing with our stakeholders a summary of the draft NEL STP. This summary document will be used to facilitate meaningful engagement on the NEL STP over the coming months, enabling us to gather feedback, test our ideas and strengthen our STP. For more information go to http://www.nelstp.org.uk or email nel.stp@towerhamletsccg.nhs.uk

RECOMMENDATIONS

The Havering Health and Wellbeing Board is recommended to:

(i) Discuss the approach set out in Appendix 1 covering the vision, draft priorities and enablers which have been identified to support the work

(ii) Provide feedback to the NEL STP Team

No formal decisions are required arising from this report.

REPORT DETAIL

1. Background

1.1. In December 2015 NHS England planning guidance required health and care systems across the country to work together to develop sustainability and transformation plans (STPs) for accelerating the implementation of the NHS Five Year Forward View (5YFV). England has been divided into 44 areas (known as footprints); Havering is part of the north east London footprint. STPs are place-based, five year plans built around the needs of local populations. Further guidance was issued on 19 May which sets out details of the requirements for 30 June. The guidance states that the draft STP will be seen as a 'checkpoint' and does not have to be formally signed off prior to submission; it will form the basis of a local conversation with NHS England in July. Further work will continue beyond this to develop the plan in more detail.

1.2. For Havering, the work to develop the detail underpinning the STP is being taken forward jointly with Barking & Dagenham and Redbridge through the development of the business case for an Accountable Care Organisation. The issues that any ACO would need to address in order to achieve improved outcomes from health and social care, in the context of a financially sustainable health economy, will be reflected in the contributions from Barking & Dagenham, Havering and Redbridge to the NEL STP.

2. Proposal

2.1 Appendix 1 provides an update on the progress towards developing the NEL STP, covering the draft vision, priorities and enablers which have been identified to support the work.

2.2 Locally there has been significant engagement activity to bring a range of perspectives and priorities into an emerging overall approach to inform the development both of the NEL STP and the ACO business case including:

- Workshops for clinicians to develop the priorities for clinical improvement
- Local authority workshops that have sought to expand a wider vision for population health improvement and links between health impact, worklessness, welfare and housing
- Substantial work to ensure a developed locality model that can form the basis for the future operating model for accountable care across Barking & Dagenham, Havering and Redbridge
- Two voluntary sector workshops to expand the range of voices informing the development of the potential ACO proposition
- Regular meetings of senior finance representatives of the constituent organisations, facilitated by PwC, in order to ensure that the emerging financial model is robust, both in terms of the challenge and the activities that can close the gap

2.3 A telephone survey of 1,000 people from each of the three boroughs has been completed and the first cut of the results are being reviewed to see how they shape and refine the vision for local health and social care services. Additionally, a staff survey received 746 responses. This is providing useful information to guide thinking about the future model of services.

3. Engagement

3.1 The involvement of patients, staff and communities is crucial to the development of the STP. We want it to be based on the needs of local patients and communities and command the support of clinicians, staff and wider partners. Where possible, we will build on existing relationships, particularly through health and wellbeing boards and patient panels and forums.

3.2 In addition, we are taking account of recent public engagement on the transformation programmes outlined above and where relevant the outputs are being fed into the STP process; this will ensure that the views of residents from each local authority area are incorporated into the draft submission. A specific session was also held for Healthwatch and patient engagement forum chairs to discuss the STP and how they would like to be engaged.

4. Financial considerations

4.1 The NEL STP will include activities to address current financial challenges across the health and social care economy. The ambition is to ensure that all NHS organisations are able to achieve financial balance by the end of the five year period of the plan.

5. Legal considerations

5.1 The NEL STP Board is developing a plan as stipulated by the NHS England guidance.

6. Equalities considerations

6.1 The NHS guidance states that the STP is required to meet the meet the health and wellbeing needs of its population. To ensure this a detailed Public Health profile of the NEL population was carried out in March 2016 to identify the local health and wellbeing challenges. The profile shows that:

- There is significant deprivation (five of the eight STP boroughs are in the worst IMD quintile); estimates suggest differentially high growth in ethnic groups at increased risk of some priority health conditions.
- There is a significant projected increase in population with projections of 6.1% (120,000) in five years and 17.7% (345,000) over 15 years. Estimates suggest differentially high growth in ethnic groups at increased risk of some priority health conditions.
- There is an increased risk of mortality among people with diabetes in NEL and an increasing 'at risk' population. The percentage of people with Type 1 and Type 2 diabetes who receive NICE-recommended care processes is poor. Primary care prescribing costs are high for endocrine conditions (which includes diabetes).
- NEL has higher rates of obesity among children starting primary school than the averages for England and London. All areas have cited this as a priority requiring system wide change across the NHS as well as local government.
- NEL has generally higher rates of physically inactive adults, and slightly lower than average proportions of the population eating 5-a-day.
- Cancer survival rates at year one are poorer than the England average and screening uptake rates below England average.

- Acute mental health indicators identify good average performance however concerns identified with levels of new psychosis presentation.
- With a rising older population continuing work towards early diagnosis of dementia and social management will remain a priority. Right Care analysis identified that for NEL rates of admission for people age 65+ with dementia are poor.

6.2 All of these challenges are linked to poverty, social exclusion, and vary by gender, age, ethnicity and sexuality. Equality impact assessment screenings will be conducted to identify where work needs to take place and where resources need to be targeted to ensure all protected groups gain maximum benefit from any changes proposed as part of the STP.

Appendices

Appendix 1: Delivering the NHS five year forward view: development of the north east London Sustainability and Transformation Plan

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BACKGROUND PAPERS

- NHS Five Year Forward View https://www.england.nhs.uk/ourwork/futurenhs/
- Guidance on submission of Sustainability and Transformation Plans https://www.england.nhs.uk/wp-content/uploads/2016/05/stp-submission-guidance-june.pdf

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Appendix 1: Delivering the NHS five year forward view: development of the north east London Sustainability and Transformation Plan

Closing the gaps: working together to deliver improved health and care for the people of north east London

Update for Havering Health and Wellbeing Board 6 July 2016

Background
Across north east London, the health and care system - clinical commissioning groups (CCGs), providers and local authorities are working together to produce a Sustainability and Transformation Plan (STP). This will set out how the NHS Five Year Forward View will be delivered: how local health and care services will transform and become sustainable, built around the needs of local people. The plan will describe how north east London (NEL) will:

- meet the health and wellbeing needs of its population
- improve and maintain the consistency and quality of care for our population
- close the financial gap.

The STP will act as an 'umbrella' plan for change: holding underneath it a number of different specific local plans, to address certain challenges. Crucially, the NEL STP will be the single application and approval process for transformation funding for 2017/18 onwards. It will build on existing local transformation programmes and support their implementation. These are:

- Barking and Dagenham, Havering and Redbridge: devolution pilot (accountable care organisation)
- City and Hackney: Hackney devolution in part
- Newham, Tower Hamlets and Waltham Forest: Transforming Services Together programme
- The STP is also supporting the improvement programmes of our local hospitals, which aim to supports Barts Health NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust out of special measures

Additional guidance issued on 19 May set out further details of the requirements for submission of a **draft STP which will be seen as a 'checkpoint'** to form the basis of a local conversation with NHS England in July. The draft which did not have to be formally signed off prior to submission, was shared with NEL STP Board members for review and comment in the second week of June, and was submitted to NHS England on 30 June. Further work is continuing to develop the plan in more detail and engage with partners on it.

Developing the submission
A NEL STP Board and Partnership Steering Group meet regularly and are attended by both health and local authority colleagues. A meeting was held for local authority chief executives and updates are being shared at each health and wellbeing board.

Havering involvement in the development of the STP
Havering health and social care colleagues are actively engaged in the development of the STP including Conor Burke (Accountable Officer for Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups) and Mathew Hopkins (Chief Executive, BHRUT), and John Brouder (Chief Executive, NELFT) who are core members of the STP leadership team and members of the STP Board.

In addition:

- Conor Burke is the senior responsible officer overseeing the development of the urgent care and transformation workstreams.
- There is Havering LA, CCG and provider representation in portfolio workshops, system leadership events (held and planned).
- A meeting for local authority chief executives took place in June.
- Havering Council officers have been in regular contact with the STP team.
- A session was held with Healthwatch and patient engagement representatives including representatives from BHRUT.

Following Cheryl Coppell's retirement, Martin Esom (Chief Executive, LB Waltham Forest) is the Local Authority executive lead supporting the development of the NEL STP.

Draft vision and priorities
Throughout May the STP team held a series of meetings and workshops with key stakeholders including providers, on a variety of topics including prevention, workforce, estates, technology and specialised commissioning. Key priorities raised have been included in the June submission.

Draft vision
• To measurably improve health and wellbeing outcomes for the people of north east London and ensure sustainable health and social care services, built around the needs of local people. • To develop new models of care to achieve better outcomes for all; focussed on prevention and out of hospital care. • To work in partnership to commission, contract and deliver services efficiently and safely.

Emerging priorities
Based on the recent assessment of our health and wellbeing (Public Health Profile of NEL, March 2016), care and quality and the financial challenges we know that in order to create a better future for the NHS, and for local people to live long and healthy lives, we must make significant changes to how local people live, access care, and how care is delivered. Some of our initiatives will be delivered at local level, some at borough level, some across boroughs and others at NEL level.

For NEL the key emerging areas of focus which we think will be key to addressing our health and wellbeing, care and quality and financial challenges are:

Transformation: focussing on prevention and better care to ensure local people can start well, live well and age well. This will include: whole system prevention and early help; urgent care and mental health. We also see community resilience as having an essential part to play: looking at wider determinants of health (e.g. work, housing, education), to make sure residents have an improved quality of life and confidence to embrace a model of self-care in managing their health and care needs.

Productivity: ensuring our providers and local authorities operate in the most effective efficient way possible to deliver value, considering shared opportunities for development.

Specialised services: establishing sustainable specialised services for NEL, both for residents and those accessing services in NEL.

We have identified the following **enablers** to support our work:

- **Workforce**: recruitment and retention of a high calibre workforce, including making NEL a destination where people want to live and work, ensuring our workforce is effectively equipped to support delivery of new care models, caring for the workforce and reduction in use of bank/agency staff.
- **Infrastructure:** considering the best use of our estates across the system. We recognise that estates are a crucial enabler for our system-wide delivery model. We need to deliver care in modern, fit-for-purpose buildings and to meet the capacity challenges produced by a growing population. The STP will establish appropriate system leadership to ensure that people think about estates at an NEL level whilst building on local priorities.
- **Communications and engagement:** ensuring stakeholders, including local people, understand and support the need to deliver the Five Year Forward View.
- **Technology:** considering the best use of technology to support and enable people to most effectively manage their own health, care and support, and to ensure a technology infrastructure which supports delivery of new care models.
- **Finance:** access and use of non-recurrent fund to support delivery of the plan, delivering financial sustainability across NEL.

These initial discussions have led us to identify the six key priorities that we need to address as a system. A summary of the priorities and actions we are going to take to address them is set out in the table on pages 4-6 of this report.

To implement this vision we have developed a common framework that will be consistently adopted across the system through our new model of care programmes. This framework is built around our commitment to person centred, place based care for the population of NEL.

The focus throughout our work is to:

1. Promote prevention and personal and psychological wellbeing
2. Support people to access care closer to home
3. Improve quality of secondary care for those who need it

We welcome the HWB's views on the following:

- Does the vision capture what we need to achieve?
- Have we identified the right priorities/issues to focus on?
- How can we continue to work with you as we develop the STP?

Next steps

We expect to publish a summary of the STP during July and to hold public events across north east London over the summer, so we can discuss it with local people. This summary document will be used to facilitate meaningful engagement on the NEL STP over the coming months, enabling us to gather feedback, test our ideas and strengthen our STP.

For more information go to http://www.nelstp.org.uk or email nel.stp@towerhamletsccg.nhs.uk

DRAFT Summary of the actions we are going to take in response to each priority is set out below.

1. How can we ensure that we meet demand with appropriate capacity in NEL?

Issue

Our population is projected to grow at the fastest rate in London (18% over 15 years to reach 345,000 additional people) and this is putting pressure on all health and social care services. Adding to this, people in NEL are highly diverse. They also tend to be mobile, moving frequently between boroughs and are more dependent on A&E and acute services. If we do not make changes, we will need to meet this demand through building another hospital. We need to find a way to **channel the demand for services** through **maximising prevention**, supporting self-care and innovating in the way we deliver services. **It is important to note that even with successful prevention, NEL's high birth rate means that we may need to increase our physical infrastructure.**

Actions

To meet the fundamental challenge of our rapidly growing, changing and diverse population we are committed to:

- Shifting the way people using health services with a step up in prevention and self-care, equipping and empowering everyone, working across health and social care;
- Ensuring our urgent and emergency care system directs people to the right place first time, with integrated urgent care system, supported by proactive accessible primary care at its heart;
- Establishing effective ambulatory care on each hospital site, to ensure our beds are only for those who really need admission, so we don't need to build another hospital;
- Ensuring our hospitals are working together to be productive and efficient in delivering patient-centred care, with integrated flows across community and social care; and
- Ensuring our estates and workforce are aligned to support our population from cradle to grave.

2. How do we transform our delivery models to deliver better care close to home and high quality secondary care?

Issue

Transforming our delivery models is essential to empowering our residents to manage their own health and wellbeing and tackling the variations in quality, access and outcomes that exist in NEL. There are still **pockets of poor primary care quality and delivery.** We have a history of innovation with two of the five **devolution pilots (see appendix for detailed plans)** in London, an Urgent and Emergency Care (UEC) vanguard and a Multispecialty Community Provider (MCP) in development. However, we realise that these separate delivery models in each health economy will not deliver the benefits of transformative change. Crucially, we must **establish a system vision** that leverages community assets and ensures that residents are **proactive** in managing their own physical and mental health and receive coordinated, quality care in the right setting.

Actions

We have a unique opportunity to bring alive our system-wide vision for better care and wellbeing. We are already working together on a system-wide clinical strategy; this will build on our two devolution pilots in BHR and CH, and the TST programme (which is being implemented already in WEL). At its core we are committed to:

- Transforming primary care and addressing areas of poor quality/access, this will include offering accessible support from 8am to 8pm (seven days a week), with greater collaboration across practices to work to support localities, and address workforce challenges; and
- Addressing hospital services: streamlining outpatient pathways, delivering better urgent and emergency care, coordinating planned care/surgery, maternity choice and encouraging provider collaboration. This will allow us to meet all of our core standards including those relating to RTT and A&E, and enable the planned ED closure of King George Hospital.

3. How can we ensure that our providers remain sustainable?

Issue

Many of our health and social care providers face challenging financial circumstances; this is especially true with Bart's Health and BHRUT being in special measures. Both are currently being re-inspected to ensure that all necessary recommendations are embedded. Although our hospitals have made significant progress in creating productivity and improvement programmes, we recognise that medium term provider-led cost improvement plans cannot succeed in isolation: our providers need to collaborate on improving the costs of workforce, support services and diagnostics. Our challenge is to create a roadmap for viability that is supported at **a whole system level** with NEL coordinated support, transparency and accountability.

Actions

Our health and social care providers are committed to working together to achieve sustainability. Changes to our NEL service model will help to ensure fewer people either attend or are admitted to hospitals unnecessarily (and that those admitted can be treated and discharged more efficiently):

- We have significant cost improvement plans, which will be complimented by a strong collective focus on driving greater efficiency and productivity initiatives. This will happen both within and across our providers (e.g. procurement, clinical services, back office and bank/agency staff);
- The providers are now evaluating options for formal collaboration to help support their shared ambitions; and
- Devolution pilots in BHR and CH are actively exploring opportunities with local authorities, which will be set out in their forthcoming business cases.

4. How do we transform specialist services through collaborative working?

Issue

NEL residents are served by a number of high quality and world class specialist services; many of these are based within NEL, others across London. We have made progress recently in reconfiguring our local cancer and cardiac provision. However, the quality and sustainability of specialist services varies and we need to ensure that we realise the benefits of the reviews that have been carried out so far. Our local financial gap of £134m and the need for **collaboration** both present challenges to the transformation of our specialised services. We need to move to a more collaborative working structure in order to ensure high quality, accessible specialist services for our residents, both within and outside our region, and to realise our vision of becoming a truly world class destination for specialist services.

Actions

We will continue to deliver and commission world class specialist services. Our fundamental challenge is demand and associated costs are growing beyond proposed funding allocations. We recognise that this must be addressed by:

- Working collaboratively with NHS England and other STP footprints, as patients regularly move outside of NEL for specialised services; and
- Working across the whole patient pathway for our priority areas from prevention, diagnosis, treatment and follow up care –aiming to improve outcomes whilst delivering improved value for money.

5. How can we create a system-wide decision making model that enables placed based care and clearly involves key partner agencies?

Issue	Actions
Our plans for proactive, integrated, and coordinated care require changes to the way we work in developing system leadership and transforming commissioning. We have plans to **transform commissioning** with capitated budgets in WEL, a pooled health and social care budget in BHR and in CH. Across NEL, we recognise that creating accountable care systems with integrated care across sectors will require joining previously separate services and close working between local authorities and other partners; our plans for **devolution** (see appendix) have made significant progress in meeting the challenge of integration. New models of system leadership and commissioning that are driven by real time data, have the ability to support delivery models that are truly **people-centred and sustainable** in the long term.	We are committed to establishing robust leadership arrangements, based on agreed principles that provide clarity and direction to the NEL health and wellbeing system, and can drive through our plans. For us, involving local authority leaders is the only way to create a system which responds to our population's health and wellbeing needs. Building on our history of collaboration, we have agreed a set of principles which our leaders will be accountable for, including a commitment to making NEL-wide decisions as opposed to local decisions whenever appropriate. This will help us to deliver the scale of change required at pace to deliver place-based care for our population.

6. How do we maximise the use of our infrastructure so that it supports our vision (and plans owned at a NEL level)?

Issue	Actions
Delivering new models of primary and secondary care at scale will require modern, fit-for-purpose and cost-effective infrastructure. Currently, our workforce model is outdated as are many of our buildings; Whipps Cross, for example, requires £80 million of critical maintenance. This issue is compounded by the fact that some providers face significant financial pressures stemming from around **£53m remaining excess PFI cost**. Some assets will require significant investment; others will need to be sold. The benefits from sale of resources will be reinvested in the NEL health and social systems. **Devolution** will be helpful in supporting this vision. **Coordinating and owning a plan** for infrastructure and estates at a NEL level will be challenging; **we need to develop approaches to risk and gain share that support our vision.**	Infrastructure is a crucial enabler for our system-wide delivery model. We need to deliver care in modern, fit for purpose buildings and to meet the capacity challenges produced by a growing population. We are now working on a common estates strategy which will identify priorities for FY16/17 and beyond. This will contain a single NEL plan for investment and disposals, utilisation and productivity and managing PFI, with a key principle of investing any proceeds from disposals in delivering the STP vision.

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	**Devolution through an Accountable Care Organisation in Barking & Dagenham, Havering, and Redbridge**
Board Lead:	Andrew Blake-Herbert, Conor Burke
Report Author and contact details:	Keith Cheesman Interim Head of Integration (Adult Services) London Borough of Havering Keith.Cheesman@havering.gov.uk 01708 433742

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 Barking, Havering and Redbridge health and wellbeing economy faces an unprecedented set of challenges between now and 2021.

"Without a new service model, demand for services will increase, we won't see sustained improvements in people's health and wellbeing, and service user experience will deteriorate. Outcomes will be poor, our providers will struggle to recruit and retain good staff and may fail to meet core standards. The situation may get worse if local authorities are forced to make substantial cuts to services as their government grant falls.

"If we deliver services in the same way that we do today, without achieving any efficiencies, expenditure is forecast to exceed income by £614 million. One simple fact remains; even including all of our current efficiency plans, there is no sight of bridging either the historic or forecast future financial gap without very radical transformation. This transformation is essential to set in motion the sustainable health and wellbeing improvements that our communities badly need.

"Doing nothing is simply not an option. Given the scale of these challenges, our only credible plan is to pursue full integration through an ACO."

Further to previous updates, the attached summary document of the Strategic Outline Case sets out the principles developed so far and begins to set out the case for an Accountable Care Organisation as a viable form for future integrated health and social care delivery across Barking & Dagenham, Havering & Redbridge.

RECOMMENDATIONS

Members of the Health and Wellbeing Board are recommended to note the progress made on developing the business case, and to provide comments on the proposal and the expected sign-off process

REPORT DETAIL

Over the past six months, nine organisations across Barking & Dagenham, Havering and Redbridge (BHR) have worked together to develop a strategic outline case for the development of an Accountable Care Organisation (ACO).

The appended summary of the draft case provides a high level distillation of the draft case, setting out the key elements of the current situation, the challenges for the BHR health and care system and the core plans to manage these. Also included are the asks of national bodies that will support the delivery of the plans. This summary was submitted as an appendix to the North East London Sustainability and Transformation Plan, included to demonstrate how the local plan is embedded within, and pivotal to, the success of the STP.

NEXT STEPS

Work is ongoing to complete the plan for submission at the end of July 2016. After that, there will be a period of briefing and engagement on the detailed case.

All signatories to the plan will then need to take the proposals through their normal decision making processes. It is expected that this will be coordinated through each of the three Boroughs to ensure alignment of timing.

Currently, it is expected that Health & Wellbeing Board will receive the full case for formal review in September, and decision made through CCG Governing Body, Provider Trust Boards and Havering Council's Cabinet in October.

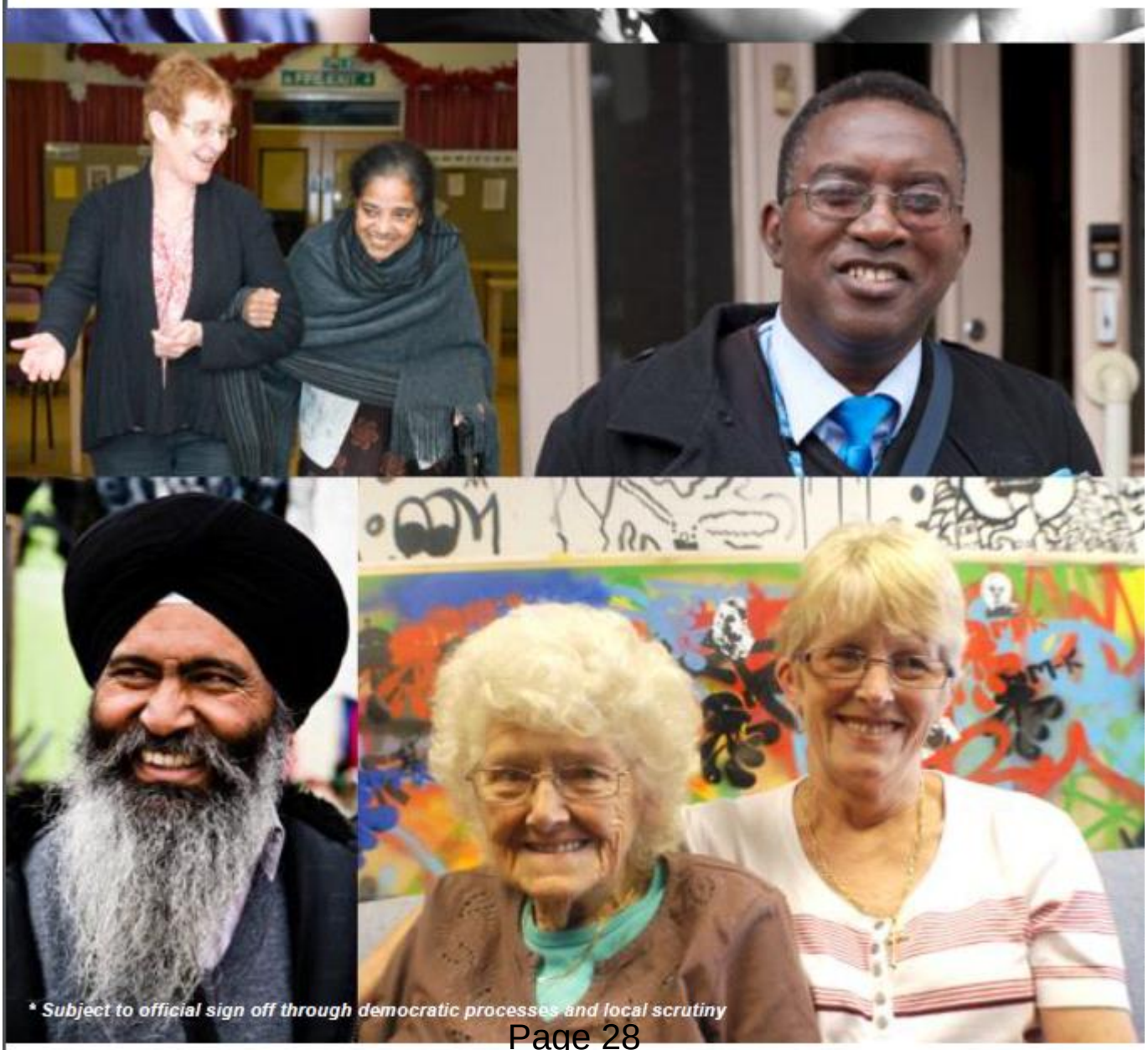
BACKGROUND PAPERS

Havering
LONDON BOROUGH

Integrated Care Coalition
Better care, better lives, together

Barking and Dagenham, Havering and Redbridge Strategic Outline Case For an Accountable Care Organisation*

June 2016



* Subject to official sign off through democratic processes and local scrutiny

Appendix

The Barking, Havering and Redbridge health and wellbeing economy faces an unprecedented set of challenges between now and 2021.

Without a new service model, demand for services will increase, we won't see sustained improvements in people's health and wellbeing, and service user experience will deteriorate. Outcomes will be poor, our providers will struggle to recruit and retain good staff and may fail to meet core standards. The situation may get worse if local authorities are forced to make substantial cuts to services as their government grant falls.

If we deliver services in the same way that we do today, without achieving any efficiencies, expenditure is forecast to exceed income by £614 million. One simple fact remains, even including all of our current efficiency plans, there is no sight of bridging either the historic or forecast future financial gap without very radical transformation. This transformation is essential to set in motion the sustainable health and wellbeing improvements that our communities badly need.

Doing nothing is simply not an option. Given the scale of these challenges, our only credible plan is to pursue full integration through an ACO.

This plan has been developed by the following organisations:

NHS Havering Clinical Commissioning Group

NELFT NHS NHS Foundation Trust

Barking, Havering and Redbridge NHS University Hospitals

London Borough of Barking & Dagenham lbbd.gov.uk

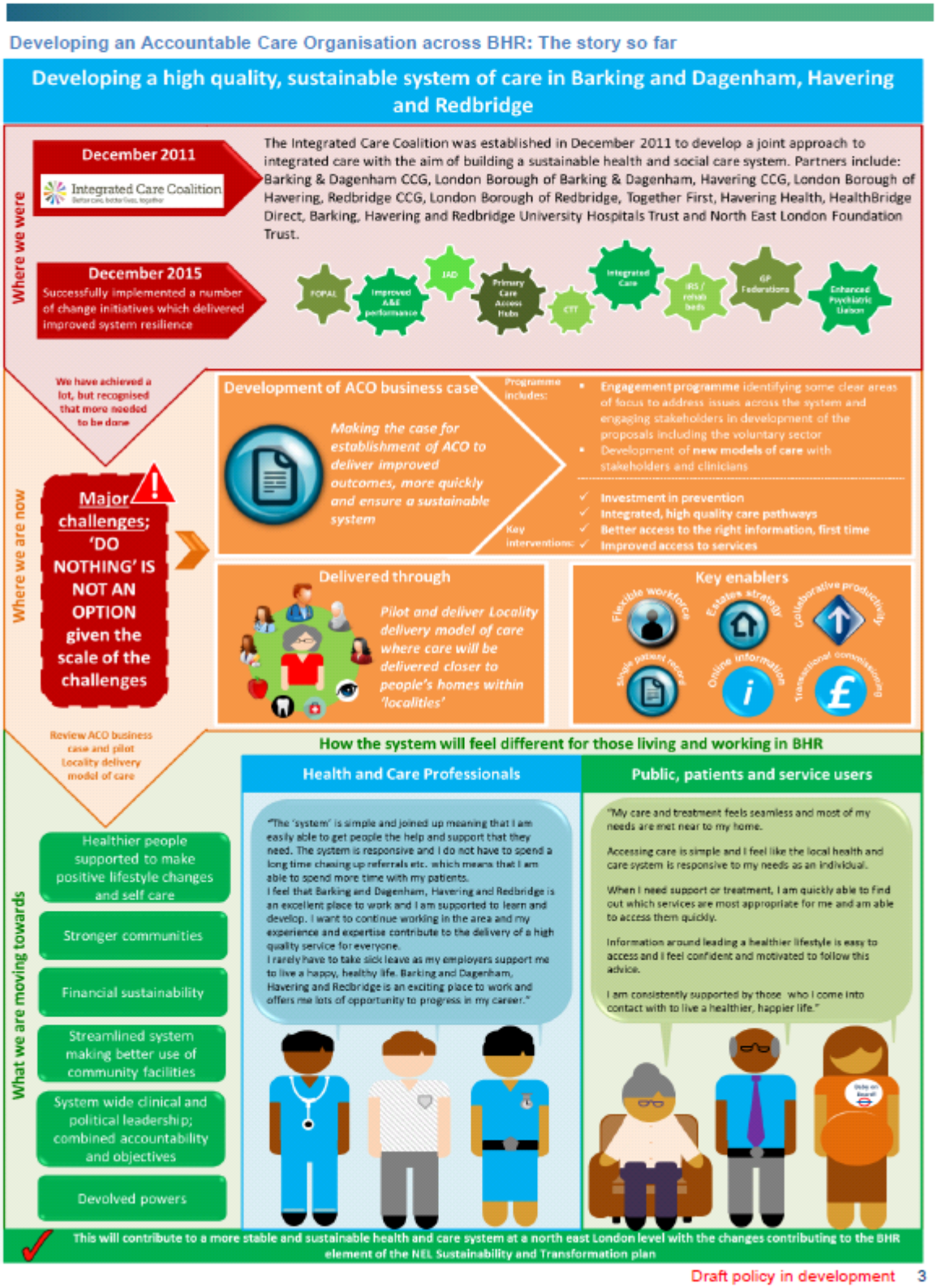
Havering London Borough

NHS Barking and Dagenham Clinical Commissioning Group

NHS Redbridge Clinical Commissioning Group

London Borough of Redbridge

Appendix


Developing an Accountable Care Organisation across BHR: The story so far
Developing a high quality, sustainable system of care in Barking and Dagenham, Havering and Redbridge
Where we were
December 2011
Integrated Care Coalition
The Integrated Care Coalition was established in December 2011 to develop a joint approach to integrated care with the aim of building a sustainable health and social care system. Partners include: Barking & Dagenham CCG, London Borough of Barking & Dagenham, Havering CCG, London Borough of Havering, Redbridge CCG, London Borough of Redbridge, Together First, Havering Health, HealthBridge Direct, Barking, Havering and Redbridge University Hospitals Trust and North East London Foundation Trust.
December 2015
Successfully implemented a number of change initiatives which delivered improved system resilience
FOPAL
Improved A&E performance
JAD
Primary Care Access Hubs
CTT
Integrated Care
IRS / rehab beds
GP Federations
Enhanced Psychiatric Liaison
We have achieved a lot, but recognised that more needed to be done
Where we are now
Major challenges; 'DO NOTHING' IS NOT AN OPTION given the scale of the challenges
Development of ACO business case
Making the case for establishment of ACO to deliver improved outcomes, more quickly and ensure a sustainable system
Programme includes:
Engagement programme identifying some clear areas of focus to address issues across the system and engaging stakeholders in development of the proposals including the voluntary sector
Development of new models of care with stakeholders and clinicians
Key interventions:
Investment in prevention
Integrated, high quality care pathways
Better access to the right information, first time
Improved access to services
Delivered through
Pilot and deliver Locality delivery model of care where care will be delivered closer to people's homes within 'localities'
Key enablers
Flexible workforce
Estates strategy
Collaborative productivity
Single patient record
Online information
Transactional commissioning
Review ACO business case and pilot Locality delivery model of care
How the system will feel different for those living and working in BHR
Health and Care Professionals
"The 'system' is simple and joined up meaning that I am easily able to get people the help and support that they need. The system is responsive and I do not have to spend a long time chasing up referrals etc. which means that I am able to spend more time with my patients.
I feel that Barking and Dagenham, Havering and Redbridge is an excellent place to work and I am supported to learn and develop. I want to continue working in the area and my experience and expertise contribute to the delivery of a high quality service for everyone.
I rarely have to take sick leave as my employers support me to live a happy, healthy life. Barking and Dagenham, Havering and Redbridge is an exciting place to work and offers me lots of opportunity to progress in my career."
Public, patients and service users
"My care and treatment feels seamless and most of my needs are met near to my home.
Accessing care is simple and I feel like the local health and care system is responsive to my needs as an individual.
When I need support or treatment, I am quickly able to find out which services are most appropriate for me and am able to access them quickly.
Information around leading a healthier lifestyle is easy to access and I feel confident and motivated to follow this advice.
I am consistently supported by those who I come into contact with to live a healthier, happier life."
What we are moving towards
Healthier people supported to make positive lifestyle changes and self care
Stronger communities
Financial sustainability
Streamlined system making better use of community facilities
System wide clinical and political leadership; combined accountability and objectives
Devolved powers
This will contribute to a more stable and sustainable health and care system at a north east London level with the changes contributing to the BHR element of the NEL Sustainability and Transformation plan
Draft policy in development 3

Appendix

Over the past six months, nine organisations across Barking & Dagenham, Havering and Redbridge (BHR) have worked together to develop a strategic outline case for the development of an Accountable Care Organisation (ACO). Each organisation faces common challenges including a growing population, a rapid increase in demand for services and scarce resources. With this in mind, our system leaders have joined forces to create a single integrated response (through the Integrated Care Coalition). Every organisation is committed to doing its part to deliver sustainability for the whole of BHR's health and wellbeing economy. In our business case, we set out exactly what we have agreed to do together, what support we need from external parties and why this is a once in a lifetime opportunity to radically improve the life outcomes for every single person in BHR.

We have significant challenges to tackle including; health and wellbeing, care and quality and financial sustainability. We have a diverse, highly mobile and in some cases very deprived population – all with unique health and wellbeing needs. Healthy life expectancy in Redbridge (63.0 years for women, 62.7 years for men) and Barking & Dagenham (55.5 years for women, 61.1 years for men) is far below comparable figures in London (63.8 years for women, 63.4 years for men) and nationally. Patients have often found it challenging to access the right service, in the right place, at the right time. Our acute trust - Barking, Havering and Redbridge University Hospitals Trust (BHRUT) -was placed in special measures in 2014 and is two years into a transformational improvement programme. It has seen significant improvement in emergency flow, staff engagement and financial performance, however, broader system wide partnership is needed to address longstanding access issues including increasing A&E attendances, admissions and reducing waiting times for elective care. Primary care also faces significant challenges with a large proportion of GPs nearing retirement, difficulty in attracting new talent and a number of practices across BHR operating in siloes. All of this together has added to an already significant financial challenge - in order to continue providing services consistently and if the system were to deliver care in the same way that it does today without achieving any efficiencies, expenditure in 2020/21 is forecast to exceed income by £614 million.

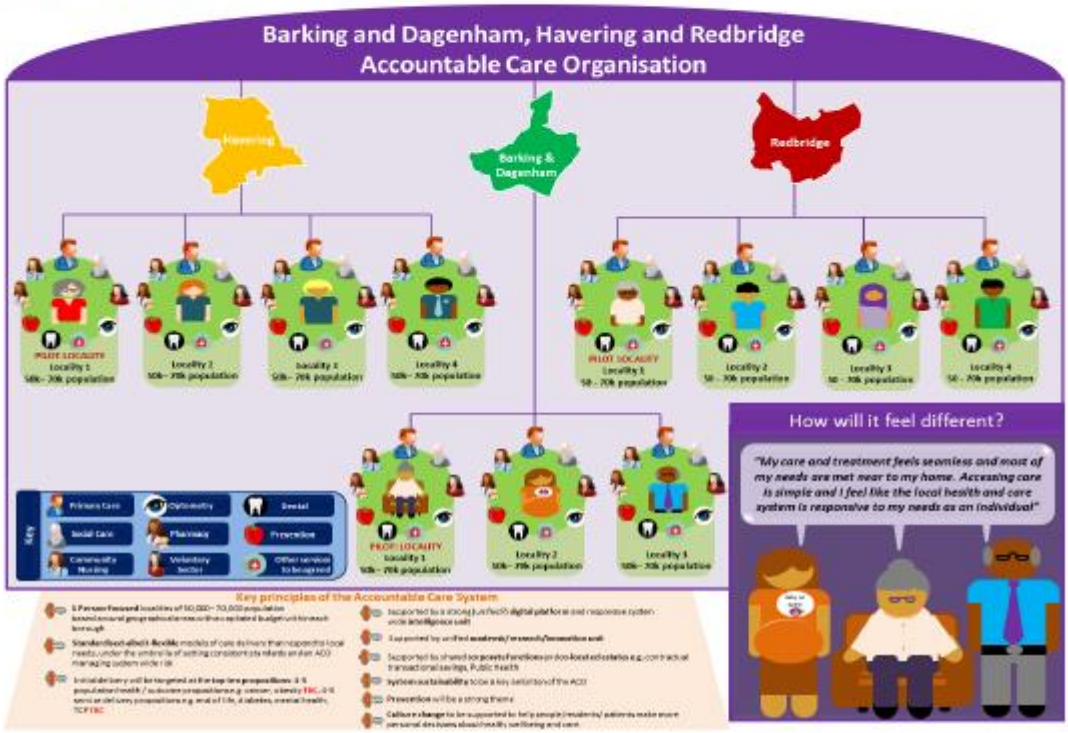
We know our communities and our staff want to see health and wellbeing improve; In a survey of over 3000 residents it was clear that there is confusion in our communities about where to access services at present and the confusion rises the more people are actually in need of assistance. In a survey of 750 of our health and social care staff, 87% identified barriers to working that prevented them for assisting their people as they would want to.

Our first priority is to develop a new integrated health and wellbeing service model for our population; based on the principles of place-based care, we are going to implement a locality delivery model, complemented by a range of targeted best practice interventions (for example changes to the diabetes and gastroenterology pathways). This will ensure BHR is delivering the best health and care services available anywhere in the country; it builds on our local experiences with Health 1000, national experiences with the Vanguard programme and international experience with examples such as the Alzira model. Collectively, these changes will strengthen the primary, secondary and social care offer in BHR while simultaneously focusing on the importance of prevention and self-care. Multidisciplinary teams involving clinicians and professionals from every part of the system will deliver treatment in homes, care homes, GP surgeries and elsewhere. Carers and the people they care for will find this model easier to navigate, accessible and responsive to their needs. Above all, this model will promote personal autonomy, helping our population to access high quality services in the right setting every time.

Our service model is designed to promote wellbeing services which will tackle the root causes of poor physical and mental health; we recognise that we need to promote healthy living and therefore prevention is critical to helping us manage demand over the next five years and beyond. Our three local authorities have worked hard to embed their services into the locality delivery model design. As part of the locality delivery model, community hubs will be set up to support people and families with their employment, education, housing and health needs. These hubs will make the best use of existing community facilities across BHR. The hubs will take integration to the next level, joining up the full spectrum of public services available, including primary care, whether you are a pregnant mother, a frail individual or an active teenager there will be services provided while help you to live a healthier and happier life.

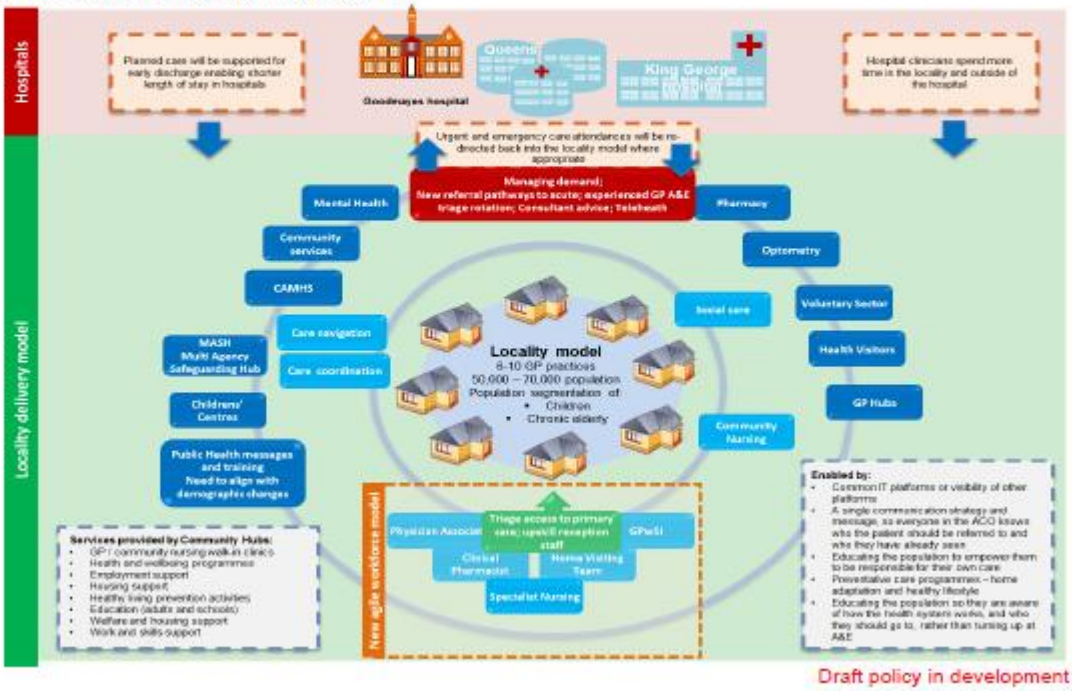
Appendix

Figure 1: Transforming the BHR service model



N.B. The locality delivery model will need to be able to flex to respond to our growing population, e.g. B&D will require an additional locality, in the future, to provide for the Barking Riverside development.'

Figure 2: The BHR locality delivery model



Draft policy in development 5

Appendix

Changing our service model alone is not enough – to achieve the full potential we need to change our business model and organisational form; We can demonstrate how further integration will help us to achieve efficiencies beyond identified opportunities and anticipated Cost Improvement Programmes (CIPs) and Quality Innovation Productivity and Prevention (QIPPs) by individual organisations. Collaborative productivity, new transactional commissioning arrangements, and rationalisation of our estate footprint all represent opportunities to go beyond our current ambition.

As part of this journey, we have identified workforce, technology and estates as the key enablers which will require investment and development; without these, we will not succeed in implementing the scale of change required. We don't yet have all of the answers but we have made good progress – for example forming an initial single estates plan across BHR and the development of a digital roadmap. We are committed to working with organisations from across north east London (NEL) to identify next steps.

Wider engagement with academia and innovation are important elements that enable us to achieve our goals; Academic Medical Centres have traditionally built alignment of strategic focus, resources, and critical mass of expertise across NHS and university partners. Going forward, we will continue to work together with our research partners and create new opportunities for research in our communities to spur innovation. A good example of our commitment to research and innovation is the NHS Innovation Test Bed, led by Care City and supported by our academia partners, which provides a unique opportunity to access cost-effective new technologies.

The financial pressures facing BHR over the next 5 years are substantial:

- There is an existing challenge: At the end of 2015/16, the health and wellbeing organisations within Barking & Dagenham, Havering and Redbridge had a combined financial challenge of £44m;
- Demand for services is increasing: This is a result of a growing, aging population, meaning that health and care needs are becoming more complex;
- Costs of provision of health and care services are rising more rapidly than general inflation; and;
- While NHS allocations are expected to increase over the 5-year period, they will still be £6m short of NHS England's needs-based target by 2020/21. In addition, there are planned reductions in social care and public health allocations for the three local authorities in line with their overall reduced spending power, and these will impact NHS local demand if the reductions result in savings being made to preventative and integrated services.

Combining these together, Barking, Havering and Redbridge are left with an overall affordability challenge of £614 million by 2020/21. Current plans already assume £198m of efficiency savings. These efficiencies would therefore further reduce the challenge to £275m, as existing savings plans would also reduce the non-recurrent element of the original £614m gap. Therefore, if current savings plans are achieved, there is a reduced gap of £275m, of which £124m is non recurrent associated with the accounting impact of future projected Clinical Commissioning Group deficits, and £151m recurrent.

If all existing organisational efficiency plans within the system are achieved they will close the gap by £198 million. They are already very stretching plans, but they leave £151 million to be found through further transformation. £48m of this challenge is assumed to be delivered through stretching STP provider efficiency plans. A further £45m savings are attributable to the Accountable Care Organisation. This would leave a challenge of £57m still to be addressed.

Some of this will be closed through Sustainability and Transformation Funding, which is currently expected to be £134m across NEL. Taking an indicative proportion of this funding, would leave a residual challenge for Barking, Havering and Redbridge of £22m.

The size of the numbers and the sheer scale of change and transformation required is daunting, but we have committed as a system to deliver. From our work to date, we cannot as yet see a firm plan to bridge the residual £22m gap. However, we are clear that our best chance is through a radical redesign of the organisational arrangements that oversee health and social care services in BHR, and this is what we are working to deliver. Our plans involve taking BHR to best in class in terms of services, integration and prevention so we believe we will be absolutely maximising the funding we receive as a system. By the end of 2020/21, NHS funding will still not be at target and that may influence how much of the residual gap we can bridge.

Appendix

The non-recurrent gap results from the application of our best estimate of how long it will take us to deliver out all of these substantial transformational savings. This needs to be seen in the context of the system remaining below target allocation during this period. If we can move forward some of our plans more rapidly we can eat into this non recurrent deficit. As we move into delivery phase we will attempt to do so, but the scale of change will make it very challenging. We are determined to work with NHS regional and national colleagues to find ways of resolving this as we move forward.

Our ACO programme will support the NEL Sustainability and Transformation Plan; the STP process has helped to bring together commissioners and providers to set realistic plans for their health challenges over the next five years. As part of our ACO programme, we have had greater involvement from local authorities above what the STP process requires. This has helped us to create a fully integrated solution to address our challenges. It is clear that some enabling imperatives are best resolved across NEL. In particular, the scale of the challenges facing the acute sector across NEL, including BHRUT and Barts Health, means that it will need to work collaboratively on productivity matters with other acute trusts. However, we ask that the enabling plans for NEL are moved forward in recognition of the need to foster powerful transformation delivery partnerships such as the BHR ACO partnership. Delivering large transformational projects only happens when real partnership and political leadership is in place and fully engaged locally.

To achieve our ambition, we have made a series of commitments as a system. To support this, we have also identified a series of "asks" for NHS England and others; all of these "asks" are designed to give BHR a foundation on which it has the opportunity to succeed. We have aligned them closely to our wider asks as a NEL footprint as part of the STP process. We have agreed to form a single system-wide leadership group, with a common set of objectives through the establishment of a Memorandum of Understanding. Our direction of travel is to build delivery functions over time that align to organisational form underpinned by a combined system budget. We want this group to work with national and regional bodies to agree what standards it should be held accountable to – doing all of this will help to drive the cultural change that is essential from day one. Greater freedom and flexibility to innovate is critical; without it we will not be able to drive the pace of change required across the BHR system.

The ACO implementation journey in BHR has already started; we are working with primary care clinicians and others to implement the first wave of locality models in each of our three boroughs (building on the lessons learned from work already implemented in all our boroughs, particularly Redbridge with the Health and Adult Social Services integration). Simultaneously, we are formalising our leadership and governance structure, developing our preferred option for the ACO commissioning and provision model and exploring how to implement capitated budgets to commission for population health outcomes.

Democratic leadership sitting alongside NHS leaders and clinicians is a key strength of this partnership; we recognise the transformation journey ahead is very challenging and that it can only be delivered through democratic leadership working to support and champion what needs to be done. We don't want to play politics in BHR; we are serious about working together to develop a system wide solution which draws together a committed and accountable leadership team to drive this programme forward for the benefit of our population.

To achieve success, all of our transformation work will need to fuse into a single programme designed to tackle the system wide challenges; we have set out a clear roadmap for the BHR health economy over the forthcoming months. Importantly, this recognises that business as usual activities (such as tackling the RTT challenges) and the ACO development work can no longer be thought of as two separate programmes - they must be brought into one system wide programme with a universal set of objectives. Demonstrating that our work can make immediate impact on the system in years one and two will be crucial for maintaining the support of outside observers, system leaders and our whole population.

The ACO and the locality delivery model will transform lives and strengthen communities across BHR; this case demonstrates that an ACO has the potential to have a positive impact on all three of our challenges. This is a one off opportunity to make a lasting system wide change to our service and delivery model. Our local leaders have recognised this and reaffirmed their commitment at the end of June 2016 to pursuing the development of an ACO at pace. While this journey is just beginning, together we are clear that we are going to use this opportunity to improve the lives of local people and build strong resilient communities across BHR.

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	JSNA Annual Report
Board Lead:	Sue Milner, Interim Director of Public Health
Report Author and contact details:	Ade Abitoye, Interim Head of Public Health Intelligence

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

- Local authorities and clinical commissioning groups have equal and joint duties to prepare Joint Strategic Needs Assessments, through the Health and Wellbeing Board (HWB) in order that the health and social care needs of the population are properly assessed and proper plans and services may be put in place.
- The HWB delegates this function to the Director of Public Health through the Joint Strategic Needs Assessment (JSNA) Steering Group.
- This is the annual report of the JSNA Steering Group to the HWB
- The JSNA work programme is developed by the steering group. A new approach was adopted last year to provide a more streamlined and fit-for-purpose JSNA, which informed the development of a new work programme. The work programme is being delivered and is on track.
- The JSNA now consists of a suite of inter-related web-based products which, taken together, provide an overview of health and social care needs of the borough and one or two carefully chosen 'deep dives' per year.

- Key JSNA resources and products have been published in the last year and more are about to be published.

RECOMMENDATIONS

The Board is asked to:

- Consider this report, the JSNA programme and the progress made
- Suggest any necessary amendments and additions

REPORT DETAIL

Background

In 2015, there was a review of the JSNA work programme and approach. This led the JSNA steering group to make the following key changes:

- The Director of Public Health assumed the chair of the steering group.
- Membership of the group was reviewed and expanded to make it more representative of partners in the local health and wellbeing economy.
- Terms of reference of the group were refreshed.
- A more streamlined work programme was established.

The JSNA Work Programme

The new JSNA approach focused on the production of a number of overarching resources plus undertaking one or two carefully chosen 'deep dives' per year.

The JSNA work programme in the last year (2015/16 till date) is as follows:

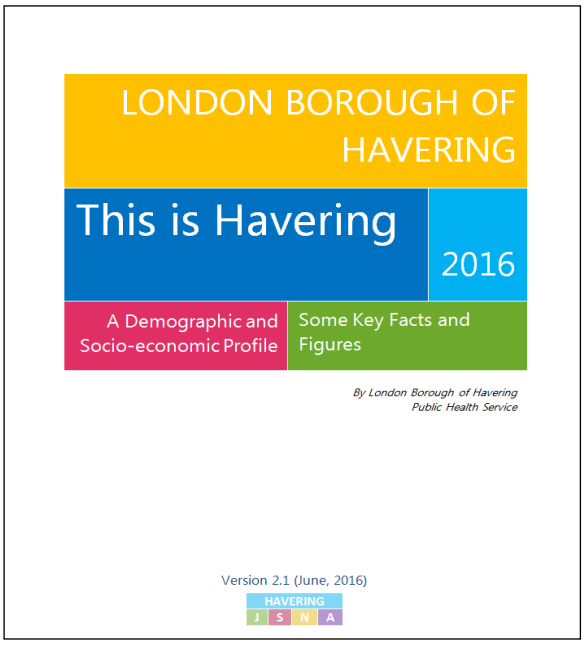
- This is Havering – a demographic and socioeconomic profile
- Overview of Health and Social Care Needs
- Interactive Ward Health Profiles
- Obesity Needs Assessment – *agreed deep dive for 2015/16*
- Special Educational Needs and Disability (SEND) Needs Assessment – *agreed deep dive for 2016/17*
- Diabetes – *agreed potential deep dive for 2016/17*
- Accountable Care Organisation (ACO) Population Health Workstream
- Public Health Outcomes Framework (PHOF) Report and list of (and links to) publicly available profiles/resources

Published JSNA resources and products are available at:
http://www.haveringdata.net/jsna/

This report summarises key features of the work programme.

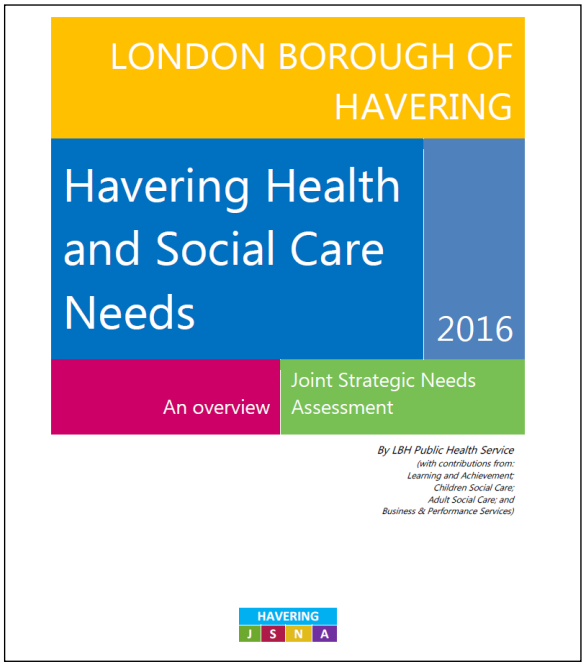
Health and Wellbeing Board

This is Havering – a demographic and socioeconomic profile



- Published originally in September 2015 and updated every quarter.
- Current version was published in June 2016 and the next is due at the end of September.
- It has been adopted as the "one version of the truth" in relation to the *demographic and socioeconomic profile of Havering*
- The product is available in 3 different formats:
    - Main document (front page pictured on the left)
    - PowerPoint Presentation
    - Infographic summary (see attachment a)

Overview of Health and Social Care Needs



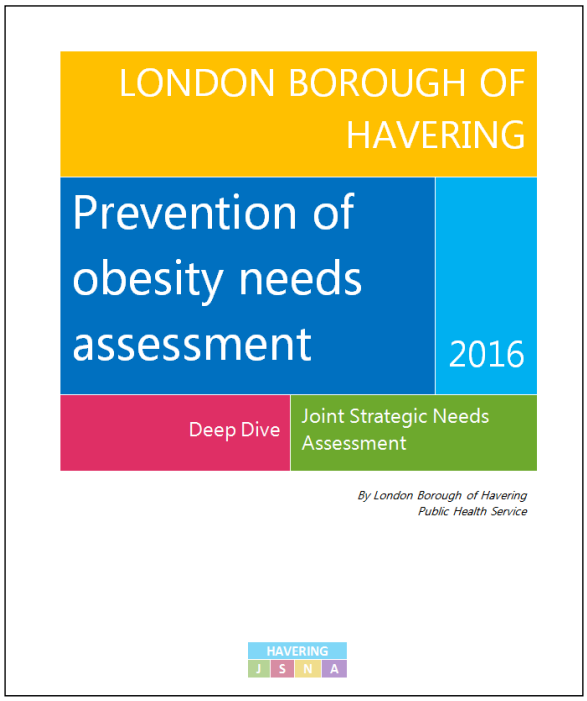
- Published in February 2016 (front page pictured on the left).
- It is updated and improved annually – the next update is due by the end of March 2017.
- The resource provides a summary of Havering's health and social care needs. It describes the pattern of risk factors for ill health, the status of health and wellbeing and how people use local services.

Interactive Ward Health Profiles

- The aim is to provide an informative and interactive insight of ward health and wellbeing issues in Havering
- Councillors were engaged in helping to shape it (see attachment b for presentation provided to councillors who attended the first of three sessions for Members)
- The product is being finalised and should be published by the end of July.
- It will be demonstrated very briefly during the Board meeting.

Health and Wellbeing Board

Obesity Needs Assessment



- Published on the JSNA website in July 2016 (front page pictured on the left).
- It was the agreed 'deep dive' for 2015/16 – more than 100 pages long.
- The Executive Summary of this needs assessment has previously been taken to the Board (as part of a report on the Obesity Strategy).
- It underpins the Obesity Strategy.
- It will underpin the upcoming Annual Director of Public Health Report.

Special Educational Needs and Disability (SEND) Needs Assessment

- Agreed 'deep dive' for 2016/17
- Impending OFSTED visit partly informed its choice.
- Currently underway – a first 'complete' draft (currently more than 100 pages long) almost ready.
- It may be brought to the Board for consideration when completed.

Diabetes Needs Assessment

- Potential second deep dive for 2016/17, which may be done for the tri-borough, i.e. Barking & Dagenham, Havering and Redbridge (BHR), subject to agreement.
- The Havering CCG initially put this forward but it has also been recognised as a priority area across the 3 boroughs based on work done as part of the Accountable Care Organisation (ACO) Population Health workstream.
- Currently on hold. Some discussions and agreements are required before work on this can begin. Work unlikely to start this summer.

ACO (Accountable Care Organisation) Population Health workstream

- On-going support work, as/when required, for the ACO Business Case (Population Health Workstream).
- An example of what has been done under this workstream is a RIGHT care review. Its aim was to identify priority health programmes which offer the best opportunities for improving healthcare for populations, the value that patients receive from their healthcare and the value that populations receive

from investment in their local health system. This was undertaken on a BHR footprint. (see attachment c).

Public Health Outcomes Framework

- A Public Health Outcomes Framework (PHOF) Report has been produced (see attachment d).
- The report is a summary for Havering, which will be updated annually.
- In addition, a list of (and links to) publicly available profiles/resources has been compiled.
- Both to be published to the JSNA website by the end of July 2016.

BACKGROUND PAPERS

The following documents are attached to this report:

a. Infographic summary of “This is Havering – a demographic and socioeconomic profile”
b. Presentation to councillors on Ward Health Profile
c. Right Care Priority Areas Report
d. PHOF Annual Report

This is Havering 2016

An infographic summary of

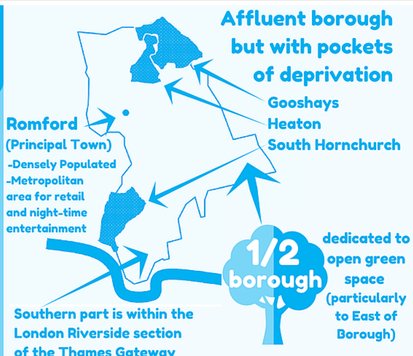
This is Havering: a demographic and socio-economic profile

Main Documents available here: www.haveringdata.net/custom/jsna.htm

GEOGRAPHY

3rd largest borough in London

43 miles²
(Size)

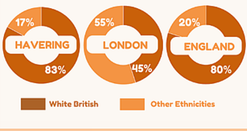


POPULATION

Oldest borough in London

40 years
(Median Age)

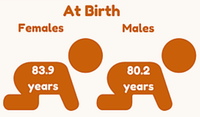
Ethnicity

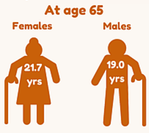


Country of Birth

90% born in UK

Life Expectancy

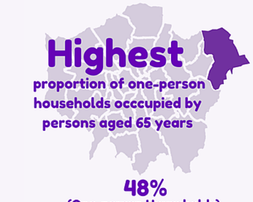




Following a net population loss of 6.3% from 1983 to 2002 the population has increased year on year from 2002, with a 10.7% increase from 2002 to 2015

Population Trend

HOUSEHOLD



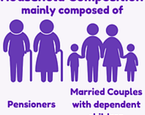
Highest proportion of one-person households occupied by persons aged 65 years

48%
(One-person Households)

Homeowner Population

Household Composition

mainly composed of



Lone Parent Households

Bedrooms per household

Statutory Homeless Households

Traveller Caravans on unauthorised sites

Short-term International Migration

32% of elderly population

live in one person households

ECONOMY

7th highest proportion of working-age residents in employment in London

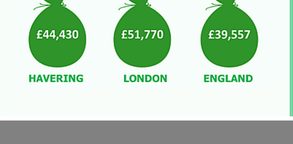
78% (Employment)

Employment Rate

(Overall)

Out of Work Benefits

Average gross income per household



Car Ownership

Child Poverty

30-33% of children live in poverty*

Children in income-deprived households

HAVERING JSNA

Havering LONDON BOROUGH

Produced by Public Health Intelligence

Havering

LONDON BOROUGH

www.havering.gov.uk

Clean • Safe • Proud

Ward Health Profile

05 April 2016

Ade Abitoye

Interim Head of Public Health Intelligence

Clean • Safe • Proud

Havering
LONDON BOROUGH

5-Stage Approach

1. Formulate **the brief**
2. Acquire, prepare and familiarise with **the data**
3. Determine **the editorial focus**
4. Conceive **the visualisation design**
5. Construct, evaluate and launch **the product**

Adapted from Andy Kirk's visualisation design methodology

The brief (I)

Aim

- To provide an informative and interactive insight of ward health and wellbeing issues in Havering

Objectives

- To produce an engaging, informative and interactive Havering-focused ward profile
- To highlight issues within Havering wards in comparison to Borough, England and statistical comparators
- To inform evidence-based decision-making & policy-making & commissioning
- To produce a high-level resolution profile

The brief (II)

Stakeholders

- Councillors, Health and Wellbeing Board, General Public, Council staff (e.g. Children's services, Adult Social Care), Academic Partners, Commissioners, CCG, BHRUT, GPs, Havering Public Health Team, Neighbouring boroughs, London KIT/PHE

Constraints

- No London data, possibly time(?), possible limitation with Tableau Public (?), updating of data (depends on when data becomes available, in what format etc)

The brief (III)

Resources

- Technical - Tableau Desktop software to construct product and (free) Tableau Public to publish it

Project Team

- Public Health Intelligence team: Ade Abitoye, Syed Rahman, Benhildah Dube, Mayoor Sunilkumar (and briefly Hasna Begum & Raza Nadim)
- Advice and feedback also sought from other analysts in the council

The data – Inclusion Criteria

Data for indicators must:

- Be publicly available and at ward level
- Be available at national level (England) for comparator purposes
- Be a measure (not numbers) e.g. rate, percentage, etc
- Have confidence intervals and/or confidence intervals can be calculated
- Be as recent as possible and/or within last 5 years, (if multiple-year average/period should at least include years 2011 or after)
- Add value (e.g. not duplicate another indicator's value)

The data – Indicator set

Indicators currently included are:

- Mainly from PHE Local Health indicator set (from various data sources)
- From some GLA indicators (mainly sourced from Census 2011 data)
- From some other relevant publicly available sources

The editorial focus – Domains

WARD PROFILE TITLE	DOMAIN	INDICATORS WOULD INCLUDE?
1. WHO IS IN THE AREA?	DEMOGRAPHY	**Age, Ethnicity, Languages, Religion, Marital Status, Place of Birth**
2. WHAT BEHAVIOUR CHOICES ARE AFFECTING OUR HEALTH?	LIFESTYLE	**Physical Activity, Sexual Health, Drugs & Alcohol**
3. WHAT OTHER FACTORS ARE AFFECTING OUR HEALTH?	WIDER DETERMINANTS	**Deprivation, Child Poverty, Green Spaces, Housing tenure, Crime Qualification, Employment, Unemployment**
4. WHAT IS MAKING US ILL?	DISEASE & POOR HEALTH	**Prevalence of long-term conditions**
5. WHAT ARE WE DYING OF?	LIFE EXPECTANCY & MORTALITY	**Life Expectancy, Mortality**

The visualisation design

The ward health profile is planned to have four main views:

- Front page
- Ward view
- Domain view
- Indicator view

Overview

FRONT PAGE

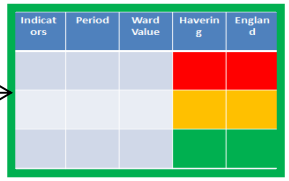
WARD VIEW

What are the priorities for the ward?

Select 1 of 18 Wards

OR

Select Ward



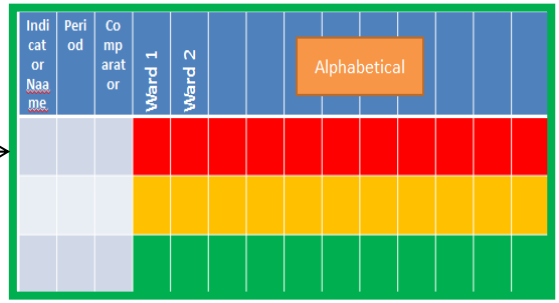
DOMAIN VIEW

What is the variation across wards for different indicators within a domain?

Select 1 of 5 Domains

D1 D2 D3

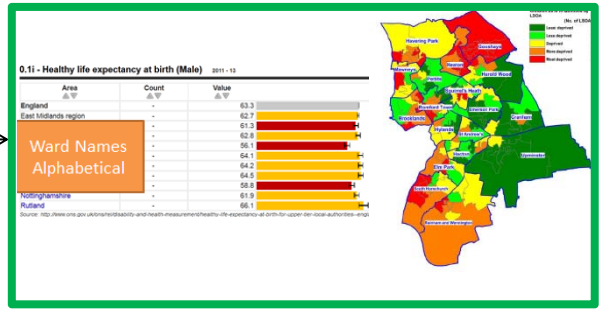
D4 D5



INDICATOR VIEW

What is the variation across wards for a specific indicator?

Select Indicator



The product

- …will now be demonstrated
- Please feel free to ask questions along the way
- Aim is to publish and/or “launch” it before the end of June 2016 or asap afterwards

Contact Details: *ade.abitoye@havering.gov.uk; ☎ 01708 431830*

RIGHT CARE review for ACO CCG area: Barking & Dagenham, Havering and Redbridge CCGs

Summary

The cluster peer group analysis implies the following:

- The programme areas that should be reviewed across the ACO CCG area are:
  - Value for money – diabetes
  - Quality only – diabetes
  - Spend only – gastrointestinal and genitourinary

- Over 100 lives could be saved if the ACO CCG area achieved the scores of the best 5 CCGs in their peer groups
  - Cancer – 48 lives
  - Neurological- 4 lives
  - Circulation – 19 lives
  - Respiratory – 12 lives
  - Gastrointestinal – 9 lives
  - Trauma and Injuries – 8 lives

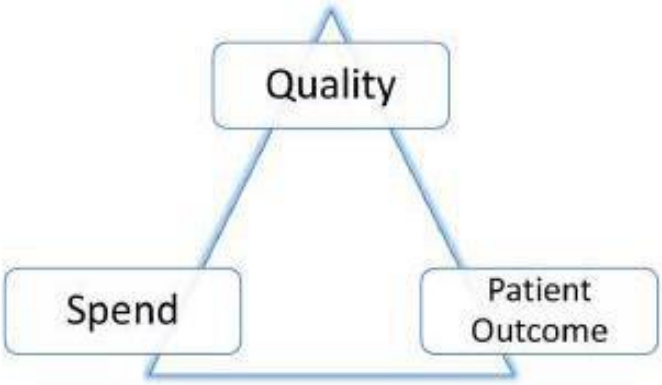
- The greatest savings could be made in the following programmes: GU, GI, Circulation, Respiratory and MSK and combined total (11 programme areas) £36M.
  - In terms of elective spend the potential opportunity is £4.2M if the ACO CCG area achieves the average score for their peer group and at best £11.1M if the ACO CCG area achieves the score of the best 5 CCGs in their peer group.
  - In terms of non-elective spend the potential opportunity is £7.5M if the ACO CCG area achieves the average score for their peer group and at best £15.7M if they achieve the score of the best 5 CCGs in their peer group.
  - In terms of primary care prescribing the potential opportunity is £1.3M if the ACO CCG area achieves the average score for their peer group and at best £7M if they achieve the score of the best 5 CCGs in their peer group.

Commissioning for Value

Commissioning for Value[1] is about identifying priority programmes which offer the best opportunities to improve healthcare for populations; improving the value that patients receive from their healthcare and improving the value that populations receive from investment in their local health system.

Commissioning for Value is not intended to be a prescriptive approach for commissioners, rather a source of insight which supports local discussions about prioritisation and utilisation of resources. It is a starting point for CCGs and partners, providing suggestions on where to look to help them deliver improvement and the best value to their populations. It also supports CCGs to meet their legal duties to have regard to reduce health inequalities.

Figure 1: Elements of value



Source: Commissioning for Value: Where to Look 2016:

The Right Care approach

Examples of the population healthcare and system impact of adopting the Right Care approach include:

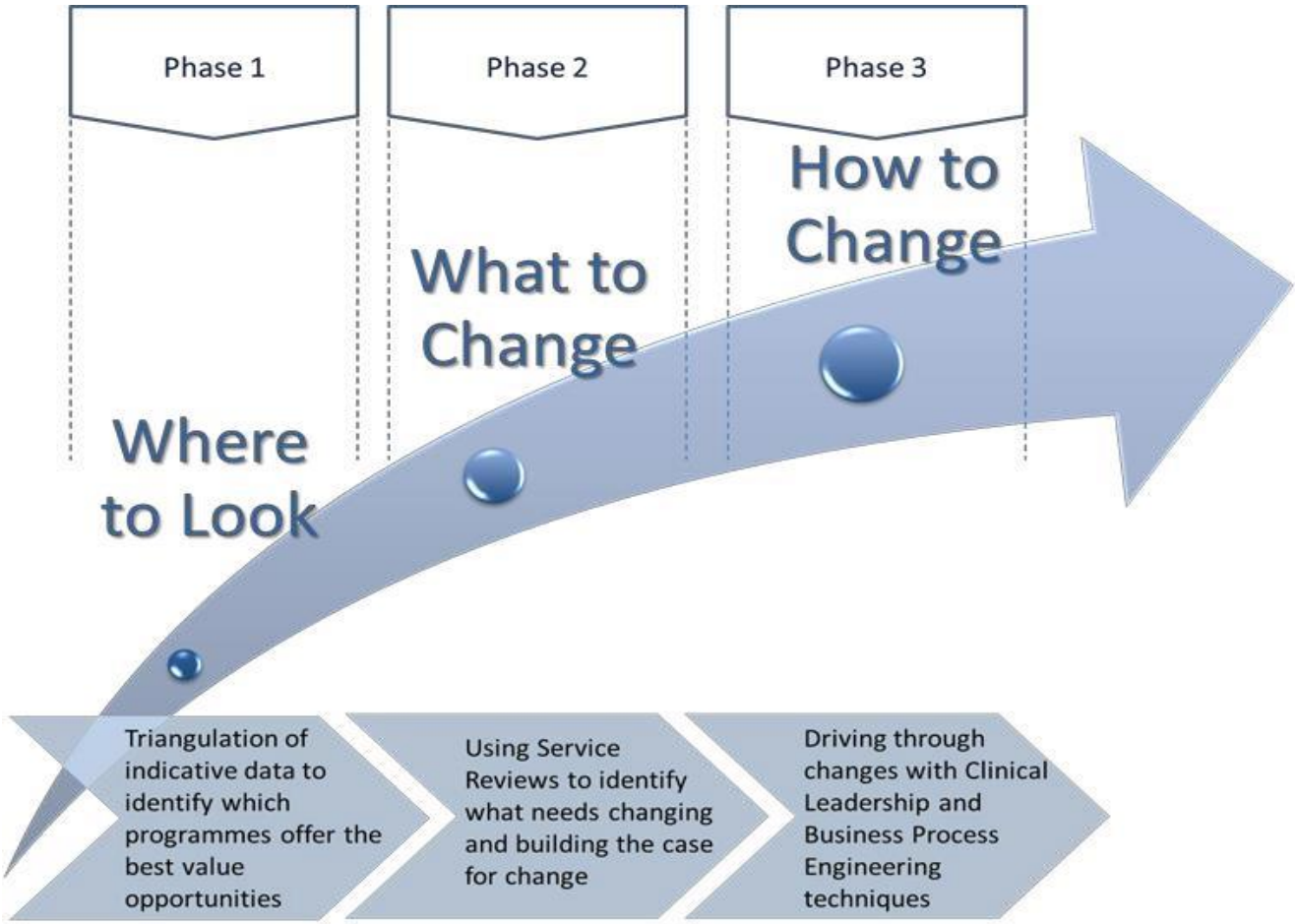
- 1000s more people at risk of or already with Type 2 diabetes detected and being supported with their primary and secondary prevention (Bradford City and Bradford Districts CCGs).
- 36% reduction in GP referrals to acute MSK services via a locally-run triage system using locally derived protocols (Ashford CCG).
- Significant reductions in unplanned activity amongst people with complex care needs via proactive primary care (Slough CCG).
- 30% reduction in COPD emergency activity from a full pathway redesign (Hardwick CCG).
- 98% reduction in calls from frequent callers via enhanced integrated care and pathway navigation (Blackpool CCG).

NHS Right Care provides a number of resources to support healthcare teams nationally, regionally and locally to reduce unwarranted variation and subsequently increase value and improve quality. These include the 2015 NHS Atlas of Variation in Healthcare, the CCG Spend and Outcomes Tool, a Quadrant analysis tool, and updated Commissioning for Value packs for 2016.

[1] Commissioning for Value: Where to Look January 2016 Barking & Dagenham CCG. Gateway ref: 04599; Commissioning for Value: Where to Look January 2016 Havering CCG. Gateway ref: 04599; Commissioning for Value: Where to Look January 2016 Redbridge CCG. . Gateway ref: 04599

The Right Care approach provides a reliable and valid methodology for quality improvement, led by clinicians. The approach begins with a review of indicative data to highlight the top priorities or opportunities for transformation and improvement. Value opportunities exist where a health economy is an outlier and will most likely yield the greatest improvement to clinical pathways and policies. Phases two and three then move on to explore *What to Change* and *How to Change.*

Figure 2: Right Care Methodology



Source: Commissioning for Value: Where to Look 2016:

Phase 1 – Where to Look

Each CCG is clustered with 10 CCGs who have the most similar population. This comparator group is used to identify realistic opportunities to improve health and healthcare for the CCG population. You may find it a powerful improvement tool to compare your opportunities with those of your similar CCGs as part of Phase 1 of the process set out earlier in the pack. By doing so, it may be possible to identify those CCGs which appear to have much better opportunities for populations with similar demographics against both your similar 10 CCGs and the average of the best five performers in the similar CCGs.

CCG performance is compared to the best 5 peer group average to calculate an 'opportunity'. Indicators (100) are a combination of PHOF, QOF and NHSOF and measurable at CCG level. The Clinical Commissioning Group Outcomes Indicators have been selected on the basis that they help contribute to better outcomes across the five domains of the NHS Outcomes Framework.

The spend indicators are based on non-elective, elective and prescribing activity by programme. For mental health spend is based on primary care prescribing

Table 1: Peer CCGs

Barking & Dagenham	*Havering*	*Redbridge*
- Greenwich CCG - Haringey CCG - Waltham Forest CCG - Slough CCG - Enfield CCG - North Manchester CCG - Luton CCG - Birmingham South and Central CCG - Croydon CCG - Sandwell and West Birmingham CCG	- Dudley CCG - Fareham and Gosport CCG - Bromley CCG - Basildon and Brentwood CCG - Solihull CCG - Nottingham North & East CCG - Bexley CCG - South Gloucestershire CCG - Trafford CCG - South East Staffs and Seisdon Peninsular CCG	- Slough CCG - Ealing CCG - Harrow CCG - Barnet CCG - Luton CCG - Birmingham South and Central CCG - Hillingdon CCG - Sandwell and West Birmingham CCG - Hounslow CCG - North Kirklees CCG

Note: London CCGs underlined
Source: Commissioning for Value: Where to Look 2016:

Table 2: List of the indicator areas for each programme budget category

Programme	Indicators
Cancer	breast lung and colorectal, screening(breast and bowel), smoking quitters; mortality
Genitourinary	chronic kidney disease, dialysis, renal replacement therapy
Gastrointestinal	alcohol related admissions, mortality GI and liver disease
Musculoskeletal	hip & knee replacement; fragility fractures ; emergency readmissions
Circulation	coronary heart disease, hypertension, TIA and stroke; mortality; atrial fibrillation; emergency readmissions
Respiratory	COPD, asthma, emergency re admissions, mortality
Endocrine	diabetic care and complications, retinopathy screening
Neurological	Epilepsy- emergency admissions, mortality, drug treatment

Source: Commissioning for Value: Where to Look 2016:

Figure 3 is a summary of priority areas by individual CCG, where 1 is the highest priority and the programme that is the biggest opportunity.

Figure 3: Headline opportunity areas – Outcomes ('Quality'), Spend, and Spend & Outcomes ('Value for money') compared to 5 best of 10 peer CCGs by order of priority for individual CCG, Barking & Dagenham, Havering and Redbridge

Order of priority	Opportunity Area / CCG								
	Outcomes			Spend			Spend & Outcomes		
	Barking & Dagenham	Havering	Redbridge	Barking & Dagenham	Havering	Redbridge	Barking & Dagenham	Havering	Redbridge
1	Musculoskeletal	Gastro-intestinal	Musculoskeletal	Respiratory	Genito-urinary	Genito-urinary	Gastro-intestinal	Gastro-intestinal	Musculoskeletal
2	Gastro-intestinal	Maternity	Endocrine	Gastro-intestinal	Gastro-intestinal	Circulation	Musculoskeletal	Genito-urinary	Genito-urinary
3	Cancer	Endocrine	Circulation	Genito-urinary	Circulation	Gastro-intestinal	Cancer	Circulation	Circulation
4	Endocrine	Circulation	Genito-urinary	Cancer	Respiratory	Endocrine	Endocrine	Endocrine	Endocrine
5	Neurological	Genito-urinary		Endocrine	Musculoskeletal	Musculoskeletal	Neurological	Respiratory	

Data Source: Commissioning for Value: Where to Look 2016:

Headline opportunity area: Outcomes (Quality)
Tri-borough issue: Endocrine
Two borough issue: Gastrointestinal (B, H), Genitourinary (H, R), Circulation (H, R)
Single borough issue: Cancer (B), Neurological (B), Respiratory (H), Musculoskeletal (R).

Headline opportunity area: Spend
Tri-borough issue: Gastrointestinal, Genitourinary
Two borough issue: Endocrine (B, R), Musculoskeletal (H, R), Circulation (H, R)
Single borough issue: Cancer (B), Respiratory (H)

Headline opportunity area: Spend & Outcomes ('Value for money')
Tri-borough issue: Endocrine
Two borough issue: Gastrointestinal (B, H), Genitourinary (H, R), Circulation (H, R), Musculoskeletal (B, R)
Single borough issue: Cancer (B), Neurological (B), Respiratory (H)

Savings opportunity across BHR

Across the ACO area the greatest savings could be made in the following (Top 5) programme areas: GU, GI, Circulation, Respiratory and MSK

Table 3: Scale of savings opportunity across BHR

Disease area	Barking & Dagenham	Havering	Redbridge	Total
Genitourinary(GU)	1,466k	3,068k	2,231k	**6,765K**
Gastrointestinal(GI)	2,001k	2,384k	1,912k	**6,297K**
Circulation Problems	906k	2,480k	2,058k	**5,444K**
Respiratory	2,312k	1,969k	663k	**4,944K**
MSK	1,018k	1,646k	1,194k	**3,858K**
Endocrine, Nutritional and Metabolic	1,132k	861k	1,552k	**3,545K**
Cancer & Tumours	1,186k	1,313k	715k	**3,214K**
Trauma and Injuries	160k	836k	97k	**1,093K**
Neurological	379k	255k	287k	**921K**
Mental Health	288k	0	27k	**315K**
Maternity and Reproductive (primary care prescribing)	20k	0	23k	**43K**
Total	**10,868K**	**14,812K**	**10,759K**	**36,439K**

Source: Commissioning for Value: Where to Look 2016:

Elective admissions

Table 4 shows the savings opportunity with respect to elective admissions. For some programmes the ACO area CCG spend is similar to the average of the peer CCGs; so the potential savings will only arise if they perform at the level of the best 5 peer CCGs.
For example 450 k could be saved in the cancer programme if the ACO area CCGs achieved the score of the best 5 CCGs in their peer group, but no savings if they achieve the average score for the peer group; or as much as 2.7M could be saved in the gastrointestinal category if the ACO area CCGs achieved the score of the best 5 CCGs in their peer group, and 1.7M if they achieved the average score for the peer group.
Across the programme areas listed, the potential opportunity across the ACO CCG area is 4.2M and at best 11.1M.

Table 4 Elective admissions

Programme	Average peer CCGs	Average + Best 5 of peer CCGs
Cancer	0	450k
Endocrine	0	140k
Neurological	0	255k
Circulation	0	460k
Respiratory	995k	1.5 M
Gastrointestinal	1.7M	2.7 M
Musculoskeletal	0	3.2M
Trauma and Injuries	92k	388k
Genitourinary	1.5M	2M
Total	**4.1M**	**11.1M**

Source: Commissioning for Value: Where to Look 2016:

Non- elective admissions

Table 5 shows the savings opportunity with respect to non-elective admissions. For the programme areas listed, the potential opportunity across the ACO CCG area is 7.5M if the average score for peer CCGs is achieved and 15.7M if the score of the best 5 CCGs is achieved.

Table 5 Non-elective admissions

Programme	**Average peer CCGs**	**Average + Best 5 of peer CCGs**
Cancer	1.4M	1.9M
Endocrine	227k	460k
Neurological	0	0
Circulation	1.2M	2.8M
Respiratory	639k	2.5M
Gastrointestinal	1.6M	2.9M
Musculoskeletal	0	1.2M

Programme	Average peer CCGs	Average + Best 5 of peer CCGs
Trauma and Injuries	0	437k
Genitourinary	2.4M	3.5M
Total	**7.5M**	**15.7M**

Source: Commissioning for Value: Where to Look 2016:

Primary care prescribing,

Table 6 shows the savings opportunity with respect to primary care prescribing. For the programme areas listed, the potential opportunity across the ACO CCG area is 1.3M if the average score for peer CCGs is achieved and 7M if the score of the best 5 CCGs is achieved.

Table 6 Primary care prescribing

Programme	Average peer CCGs	Average + Best 5 of peer CCGs
Cancer	0	152k
Endocrine	307k	1.5M
Neurological	82k	379k
Circulation	0	469k
Respiratory	579k	1.4M
Gastrointestinal	280k	950k
Musculoskeletal	12k	1.3M
Trauma and Injuries	45k	169k
Genitourinary	276k	633k
Total	**1.3M**	**7M**

Source: Commissioning for Value: Where to Look 2016:

Quality indicators- quality improvement opportunities by programme budget category

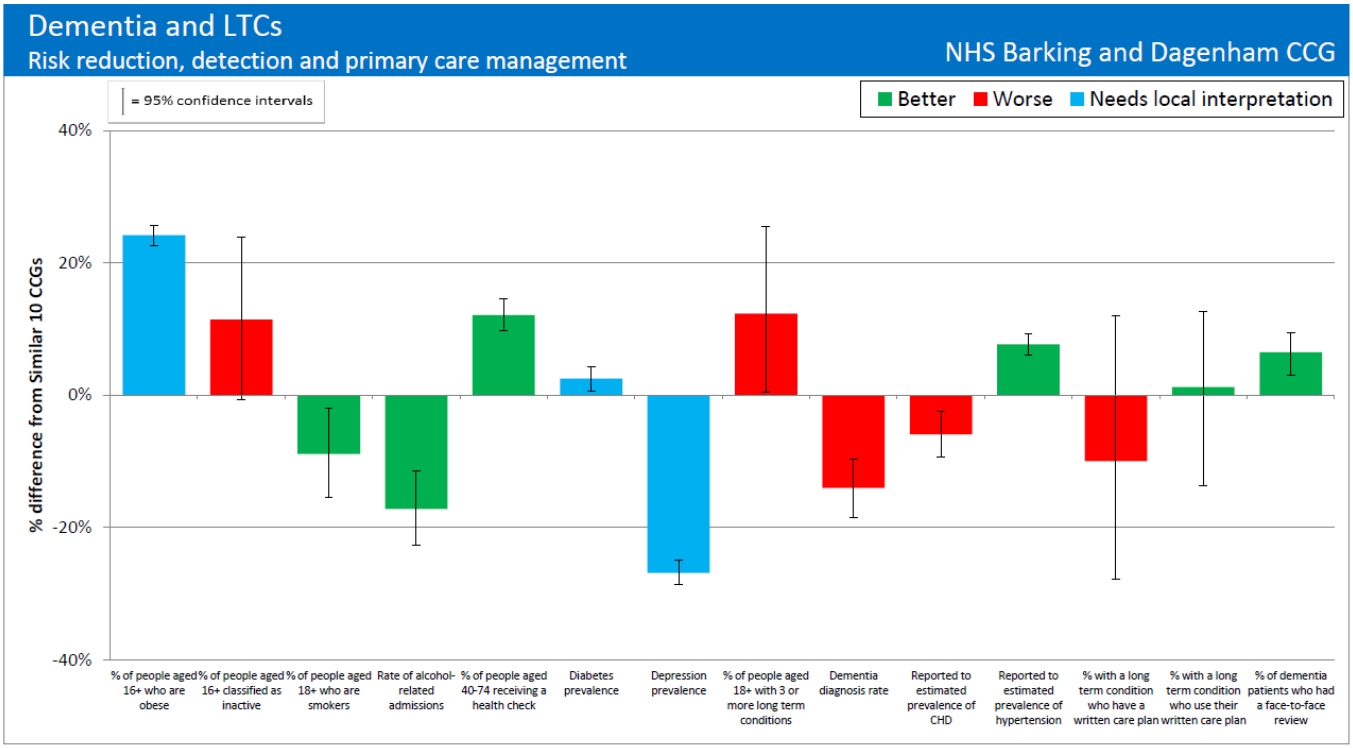
Table 7 shows the opportunity for improvements when quality indicators are compared with peer CCGs. For example 2880 more people need to be screened across the ACO CCG area to match peer CCGs.

Pathways

The pathways produced in the Right Care pack describe graphically the % difference from the average of peer CCGs for the relevant indicators (see Figure 4 Dementia and LTCs pathway as an example).

Table 8 looks at each pathway and the relevant indicators across the ACO CCG area to identify where there is an ACO area opportunity.

Figure 4: Example of a Right Care Pathway



Source: Commissioning for Value: Where to Look 2016:

Healthy London Partnership Right care analysis for NE London

The Healthy London Partnership produced a series of Right Care analysis for NE London[2], to support the development of the Sustainability and Transformation Plans (STP).

The report uses the information from the Right Care Programme but the method of analysis differs from that of the Right Care Approach (Where to look). However, the areas of poor performance across the ACO CCG area align with those highlighted in the original Right Care 2016 report. A summary is included here for information.

ACO CCGs were considered within the bottom quintiles (4th and 5th) compared to England for

- cancer 1 year survival
- place of death indicators
- child weight in 10 - 11 year olds
- antibiotic prescribing
- emergency admissions with dementia
- childhood immunisations
- A&E attendances
- Diabetics receiving NICE recommended care processes

[2] Healthy London Partnership- Right Care Analysis for London, Report for NEL STP Area March 2016

ACO CCGs were considered within the bottom 30% of their peer cluster for

- cancer 1 year survival
- Diabetics receiving NICE recommended care processes
- Rate of Barium enema procedures
- Emergency admissions with dementia

Improvement opportunity for the ACO cluster:

- cancer 1 year survival (all CCGs)
- Rate of emergency admissions to hospital of people with dementia aged 65 years and over
- Rate of COPD emergency admissions to hospital
- Percentage of people aged 16 years and over who were classified as physically inactive
- Child weight age 4-5 years
- hospital admission for heart failure in diabetic patients
- Percentage of people in the National Diabetes Audit (NDA) with Type 1 and Type 2 diabetes who received NICE-recommended care processes
- Rate of mortality in infants aged under one year

So what does the Right Care approach mean for the ACO?

The following is a worked example of a programme identified as an opportunity across all CCGs in the ACO area.

Diabetes (Endocrine)

The Right Care analysis for the ACO CCG area (see Fig 5) indicates that Diabetes (Endocrine programme category) could be improved in terms of value for money and quality of care. The next section describes in brief the added value of an ACO in relation to diabetes care.

There are statistically significant differences between the ACO CCG area and the peer group average for the following indicators:

1. % diabetes patients cholesterol <5 mmol/l
2. % diabetes patients HbA1C is 64mmol/mol
3. % receiving 8 care processes

The risk of stroke is also higher in diabetics within the ACO CCG area but not statistically significant.

There are also a number of other indicators where quality improvements are needed including those described as 'needing local interpretation' such as obesity prevalence, diabetes prevalence, and primary care prescribing.

The expected outcomes would be an additional
1213 diabetic patients with a recorded cholesterol <5mmol/l;
2388 diabetic patients with a recorded HbA1C of 4 mmol/mol
6573 diabetic patients that received the '8 care processes' and
187 less diabetic patients at risk of heart failure

In terms of spends the analysis indicates the following efficiencies:
Elective admissions – 140k
Non-elective admissions – 460k
Primary care prescribing – 1.5M

The ACO response to Diabetes prevention could include:
Primary prevention

1. Consistent offer across the ACO area that addresses lifestyle risk factors for diabetes. This will also lower the risk of developing other conditions such heart disease, cancers and dementia and therefore the demand for services to meet the health and social care needs that arise.
2. Consistent approach to screening ' Health Checks'- targeted with an improvement in uptake and early identification of those at risk (less expensive interventions required to manage at risk patients)
3. Strong proposal to be in the next wave of the National Diabetes Prevention Programme to support 'pre diabetics'

Secondary prevention

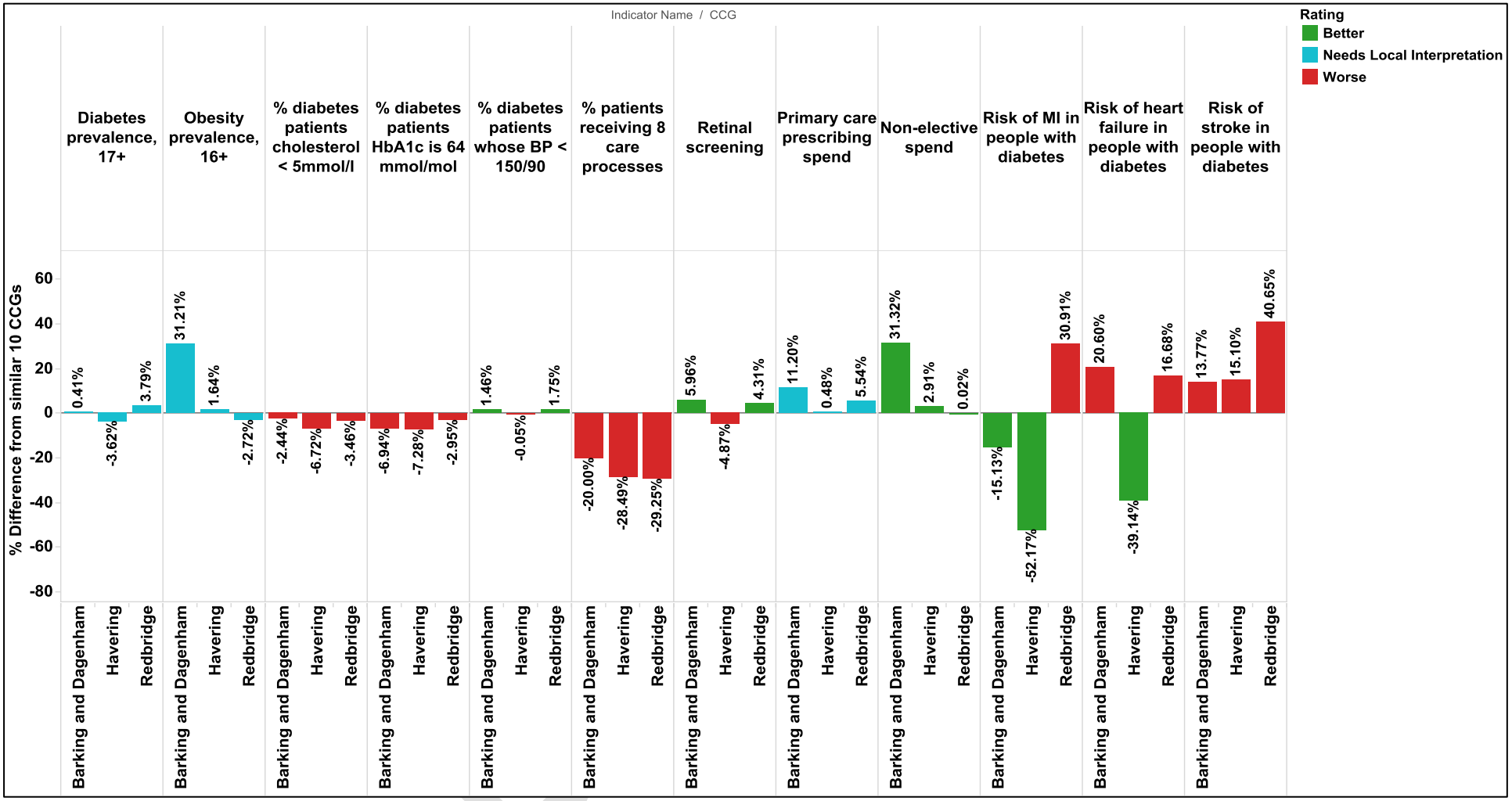
4. Consistent offer in primary care so that there is reduction in variation in quality across the ACO CCG area. This includes completeness of QOF registers for Diabetes; implementation of NICE recommended 8 care processes; lifestyle advice and prescribing/medicines management; diabetic retinopathy screening.
5. Consistent offer in relation to planned and urgent and emergency care. This will include the use of care plans that address the needs of patients with uncomplicated diabetes, those with diabetic complications and those with other long term conditions.

Tertiary prevention

6. Consistent approach to rehabilitation and re-ablement for diabetic patients who have had amputations; visual impairment; strokes etc.

Outcome indicators can be mapped to each aspect of this prevention 'strategy'.

Figure 5 Diabetes Pathway for the ACO CCG area



Data Source: Commissioning for Value: Where to Look 2016:

Table 7: Quality indicators- quality improvement opportunities by programme budget category

The quality indicators show the opportunity for improvements when compared to peer CCG.

Please note that a value of zero means that for the indicator the CCG is doing as well as its peer CCGs.

Disease area	Indicator	Barking & Dagenham	Havering	Redbridge	ACO
Cancer	Receiving 1st definitive treatment within 2 months of urgent GP referral	22	28	21	**71**
	Successful quitters, 16+	112	14	17	**143**
	Bowel cancer screening	878	1361	641	**2880**
Circulation	TIA cases with a higher risk who are treated within 24 hours	11	13	23	**47**
	% hypertension patients whose BP < 150/90	294	0	605	**899**
	Emergency readmissions within 28 days	7	6	10	**23**
Endocrine	% diabetes patients cholesterol < 5 mmol/l	360	914	759	**1213**
	% diabetes patients HbA1c is 64 mmol/mol	702	929	757	**2388**
	% patients receiving 8 care processes	949	1991	3633	**6573**
	Risk of heart failure in people with diabetes	90	0	97	**187**
Gastrointestinal	Emergency admissions for alcohol related liver disease	39	32	0	**71**
Genitourinary	Creatinine ratio test used in last 12 months	339	517	1,108	**1964**
Maternity and Reproductive Health	Teenage conceptions	48	31	0	**79**
	Smoking at time of delivery	148	87	0	**235**
	Live and stillbirths ,2500 grams	0	31	43	**74**
	Breastfeeding initiation (first 48 hrs.)	214	97	234	**545**
	Breastfeeding at 6-8 weeks	406	499	0	**905**
	% receiving 3 doses of 5-in-1 vaccine by age 2	173	333	134	**640**
	% receiving 2 doses of MMR vaccine by age 5	157	281	499	**937**
	Flu vaccine uptake by pregnant women	0	397	196	**593**
Mental Health	Reported to estimated prevalence of dementia	353	441	240	**1034**

Disease area	Indicator	Barking & Dagenham	Havering	Redbridge	ACO
	(%)				
	Assessment of severity of depression at outset	110	0	126	**236**
	Access to IAPT services	860	982	2243	**4085**
	Completion of IAPT treatment	0	200	183	**383**
	Service users on CPA	191	839	486	**1516**
Musculoskeletal Excludes trauma	Hip replacement, EQ-5D index, average health gain	3	0	4	**7**
	% osteoporosis patients 50-74 treated with Bone Sparing Agent	4	0	7	**11**
Neurological	Mortality from epilepsy under 75 years	2	0	2	**4**
Respiratory	Emergency admission rate for children with asthma, 0-18 years	0	21	58	**79**
	% of COPD patients with a record of FEV1	0	175	89	**264**
	% of COPD patients with review (12 months)	0	60	89	**149**
Trauma and Injuries	% fractured femur patients returning home within 28 days	13	0	26	**39**

Source: Commissioning for Value: Where to Look 2016:

Table 8: A review of the indicators by programme pathway for the ACO CCGs (X implies it is an opportunity for the CCG; 0 implies no opportunity)

Pathway	Indicator	Barking & Dagenham	Havering	Redbridge
Breast Cancer	% First definitive treatment within 2 months	X	X	X
	<75 Mortality from breast cancer	X	0	0
Gastrointestinal Cancer	Bowel Cancer Screening	X	X	X
	% First definitive treatment within 2 months	X	X	X
	Lower GI detected at an early stage	X	0	0
Lung Cancer	Successful quitters	X	0	0
	% First definitive treatment within 2 months	X	X	X
	Non elective spend	X	X	0
	Lung cancer detected at an early stage	X	X	X
	<75 Mortality from breast cancer	X	0	X
	1 year survival (breast, lung, colorectal)	X	0	0
Diabetes	% diabetes patients cholesterol <5 mmol/l	X	X	X
	% diabetes patients HbA1C is 64mmol/mol	X	X	X
	% receiving 8 care processes	X	X	X
	Non elective spend	X	X	0
	Risk of heart failure in people with diabetes	X	0	X
	Risk of stroke in people with diabetes	X	X	X
Psychosis	Service users on a CPA	X	X	X
	People on CPA in employment	X	X	X
Common mental health disorder	Assessment of severity of depression at outset	X	0	X
	Access to IAPT	X	X	X
	IAPT- % receiving treatment	X	X	0
	IAPT-% achieving reliable improvement	0	X	X
Heart Disease	Reported to estimated prevalence of CHD	X	X	0
	Non-elective spend	X	X	X

Pathway	Indicator	Barking & Dagenham	Havering	Redbridge
Stroke	% of stroke/TIA patients on anti0platelet agent	0	X	X
	TIA cases treated within 24 hours	X	X	X
	Non-elective spend	X	X	X
	Emergency readmissions within 28 days	X	X	X
COPD	Non-elective spend	X	X	0
	<Mortality from bronchitis, emphysema and COPD	X	X	0
Asthma	% patients (8yrs) with asthma	0	X	X
MSK	% osteoporosis pats 50074 treated with bone sparing agent	X	0	X
	EQ5D health gain	X	0	X
	Hip replacement emergency readmissions 28 days	X	0	X
Trauma and injury	Hip fractures in people aged 65+	X	X	X
	Hip fractures in people aged 80+	X	X	X
	% fractured femur patients returning home within 28 days	X	0	X
Renal	Reported to estimated prevalence of CKD	X	X	X
	Creatinine ration test in last 12 months	X	X	X
	Non-elective spend	X	X	X
	% of patients on RRT who have a transplant	X	X	0
Maternity and early years	Under 18 conception rate	X	X	0
	Flu vaccine	0	X	X
	Smoking at time of delivery	X	X	0
	% LBW babies	X	X	X
	% receiving 3 doses 5 in 1 vaccine	X	X	X
	A&E attendance for <5s	X	X	0
	% children 405 who are overweight	X	X	0
	% receiving 2 doses of MMR by age 5	X	X	X

Source: Commissioning for Value: Where to Look 2016:

Public Health Outcomes Framework 2016

Summary for Havering

Annual Report

Based on May 2016 PHOF Data

Version 1.0
(July 2016)

By London Borough of Havering
Public Health Service

Contents

Introduction

This document summarises performance pertaining to the health and wellbeing of residents of Havering, sourced from Public Health England's Public Health Outcomes Framework.

The Department of Health published the Public Health Outcomes Framework (PHOF) for England 2013-2016 in January 2012. It sets the desired outcomes for Public Health and how outcomes will be measured. The framework consists of 66 outcomes in total: an **overarching domain** (consisting of 2 outcomes) and **four domains** (consisting of the remaining 64 outcomes, covering the full spectrum of public health and the life course) – see Table 1.

Table 1: Public Health Outcomes Framework – domains and outcomes

OVERARCHING	**To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest**
DOMAIN 1	**Improving the wider determinants of health** ***Improvements against wider factors which affect health and wellbeing and health inequalities***
DOMAIN 2	**Health Improvement** ***People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities***
DOMAIN 3	**Health Protection** ***The population's health is protected from major incidents and other threats, whilst reducing health inequalities***
DOMAIN 4	**Healthcare public health and preventing premature mortality** ***Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities***

Source: Public Health Outcomes Framework 2013-2016, Department of Health

Indicators across outcomes

The 66 outcomes of the PHOF consist of a total of 224 indicators. There is more than one indicator associated with some outcomes because there may be a number of sub-indicators (e.g. based on either gender/age).

Table 2 provides a summary of indicator breakdown across the domains.

Table 2: Distribution of number of outcomes and indicators across the different domains of the Public Health Outcomes Framework

	Number of Outcomes	Number of Indicators
Total	66	224
Overarching	2	20
Domain 1: Improving the wider determinants of health	18	52
Domain 2: Health improvement	23	61
Domain 3: Health Promotion	7	25
Domain 4: Healthcare public health and preventing premature mortality	16	66

Source: Public Health Outcomes Framework 2013-2016, Department of Health

Purpose of Report

The main aim of this annual report is to provide an overview of PHOF indicators for Havering compared to England[1] (based on PHOF May 2016 update).[2] However, in many cases, it is advisable to also consider comparisons with other relevant comparators (such as London and boroughs that are most similar to Havering).

Therefore, this report also provides summary information (in the appendix) of Havering indicators that are benchmarked with both England and London averages (to identify if Havering is significantly different); their rank (1 = Best) among London boroughs (out of 32) and statistical comparators (out of 16)[3]; and trend (most recent performance compared to previous years – time period dependent on each indicator).

Overview

164 of 224 PHOF indicators (73%) can be statistically compared with national (England) values as either better or worse.

- 27% of the 164 PHOF comparable indicators (44) for Havering are better than England.
- 20% of the 164 PHOF comparable indicators (32) for Havering are worse than England.
- 54% of the 164 PHOF comparable indicators (88) for Havering are similar than England.

Table 3 provides similar overview for all and individual domains.

[1] *Only 164 of the 224 indicators of the PHOF can be statistically compared with England for significance.*

[2] *PHOF updates are staggered at periodic intervals across the year by Public Health England, with approximately 25% of the data set being updated each February, May, August and November. Resultantly, all of the metrics within the PHOF are updated on an annual basis.*

[3] *Statistical comparators provide a method for benchmarking progress. For each local authority (LA), statistical models designate a number of other LAs deemed to have similar characteristics (e.g. age, demography, geography, socio-economic factors etc). These designated LAs are known as statistical neighbours.*

Table 3: Distribution of indicators that are statistically comparable with England for significance

PUBLIC HEALTH OUTCOMES FRAMEWORK											
	All		Overarching		Domain1		Domain2		Domain3		Domain4	
INDICATORS	164		8		27		48		18		63	
Better	44	27%	5	63%	9	33%	22	46%	1	6%	7	11%
Worse	32	20%	0	0%	3	11%	9	19%	11	61%	9	14%
Similar	88	54%	3	38%	15	56%	17	35%	6	33%	47	75%

Data Source: Public Health England's Public Health Outcomes Framework

Overarching Indicators

5 of the 8 Havering indicators that can be statistically compared with national (England) values are better and the others (3) are similar to England. See Table 4 for these indicators.

In addition, see Appendix 2 for information on Havering indicators benchmarked against both England and London averages; their rank among London boroughs and statistical comparators; and trend (most recent performance compared to previous years – time period dependent on each indicator). For more information, see the Public Health Outcomes Framework website.

Table 4: Overarching Indicators: significantly better, worse, similar to England

BETTER ▲	SIMILAR	WORSE ▼
• Life Expectancy at Birth (M, F) • Life Expectancy at 65 (F) • Gap in Life Expectancy at Birth (M,F)	• Healthy Life Expectancy at Birth (M, F) • Life Expectancy at 65 (M)	

M=Male; F=Female. (M, F) means same indicator but for male and female (counted as 2 indicators)
Data Source: Public Health Outcomes Framework

Domain 1 – Wider Determinants of Health

9 of the 27 Havering indicators (33%) in this domain are better than the national values. Only 3 of the 27 indicators (11%) are worse than the national values (see Table 5).

In addition, see Appendix 3 for information on Havering indicators benchmarked against both England and London averages; their rank among London boroughs and statistical comparators; and trend (most recent performance compared to previous years – time period dependent on each indicator). For more information, see Public Health Outcomes Framework website.

Table 5: Domain 1 - Wider Determinants of Health: significantly better, worse, similar to England

BETTER ▲	SIMILAR	WORSE ▼
• Children in poverty (all dep. children <20) • Children achieving good level of development at end of reception (M,P) • First time entrants to youth justice system • 16-18 year olds NEET[4] • Killed & seriously injured England's roads • Hospital admissions for violence • Complaints about noise • Fuel poverty	• Children in poverty (<16s) • Children achieving a good level of development at the end of reception (F) • FSM Children achieving a good level of development at end of reception (M, F, P) • Year 1 pupils achieving the expected level in the phonics screening check (M,F,P) • FSM Year 1 pupils achieving the expected level in phonics screening check (M,F,P) • Employees who had at least one day off in the previous week • Working days lost due to sickness absence • Utilisation of outdoor space for exercise	• Pupil Absence • Households in temporary accommodation • Adult social care users who have as much contact as they would like

M=Male; F=Female; P=Persons. (M, F, P) means same indicator but for male, female and persons (counted as 3 indicators)

Data Source: Public Health Outcomes Framework

Domain 2 – Health Improvement

22 of 48 Havering indicators (46%) in this domain are better than the national values. 19% (9 indicators) are worse than the national values (see Table 6).

Also see Appendix 4, Appendix 5, and Appendix 6 for information on Havering indicators benchmarked against both England and London averages; their rank among London boroughs and statistical comparators; and trend (most recent performance compared to previous years – time period dependent on each indicator). For more information, see Public Health Outcomes Framework website.

Table 6: Domain 2 - Health Improvement: significantly better, worse, similar to England

BETTER ▲	SIMILAR	WORSE ▼
• Hospital admissions caused by unintentional and deliberate injuries in children (0-14 years, 0-4 years,15-24 years) • Current smoker prevalence at	• Low birth weight of term babies • Breastfeeding initiation • Smoking status at time of delivery • Conceptions in those aged <	• Excess weight in 4-5 year olds • Excess weight in 10-11 year olds • Population meeting '5-a-day' fruit

[4] NEET - Not in Education, Employment or Training

BETTER ▲	SIMILAR	WORSE ▼
age 15 • Regular smoker prevalence at age 15 • Successful completion of drug treatment - non-opiate users • Admission episodes for alcohol-related conditions - narrow definition (M,F,P) • Breast cancer screening coverage • Cervical cancer screening coverage • Newborn bloodspot screening coverage • Abdominal aortic aneurysm screening • Eligible pop. offered NHS Health Check • Falls injuries people aged 65+ (M,F,P) • Falls injuries people aged 65-79 (M,F,P) • Falls injuries people aged 80+ (F,P)	18 and <16 • Occasional smoker prevalence at age 15 • Excess weight in Adults • Physically active adults • Physically inactive adults • Smoking prevalence • Smoking prevalence - routine and manual • Successful completion of drug treatment - opiate users • People with substance dependence issues entering prison previously unknown to community treatment • Newborn hearing screening coverage • Self-reported wellbeing - low happiness score • Self-reported wellbeing - high anxiety score • Falls injuries people aged 80+ (M)	• Portions of fruit consumed daily • Portions of vegetables consumed daily • Bowel cancer screening coverage • Access to diabetic retinopathy screening programmes • Eligible pop. offered NHS Health Check who received NHS Health Check • Eligible pop. received NHS Health check

M=Male; F=Female; P=Persons. (M, F, P) means same indicator but for male, female and persons (counted as 3 indicators)

Data Source: Public Health Outcomes Framework

Domain 3 – Health Protection

Only 1 of the 18 Havering indicators in this domain is better than the national value. 11 of the 17 indicators are worse than the national values (see Table 7).

In addition, see Appendix 7 for information on Havering indicators benchmarked against both England and London averages; their rank among London boroughs and statistical comparators; and trend (most recent performance compared to previous years – time period dependent on each indicator). For more information, see Public Health Outcomes Framework website.

Table 7: Domain 3 - Health Protection: significantly better, worse, similar to England

BETTER ▲	SIMILAR	WORSE ▼
• Dtap / IPV / Hib (1 year old)	• PCV • Hib / MenC booster 5 years old • HPV • HIV late diagnosis • Treatment completion for TB	• Chlamydia detection rate (15-24 years old) • Dtap / IPV / Hib (2 years old) • Hib / Men C booster (2 years old) • MenC

BETTER ▲	SIMILAR	WORSE ▼
	• Incidence of TB	• PCV booster • MMR for one dose 2 years old and 5 year olds • MMR for two doses (5 years old) • PPV • Flu (aged 65+) and Flu (at risk individuals)

Data Source: Public Health Outcomes Framework

Domain 4 – Healthcare and Premature Mortality

7 of the 63 Havering indicators (11%) in this domain are better than the national values. 9 of 63 indicators (14%) are worse than the national values (see Table 8).

In addition, see Appendix 8 for information on Havering indicators benchmarked against both England and London averages; their rank among London boroughs and statistical comparators; and trend (most recent performance compared to previous years – time period dependent on each indicator). For more information, see Public Health Outcomes Framework website.

Table 8: Domain 4 - Healthcare and premature mortality: significantly better, worse, similar to England

BETTER ▲	SIMILAR	WORSE ▼
• Tooth decay in children aged 5 • Mort. rate causes preventable (M,F,P) • Suicide rate (P) • Hip fractures in people aged 65-79 (F)	• Infant mortality • <75 mort. rate CVD (M,F,P) • <75 mort. rate CVD preventable (M,F,P) • <75 mort. cancer (M,F,P) • <75 mort. cancer preventable (M,F,P) • < 75 mort. liver disease (M,F,P) • <75 mort. liver disease preventable (M,F,P) • < 75 mort. resp disease (M,F,P) • <75 mort. resp disease preventable (M,F,P) • Mortality communicable diseases (M,F,P) • Suicide rate (M) • Emergency readmissions within 30 days of discharge from hospital (P,M) • Preventable sight loss: • AMD, glaucoma, diabetic eye disease • Health related QoL* for older people	• Emergency readmissions within 30 days of discharge from hospital (F) • Preventable sight loss - sight loss certifications • Hip fractures in people aged 65+ (M) • Hip fractures in people aged 80+ (P,M) • EWDI* (single year, all ages) (F) • EWDI* (single year, 85+) (F,P) • EWDI* (3 years, age 85+) (F)

BETTER ▲	SIMILAR	WORSE ▼
	• Hip fractures in people aged 65+ (F,P) • Hip fractures in people aged 65-79 (M,P) • Hip fractures in people aged 80+ (F) • EWDI* (single year, all ages) (M,P) • EWDI* (single year, 85+) (M) • EWDI* (3yrs, all ages) (M,F,P) • EWDI* (3 years, age 85+) (P,M)	

**QoL = Quality of Life; EWDI = Excess Winter Deaths Index*
M=Male; F=Female; P=Persons. (M, F, P) means same indicator but for male, female and persons (counted as 3 indicators)
Data Source: Public Health Outcomes Framework

Other

There are a couple of indicators that are not categorised as significantly better or worse, compared to England, but are categorised as either significantly higher or lower. These are shown below in Table 9.

Table 9: Other Public Health Outcomes Framework indicators (categorised as significantly higher, lower, or similar to England

HIGHER ▲	SIMILAR	LOWER ▼
		• Statutory Homelessness (homelessness acceptances) • Recorded Diabetes

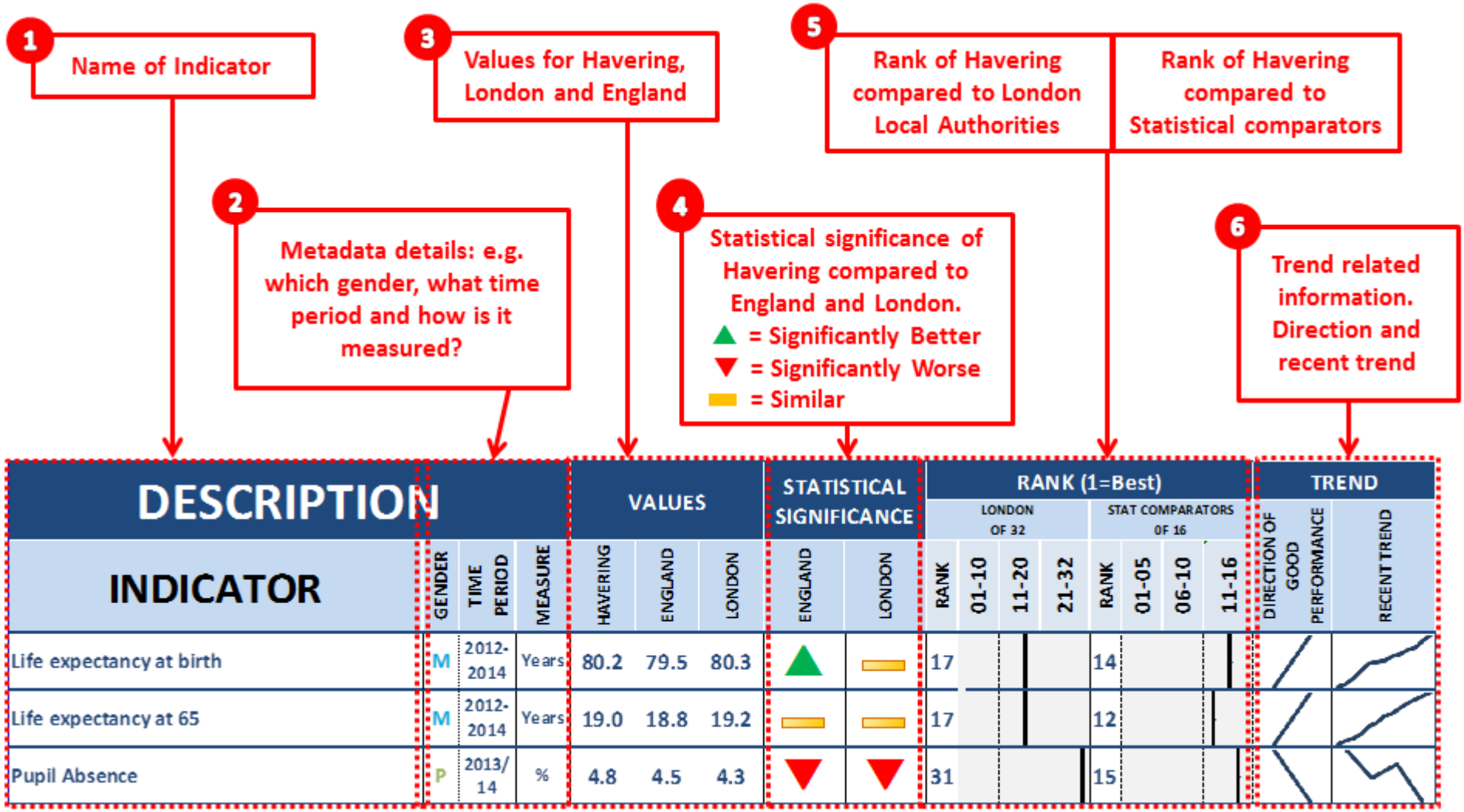
Data Source: Public Health Outcomes Framework

Appendix

Appendix 1: Public Health Outcomes Framework Data Tables

Tables in the appendix provide a summary of those Havering PHOF indicators that are significantly better/worse than England. However, for the table on overarching indicators only, Havering indicators similar to England have also been included.

How to interpret the tables:



DESCRIPTION				VALUES			STATISTICAL SIGNIFICANCE		RANK (1=Best)								TREND	
									LONDON OF 32				STAT COMPARATORS OF 16					
INDICATOR	GENDER	TIME PERIOD	MEASURE	HAVERING	ENGLAND	LONDON	ENGLAND	LONDON	RANK	01-10	11-20	21-32	RANK	01-05	06-10	11-16	DIRECTION OF GOOD PERFORMANCE	RECENT TREND
Life expectancy at birth	M	2012-2014	Years	80.2	79.5	80.3	▲	▬	17				14					
Life expectancy at 65	M	2012-2014	Years	19.0	18.8	19.2	▬	▬	17				12					
Pupil Absence	P	2013/14	%	4.8	4.5	4.3	▼	▼	31				15					

Appendix 2: Overarching indicators

DESCRIPTION				VALUES			STATISTICAL SIGNIFICANCE		RANK (1=Best)								TREND	
									LONDON OF 32				STAT COMPARATORS 0F 16					
INDICATOR	GENDER	TIME PERIOD	MEASURE	HAVERING	ENGLAND	LONDON	ENGLAND	LONDON	RANK	01-10	11-20	21-32	RANK	01-05	06-10	11-16	DIRECTION OF GOOD PERFORMANCE	RECENT TREND
Healthy life expectancy at birth	M	2012-2014	Years	64.0	63.4	64.0	–	–	18				13					
	F			66.4	64.0	64.1	–	–	6				5					
Life expectancy at birth	M	2012-2014	Years	80.2	79.5	80.3	▲	–	17				14					
	F			83.9	83.2	84.2	▲	–	17				11					
Life expectancy at 65	M	2012-2014	Years	19.0	18.8	19.2	–	–	17				12					
	F			21.7	21.2	21.9	▲	–	17				11					
Gap in life expectancy at birth between each local authority and England as a whole	M	2012-2014	Years	0.7	0.0	0.8	▲	–	16				3					
	F			0.7	0.0	1.0	▲	–	13				4					

Appendix 3: Domain 1 – Wider Determinants

DESCRIPTION				VALUES			STATISTICAL SIGNIFICANCE		RANK (1=Best)								TREND	
									LONDON OF 32				STAT COMPARATORS OF 16					
INDICATOR	GENDER	TIME PERIOD	MEASURE	HAVERING	ENGLAND	LONDON	ENGLAND	LONDON	RANK	01-10	11-20	21-32	RANK	01-05	06-10	11-16	DIRECTION OF GOOD PERFORMANCE	RECENT TREND
Children in poverty (all dependent children under 20)	P	2013	%	17.5	18.0	21.8	▲	▲	8				8				↓	↑
Children achieving a good level of development at the end of reception	P	2014/15	%	68.5	66.3	68.1	▲	–	13				7				↓	↑
	M			61.3	58.6	61.1	▲	–	13				7				↓	↑
Pupil Absence	P	2013/14	%	4.8	4.5	4.3	▼	▼	31				15				↓	↓
First time entrants to the youth justice system	P	2014	Rate per 100,000	234.6	409.1	425.7	▲	▲	2				2				↓	↓
16-18 year olds not in education employment or training	P	2014	%	4.0	4.7	3.4	▲	▼	24				13				↓	↓
Killed and seriously injured (KSI) casualties on England's roads	P	2012-14	Rate per 100,000	24.1	39.3	29.8	▲	▲	13				10				↓	↓
Violent crime (including sexual violence) - hospital admissions for violence	P	2012/13-14/15	DSR per 100,000	27.8	47.5	45.9	▲	▲	5				5				↓	↓
Complaints about noise	P	2013/14	Rate per 100,000	2.7	7.4	17.4	▲	▲	1				1				↓	↓
Statutory homelessness - households in temporary accommodation	P	2014/15	Rate per 1,000	6.5	2.8	14.0	▼	▲	7				5				↓	↑
Fuel poverty	P	2013	%	7.5	10.4	9.8	▲	▲	1				1				↓	↓
Adult social care users who have as much social contact as they would like	P	2014/15	%	39.2	44.8	41.8	▼	–	9				3				↓	↑

Appendix 4: Domain 2 – Health Improvement

DESCRIPTION				VALUES			STATISTICAL SIGNIFICANCE		RANK (1=Best)								TREND	
									LONDON OF 32				STAT COMPARATORS OF 16					
INDICATOR	GENDER	TIME PERIOD	MEASURE	HAVERING	ENGLAND	LONDON	ENGLAND	LONDON	RANK	01-10	11-20	21-32	RANK	01-05	06-10	11-16	DIRECTION OF GOOD PERFORMANCE	RECENT TREND
Excess weight in 4-5 year olds	P	2014/15	%	23.7	21.9	22.2	▼	▼	25				15					
Excess weight in 10-11 year olds	P	2014/15	%	35.9	33.2	37.2	▼	–	12				10					
Hospital admissions caused by unintentional and deliberate injuries in children (0-14 years)	P	2014/15	Rate per 10,000	76.9	109.6	83.3	▲	–	13				7					
Hospital admissions caused by unintentional and deliberate injuries in children (0-4 years)	P	2014/15	Rate per 10,000	100.2	137.5	100.4	▲	–	17				9					
Hospital admissions caused by unintentional and deliberate injuries in young people (15-24 years)	P	2014/15	Rate per 10,000	82.4	131.7	98.6	▲	▲	8				5					
Current smoker prevalence at age 15	P	2014/15	%	5.8	8.2	6.1	▲	–	15				7					
Regular smoker prevalence at age 15	P	2014/15	%	3.5	5.5	3.4	▲	–	16				7					
Population meeting recommended '5-a-day'	P	2015	%	42.1	52.3	49.4	▼	▼	30				16					
Portions of fruit consumed daily	P	2015	Average	2.1	2.5	2.5	▼	▼	31				16					
Portions of vegetables consumed daily	P	2015	Average	2.1	2.3	2.2	▼	▼	24				14					
Successful completion of drug treatment - non-opiate users	P	2014	%	46.1	39.2	39.4	▲	▲	8				6					

Appendix 5: (continued...Pg2) Domain 2 – Health improvement

DESCRIPTION				VALUES			STATISTICAL SIGNIFICANCE		RANK (1=Best)								TREND	
									LONDON OF 32				STAT COMPARATORS OF 16					
INDICATOR	GENDER	TIME PERIOD	MEASURE	HAVERING	ENGLAND	LONDON	ENGLAND	LONDON	RANK	01-10	11-20	21-32	RANK	01-05	06-10	11-16	DIRECTION OF GOOD PERFORMANCE	RECENT TREND
Admission episodes for alcohol-related conditions - narrow definition	P	2014/15	Rate per 100,000	429.7	640.8	526.2	▲	▲	2				1					
	M			604.9	826.9	716.8	▲	▲	6				5					
	F			286.1	474.2	358.0	▲	▲	4				3					
Breast cancer screening coverage	F	2015	%	78.7	75.4	68.3	▲	▲	1				1					
Cervical cancer screening coverage	F	2015	%	76.3	73.5	68.4	▲	▲	2				2					
Bowel cancer screening coverage	P	2015	%	50.6	57.1	47.8	▼	▲	11				11					
Newborn bloodspot screening coverage	P	2014/15	%	98.2	95.8	97.2	▲	▲	11				6					
Access to diabetic retinopathy screening programmes	P	2012/13	%	75.5	79.1	77.0	▼	▼	18				9					
Abdominal aortic aneurysm screening	M	2014/15	%	99.8	97.4	99.1	▲	▲	11				7					
Eligible population offered an NHS Health Check	P	2013/14-14/15	%	39.8	37.9	44.6	▲	▼	21				7					
Eligible population offered an NHS Health Check who received an NHS Health Check	P	2013/14-14/15	%	43.3	48.9	48.1	▼	▼	22				12					
Eligible population who received an NHS Health check	P	2013/14-14/15	%	17.2	18.6	21.5	▼	▼	26				10					

Appendix 6: (continued...Pg3) Domain 2 – Health improvement

DESCRIPTION				VALUES			STATISTICAL SIGNIFICANCE		RANK (1=Best)								TREND	
									LONDON OF 32				STAT COMPARATORS OF 16					
INDICATOR	GENDER	TIME PERIOD	MEASURE	HAVERING	ENGLAND	LONDON	ENGLAND	LONDON	RANK	01-10	11-20	21-32	RANK	01-05	06-10	11-16	DIRECTION OF GOOD PERFORMANCE	RECENT TREND
Admission episodes for alcohol-related conditions - narrow definition	P	2014/15	Rate per 100,000	429.7	640.8	526.2	▲	▲	2				1					
	M			604.9	826.9	716.8	▲	▲	6				5					
	F			286.1	474.2	358.0	▲	▲	4				3					
Injuries due to falls in people aged 65 and over	P	2014/15	DSR per 100,000	1677.6	2124.6	2253.4	▲	▲	2				1					
	M			1512.6	1739.8	1932.7	▲	▲	5				2					
	F			1842.7	2509.5	2574.2	▲	▲	1				1					
Injuries due to falls in people aged 65 and over - aged 65-79	P	2014/15	DSR per 100,000	689.2	1012.0	1137.7	▲	▲	1				1					
	M			625.9	825.7	1026.1	▲	▲	2				2					
	F			752.5	1198.2	1249.3	▲	▲	1				1					

Appendix 7: Domain 3 – Health Protection

DESCRIPTION				VALUES			STATISTICAL SIGNIFICANCE		RANK (1=Best)								TREND	
									LONDON OF 32				STAT COMPARATORS 0F 16					
INDICATOR	GENDER	TIME PERIOD	MEASURE	HAVERING	ENGLAND	LONDON	ENGLAND	LONDON	RANK	01-10	11-20	21-32	RANK	01-05	06-10	11-16	DIRECTION OF GOOD PERFORMANCE	RECENT TREND
Chlamydia detection rate (15-24 year olds)	P	2014	Rate per 100,000	1383	2313	2035	▼	▼	26				10					
Population vaccination coverage - Dtap / IPV / Hib (1 year old)	P	2014/15	%	95.2	94.2	90.6	▲	▲	2				1					
Population vaccination coverage - Dtap / IPV / Hib (2 years old)	P	2014/15	%	92.3	95.7	92.5	▼	▬	21				12					
Population vaccination coverage - MenC	P	2012/13	%	92.0	93.9	89.9	▼	▲	10				7					
Population vaccination coverage - Hib / Men C booster (2 years old)	P	2014/15	%	91.2	92.1	86.8	▼	▲	3				2					
Population vaccination coverage - PCV booster	P	2014/15	%	90.9	92.2	86.4	▼	▲	2				1					
Population vaccination coverage - MMR for one dose (2 years old)	P	2014/15	%	90.4	92.3	87.3	▼	▲	5				4					
Population vaccination coverage - MMR for one dose (5 years old)	P	2014/15	%	93.3	94.4	90.7	▼	▲	7				4					
Population vaccination coverage - MMR for two doses (5 years old)	P	2014/15	%	85.5	88.6	81.1	▼	▲	10				5					
Population vaccination coverage - PPV	P	2014/15	%	67.3	69.8	64.9	▼	▲	9				5					
Population vaccination coverage - Flu (aged 65+)	P	2014/15	%	70.7	72.7	69.2	▼	▲	10				5					
Population vaccination coverage - Flu (at risk individuals)	P	2014/15	%	47.9	50.3	49.8	▼	▼	20				9					

Appendix 8: Domain 4 - Healthcare and premature mortality

DESCRIPTION				VALUES			STATISTICAL SIGNIFICANCE		RANK (1=Best)								TREND	
									LONDON OF 32				STAT COMPARATORS OF 16					
INDICATOR	GENDER	TIME PERIOD	MEASURE	HAVERING	ENGLAND	LONDON	ENGLAND	LONDON	RANK	01-10	11-20	21-32	RANK	01-05	06-10	11-16	DIRECTION OF GOOD PERFORMANCE	RECENT TREND
Tooth decay in children aged 5	P	2011/12	Mean DMFT per child	0.5	0.9	1.2	▲	▲	4				6				\	
Mortality rate from causes considered preventable	P	2012-14	DSR per 100,000	159.3	182.7	169.5	▲	▲	9				8				\	↘
	M			202.7	230.1	219.0	▲	▬	11				10				\	↘
	F			120.7	138.4	124.7	▲	▬	14				10				\	↘
Under 75 mortality rate from all cardiovascular diseases	P	2012-14	DSR per 100,000	68.5	75.7	78.7	▲	▲	8				6				\	↘
Suicide rate	P	2012-14	DSR per 100,000	6.5	8.9	7.0	▲	▬	9				9				\	↗
Emergency readmissions within 30 days of discharge from hospital	F	2011/12	ISR	12.1	11.5	11.7	▼	▬	21				10				\	↗
Preventable sight loss - sight loss certifications	P	2013/14	Rate per 100,000	56.6	42.5	30.2	▼	▼	32				16				\	↗
Hip fractures in people aged 65 and over	M	2014/15	DSR per 100,000	554.6	425.1	394.5	▼	▼	32				16				\	/
Hip fractures in people aged 65 and over - aged 65-79	F	2014/15	DSR per 100,000	192.3	311.6	269.9	▲	▬	4				2				\	\
Hip fractures in people aged 65 and over - aged 80+	P	2014/15	DSR per 100,000	1852.2	1534.6	1367.5	▼	▼	32				16				\	↗
	M			1524.5	1174.1	1026.3	▼	▼	31				15				\	/
Excess winter deaths index (single year, all ages)	F	Aug-13 - Jul-14	Ratio	27.5	13.2	12.9	▼	▼	32				16				\	↗
Excess winter deaths index (single year, age 85+)	P	Aug-13 - Jul-14	Ratio	36.5	15.8	18.5	▼	▼	30				16				\	↗
	F			54.7	15.5	19.2	▼	▼	32				16				\	↗
Excess winter deaths index (3 years, age 85+)	F	Aug-11 - Jul-14	Ratio	39.9	22.5	25.1	▼	▼	31				16				\	↗

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Social Isolation Project
Board Lead:	John Green
Report Author and contact details:	Samantha Saunders, Social Inclusion Coordinator, ASC Strategy and Commissioning.

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

- x 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 Social Isolation Project, managed by the Adults Social Care (ASC) Strategy and Commissioning Team is a one year project providing outreach support, in the form of Community Navigators, to socially isolated Older Adults in the Community.

The project is working with Older Adults who are in receipt of an Adult Social Care service to test whether, by providing direct practical support, the Older Adults can develop meaningful community engagements to improve wellbeing. The project will also test the hypothesis that, by making lives more full, care packages could be reduced.

RECOMMENDATIONS

The project will continue to work with clients until November and a report of the project's findings will be produced, with recommendations for future service development and the role of the Community Navigator within the care pathway.

REPORT DETAIL

1.0 Introduction and Background

1.1 This Project is aligned with the Health and Wellbeing Strategy; THEME A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing, and specifically Priority 1: Early help for vulnerable people to live independently for longer.

1.2 It has been set up to respond to the increasing issue of social isolation and loneliness in our Older Adult community. Adult Social Care, Strategy and Commissioning, has responded to this issue through the recruitment of the Social Inclusion Coordinator, to lead on the project.

1.3 The work has led to significant intelligence that is contributing to an evidence based commissioning approach. This aligns with the Health and Wellbeing Strategy objectives to: *Tackle isolation and support vulnerable people to help maintain independent living. We will do this by commissioning innovative and targeted volunteer-led schemes that focus on befriending and supporting vulnerable people.*

1.4 The Social Isolation Project has taken an outreach approach to supporting Older Adults in the community, with the team recruiting two Community Navigators to work alongside the older adults as enablers.

1.5 This approach focuses on addressing the barrier to overcoming social isolation. This enabling approach supports the person to access services that are meaningful, outcome focused and increases their social networks.

1.6 Additionally, this approach is reviewing the current services available within Havering to understand whether they provide the right types of opportunities to meet the needs of the socially isolated Older Adult community.

1.7 The project has clear outcomes set to test the approach from a preventative perspective;

- Cost Effectiveness of Personalised Social Isolation Intervention – The cost of the Adult Social Care Packages and impact on the draw on health services.
- Effectiveness of Personalised Social Isolation Intervention - The change in the service user's perception of their social isolation.
- Assess the potential of the existing wider community resources as a method to address social isolation.
- Identify gaps in existing community resources to inform future market shaping to address social isolation with wider cohorts.

1.8 The Project Steering Group agreed that a cohort of Older Adults who were in receipt of long term care support in the community would be most appropriate

to test this approach against the project objectives. These Cohort members were recruited through operational health and social care staff referring into the project.

1.9 The initial project plan was to identify and work closely with 100 Older Adults. The Community Navigators would support these Older Adults through a process of change toward increased engagement in meaningful community activity. Additionally a control group of 100 Older Adults would be used to monitor the effectiveness of the approach, through comparison in changes in use of health and social care services.

2.0 Project Progress to date

2.1 The project has been accepting referrals since November 2015 and has received 275 referrals to date. The project will run until October 2016 and is now closed to new referrals.

2.2 Of the 275 referrals, 137 have been screened as not eligible. Of 138 eligible referrals, 68 have progressed to active cases that the Community Navigators have been able to support through the change process.

2.3 Due to the number of clients who have been unable to engage for the duration of the intervention, the Project Steering Group has agreed that a cohort of 50 will be reported on in the final evaluation.

2.4 The Community Navigators have gathered importance intelligence regarding the barrier to community engagement, and the range and quality of community resources. This intelligence is contributing to the ASC Voluntary Sector Co-production re-commissioning of services.

2.5 The project is also contributing to ASC commissioning understanding of the profile and needs of the socially isolated older adults and this will enable future planning to meet these needs.

3.0 Emerging Themes

3.1 The project has provided detailed evidence of a number of key barriers which impact on the older adult achieving a positive change to their routine and engagement in the wider community. The Community Navigators are working through these barriers with the Older Adults and the timescale to achieve change has been evidenced as a prolonged process.

3.2 The effectiveness of the Community Navigator role in realising reduction in care packages and use of health services is dependent on a prolonged period of involvement to work through the current barriers experienced by older adults.

3.3 Some of these barriers to engagement are being considered as areas for service development through ASC commissioning with the voluntary sector:

- Home Based Support. There is a lack of options to refer older adults to who are limited in their ability to leave their homes, either due to physical disability or cognitive impairment. They function within their home with an appropriate level of support but report low mood, loneliness and social isolation due to these limitations.

- Enhanced Personal Assistant market to respond the Social Needs of Older Adults. Service users in receipt of Personal Budgets which includes Social Isolation need support to understand what their options are and the PAs need to be skilled in how they can assist and motivate clients.

- Transport +. Transport options do not provide the level of support needed for older adults to access the wider community resources. Chaperoned transport to community activities is required to bridge the gap between the Older Adult and the community group.

- Collaborative approach to providing groups. Older Adults that want to attend groups but are limited by need to have accessible facilities. Community Groups could come together in one Community location with accessible facilities and PA support.

- Bringing People Together. Supporting Older Adults with similar interests to connect. A coordinator who can enable peer support groups to be established. An example of this has been support we have given to ex-servicemen and women to come together through SSAFA (The Armed Forces Charity), who are establishing a lunch club to meet this need.

3.4 Additionally the timescale for change, and complexity of barriers to change, experienced with some of the cohort, has provided an understanding of where the Community Navigator role is best placed in the care pathway for Adults. The stage at which the adult is supported to develop meaningful and sustainable relationships in the community will have an impact to the preventative nature of this approach.

3.5 The project is also developing a broad understanding of the wider community resources and compiling a spread sheet to populate 'Earthlight, which is mapping software to collate geographic information. This will be transferred to business as usual

4.0 Emerging Outcomes

4.1 The method being used to measure impact on people's lives is through the 'outcomes star'. This basically asks a set of questions around well-being at the outset of the engagement with the older person and quantifies the responses against a scale. This exercise is repeated after a set period of engagement with the person. We are just reaching the stage where second interviews about perceptions of well-being are being conducted. There are very low numbers to evaluate but where they have been done outcomes are positive. This is too

early, however, to make assertions or claims about impacts on people's lives. We will however continue to gather data.

4.2 In regard to the reduction in the cost of ASC packages there is little evidence as yet that the interventions have led to reduced dependence. The learning is that the complexity involved, once you start to work with people on a one to one basis, is significant and that once dependency is embedded it is very difficult to change perceptions of need. We are considering, time allowing, working with a small cohort of people who are not yet receiving Adults Social Care to see if the impact is different and would suggest value in earlier prevention.

BACKGROUND PAPERS

- Social Isolation Project PID
- Havering Health and Wellbeing Strategy 2012-2014

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Launch of face to face intervention (working with children in social care)
Board Lead:	Tim Aldridge, Acting Director of Children's Services
Report Author and contact details:	

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

Over the last three years Children's Services has witnessed a sharp increase in demand on Early Help, Child Protection, Children in Need and Looked After Children services. This has created significant cost pressures to meet demand. In response, Children's Services has launched a 2 year programme of transformative change with the aim of improving services, providing cost avoidance opportunities, and developing a sustainable high quality workforce.

In May 2016 Children's Services launched the Face-to-Face vision, with these objectives:-

- Social workers to spending more time in direct work with families, offering purposeful, evidence-based interventions.
- Supporting a more concise, analytical, and reflective approach to thinking and writing about their work.
- Working intensively with families to build resilience and support sustained change.
- Improving outcomes, reducing costs and stabilising the workforce

The transformation programme will take two years to implement – cultural change is likely to take at least 18 month to start to take root. The workforce lies at the centre of this approach as it is based on the quality of trusting, consistent, and purposeful relationships with families. Through cultivating a systemic approach to practice, and by creating an environment where good social work can flourish, we will make significant steps to improve outcomes for children and families.

RECOMMENDATIONS

Members of the Health and Wellbeing board are asked to note the contents of the report.

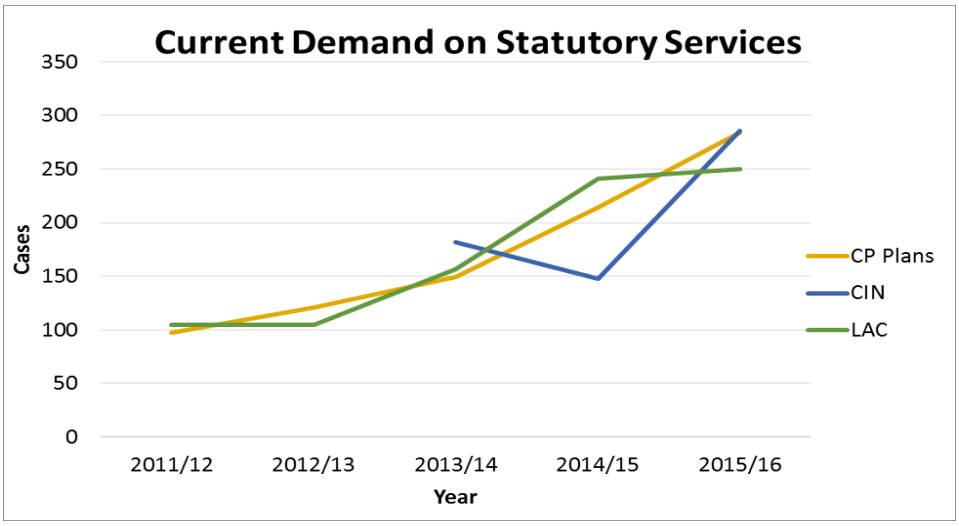
REPORT DETAIL

1.0 Background

Our statistics illustrate that Havering has experienced a change in demand on statutory services since 2011/12. We have seen an increased deprivation index and have the highest growth in the 0 -18 years population in London. The demand profile mirrors experiences in other outer London Boroughs with a

migration of families from inner London to areas of more affordable housing. We are seeing larger families with increased complex needs, from diverse communities.

Graph 1: Demonstrates increasing demand on statutory services within children's services.



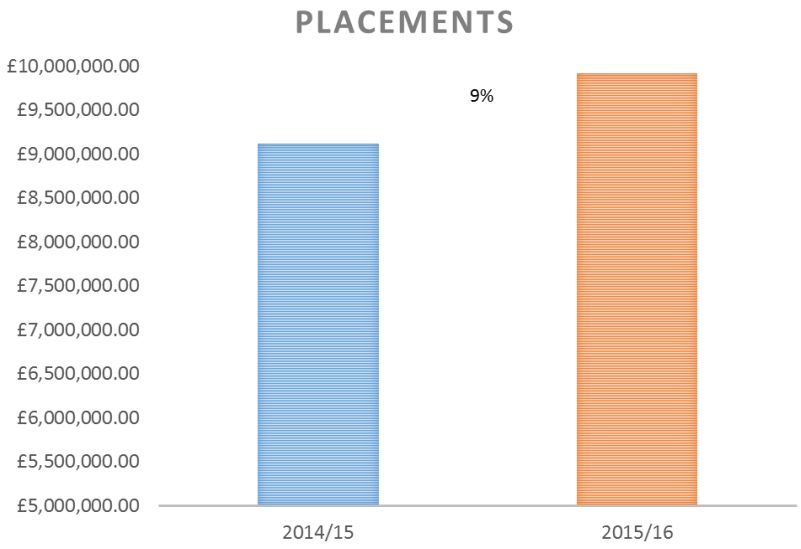
During this period of demand in statutory services, children's services had an unprecedented level of agency staff (43%); a feature we share with a number of other outer London Boroughs.

The lack of stability within the workforce presents a significant barrier to improving outcomes for children and families. During 2015/16, 30% of our children and young people experienced 3 or more changes of social worker. Agency staffing levels have created a significant budget pressure due to an on average 25% inflation of salary costs. In order to achieve the aims of the programme, an increase in the proportion of permanent staff is required.

The increased number of children in care has led to increased costs of providing foster care placements, with demand exceeding the numbers of available in-house carers, leading to greater reliance on more expensive Independent Fostering Agency placements.

There has also been a changing profile of children in care, with a growth n the number aged 11 – 15 year olds who often have more complex needs. The unit cost of placements is increasing; with more out of borough placements, greater use of independent fostering agencies and residential placements. There has been a 9% increase in placement spend from 2014/15 – 2015/16.

Graph 2: Demonstrates placement spend.



2.0 Implementation of Change

2.1 Systemic approach to social care

Through the programme, we will support all permanent front-line staff and their managers to attend a 15 day accredited foundation qualification in Systemic Family Therapy over the next two years. Support staff will receive a shorter tailored workshop to enable them to support frontline staff.

2.2 A Systemic team

The Head of Systemic Practice, Dave Tapsell, joined the CYPS senior leadership team on the 4th July. Dave will recruit a small team of systemic Family therapists who will contribute to teaching, coaching and modelling interventions. These practitioners will be embedded with social work teams and also engage in direct work with families, alongside social workers.

2.3 Workforce

A recruitment and retention strategy has been developed to stabilise the workforce and reduce the level of dependency on agency social workers.

2.4 Creating an enabling environment

The Principal Social Worker, Kate Dempsey, and Head of Systemic Practice will develop a framework to support reflective case supervision. This will include

facilitating peer supervision through both formal and informal reflective case discussions.

2.5 Mobile Working

Mobile working devices are being distributed to frontline staff to enable greater flexibility. Currently we are in phase 2 of this programme, with an expected completion date by September.

2.6 New Programmes

We have implemented two tools, the Outcome Star and Mind of my Own (MOMO). MOMO is an online application which offers a young person aged 8 years and above the opportunity to express their thoughts and feelings prior to important case meetings. They can also provide ad hoc feedback and request to 'Make a Change'. The Outcome star has been piloted in Early help and is an assessment and planning tool, and also a way of measuring progress or 'distance travelled'. This tool supports a more collaborative, co-production approach, and is a more visual and concise approach to recording.

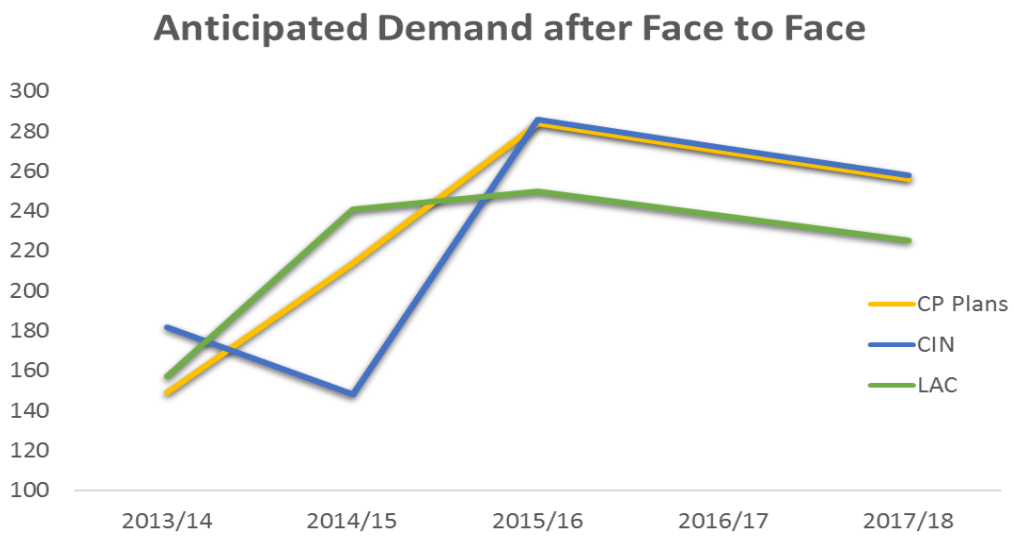
3.0 The key implications for practices based on face to face intervention.

The Face–to–Face programme aims to reduce demand across children's services by delivering more effective interventions – aiming to resolve issues in a way that is sustainable and builds on families strengths, supporting greater resilience. The intention is to reduce the proportion of cases that require statutory interventions (such as child protection plans or children being taken into care). Through supporting families to make sustainable changes, this should result in fewer families subject to repeat referrals.

This is an evidence-based approach with results from local authorities indicating a 10% reduction in demand on statutory services over a two year period.

The aim is that as the number of families we are actively working with reduces, this will lead to smaller case loads, and enable social workers to conduct more intensive high-quality interventions, leading to better outcomes for children and families.

Graph 3: Demonstrates anticipated demand based on LA's who have already undergone similar transformative change, with 10% reductions in activity over a two year period.



4.0 Future Development

Currently Children's Services is leading a partnership application to the DfE Innovation Fund. If we are successful, this would lead to the creation of a multi-agency systemic pathway for Children in Care and Care Leavers aged 11-24 years.

The proposal also entails the recruitment of specialist foster carers, trained in systemic practice and provided with intensive support. The aim is to improve the quality of foster placements and reduce placement disruptions.

BACKGROUND PAPERS

Children's Services plan 2016/17