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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD
AGENDA

1.00 pm	Wednesday, 16 November 2016	Committee Room 3A - 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 Jacob, NHS England Jacqui Van Rossum, NELFT

For information about the meeting please contact:
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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

- receive.

Apologies have been received from Andrew Blake-Herbert, Chief Executive, London Borough of Havering and from Barbara Nicholls, Director of Adult Services, London Borough of Havering.

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 21 September 2016 (attached) and to authorise the Chairman to sign them. To also consider any matters arising not on the action log or agenda.

Councillor Brice-Thompson

Start time: 13:05

5. ACTION LOG (Pages 9 - 10)

To consider the Board's action log (attached).

Councillor Brice-Thompson

Start time: 13:10

6. DRAFT HEALTH AND WELLBEING STRATEGY (Pages 11 - 56)

Report attached.

Susan Milner

Start time: 13:15

7. LOCAL CHILDREN SAFEGUARDING AND ADULT SAFEGUARDING BOARD REPORTS (Pages 57 - 150)

Reports attached.

Brian Boxall

Start time: 13:25

8. SINGLE INSPECTION FRAMEWORK UPDATE (VERBAL)

Tim Aldridge

Start time: 13:40

9. LOOKED AFTER CHILDREN - HEALTH CHECK UPDATE (VERBAL)

Tim Aldridge, Alan Steward, Carol White

Start time: 13:45

10. ADULT SOCIAL CARE LOCAL ACCOUNTS FOR 2015/16 (Pages 151 - 196)

Report attached.

Caroline May

Start time: 13:50

11. REFERRAL TO TREATMENT DELAYS IN BHRUT UPDATE (Pages 197 - 208)

Report attached.

Sarah Tedford/Louise Mitchell

Start time: 14:05

12. ACO/STP UPDATE (VERBAL)

Conor Burke, Alan Steward, Andrew Blake-Herbert

Start time: 14:15

13. HOUSING DEVELOPMENT (Pages 209 - 222)

Report attached.

Neil Stubbings

Start time: 14:25

14. BHR CCGs' LOCAL DIGITAL ROADMAP (Pages 223 - 292)

Report attached.

Ron Meaker/Simrath Bhandal

Start time: 14:40

15. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT (INFORMATION ONLY, NOT FOR DISCUSSION) (Pages 293 - 310)

Report attached.

Susan Milner

16. FORWARD PLAN (TO BE TABLED)

Susan Milner

Start time: 14:55

17. DATE OF NEXT HEALTH AND WELLBEING BOARD MEETING

18 January 2017.

MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD
Committee Room 3B - Town Hall
21 September 2016 (1.00 - 2.51 pm)

Board Members present:

Councillors Wendy Brice-Thompson (Chairman) Roger Ramsey, Robert Benham and Gillian Ford

Elaine Greenway, Senior Public Health Strategist (EG)*

Barbara Nicholls, Director of Adult Services (BN)

Dr Atul Aggarwal, Chair, Havering Clinical Commissioning Group (CCG) (AA)

Dr Gurdev Saini, Board Member, Havering CCG (GS)

Alan Steward, Chief Operating Officer, Havering CCG (AS)

Anne-Marie Dean, Chair, Healthwatch Havering (AMD)

Fiona Peskett, Barking, Havering and Redbridge University Hospitals' NHS Trust (BHRUT)** (FP)

Jacqui van Rossum, North East London NHS Foundation Trust (NELFT) (JVR)

*Substituting for Dr Susan Milner, Interim Director of Public Health

** Substituting for Matthew Hopkins, Chief, executive, BHRUT

Also present:

Mary Phillips, Assistant Director, Learning and Achievement (MP)

Philipa Brent-Isherwood, Head of Business and Performance (PBI)

Gloria Okewale, Administrator, Public Health (GO)

Mayoor Sunilkumar, Senior Public Health Analyst (MS)

Anthony Clements, Principal Committee Officer (AC)

One member of the public was also present.

All decisions were taken with no votes against.

12 WELCOME AND INTRODUCTIONS

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

13 APOLOGIES FOR ABSENCE

Apologies were received from Andrew Blake-Herbert, Chief Executive, Susan Milner, Interim Director of Public Health (Elaine Greenway substituting) Tim Aldridge, Director of Children's Services, Conor Burke, BHR CCGS and Matthew Hopkins, BHRUT (Fiona Peskett substituting).

14 DISCLOSURE OF INTERESTS

There were no disclosures of interest.

15 MINUTES

The minutes of the meeting held on 20 July 2016 were agreed as a correct record and signed by the Chairman. There were no matters arising not covered elsewhere on the agenda.

16 ACTION LOG

It was noted that the finalised Board terms of reference had been circulated to Board members as agreed.

The draft of the refreshed Joint Health and Wellbeing Strategy would be circulated after the meeting and comments invited.

17 COMBINED UPDATE ON ACO/STP

The local Sustainability and Transformation Plan (STP) was at framework level and covered the whole of North East LondonThe STP is the mechanism for delivering the NHS 5 year Forward View and a draft business case had been submitted at the end of June. A further submission was due by 21 October which would address, as requested, the impact of the plans on quality of care.

Havering was involved with a Democratic Oversight Group looking at governance issues regarding the STP. AS added that a number of different workstreams had been set up in order to deliver the plan covering areas such as A & E, planned care, prevention and IT issues. A successful three-borough workshop had been held on how improvement could be delivered and it was emphasised that Councils had a key role to play in this.

Support had been received from the Local Government Association to deliver a major workshop covering readiness of all relevant parties for the proposals. BN added that updates on governance issues would be brought

to both the CCG and the Council. Priorities for Havering under the STP included work with children and families and frailty issues.

AS added that engagement was planned with local people and communities. It was necessary to develop however how this would be carried out. Councillor Ford felt that social media could assist with this. AMD felt that it was important that local messages from the STP were also focussed upon. A wider meeting was planned in the next 2-3 weeks to discuss how best communities could be engaged with.

It was noted that the reference to Redbridge in paragraph 1.1 of the report should have referred to Havering. It was uncertain at this stage if there were any conflicts between the plans for the STP and the proposals around the work of the Accountable Care Organisation (ACO).

It was accepted that there was a lack of knowledge around the STP outside of the local Councils. Councillor Ramsey felt that public engagement should focus on succinct messages and a summarised version of the STP should be developed for the public. AS agreed to note this.

18 **SEND INSPECTION AND NEEDS ASSESSMENT**

MP explained that Children and Families services were preparing for a future inspection by Care Quality Commission and OFSTED. The inspection had a wide-ranging scope covering SEND outcomes from 0-25 and included such topics as understanding local need, education, health and care plans, and joint commissioning. The scope of the inspection covered all children with an identified special need and was not restricted to those with Education, Health and Care Plans etc. The organisations that anticipate being inspected include the local authority, those in the youth justice system, CCG, NHS England, health providers, early years settings, schools and further education colleagues

Reports of most previous inspections in other areas were available and five days' notice of the start of the inspection would be given to the Council and CCG. Inspectors would expect evidence-based information, including sharing of information. The inspectors would meet with providers and commissioners as well as parents, carers and children & young people themselves. Officers had put in a great deal of work in order to be ready for the inspection and the implementation of the Children and Families Act.

It was emphasised that the Children and Families Act aimed for children to be prepared for an independent adulthood. All working was required to be joint between education, health and social care. The Local Offer for Havering would therefore be closely inspected.

Associated risks included a need to articulate funding challenges and low numbers of personal budget holders, although the Council wished to increase this. Other risk areas included the transition process, a lack of evidence of joint commissioning taking place and not having a live system of

tracking from pre-birth onwards. It was recognised that integration could be improved, including for example integration between early years providers and health visitors.

Joint working for commissioning, assessments and an integrated 16-25 provision also needed to be addressed. ICT needed to be used as part of the solution around joint assessments given the limited time and other resources available to GPs, physios etc. MP felt there was a full commitment to addressing these issues. Next steps included the appointment of an officer to support inspection preparation.

MP felt that other inspected authorities had received similar results around joint working and the inspection team would not be expecting all issues around Children and Families to be fully resolved at this stage.

Councillor Ramsey felt it was important to show if Havering was making similar progress to other Local Authorities. MP felt Havering was in a similar position to other Council areas. The inspection report would identify areas where progress needed to be made, rather than make judgements.

MP would bring to a future meeting of the Board the self-evaluation that had been worked on with the CCG. It was confirmed that there was a list of services commissioned for children and the delivery plan was being written at the same time.

Data sharing was difficult to implement fully at present due to there being a number of different ICT systems across the various organisations that did not fully communicate with each other. MP gave an example where children's pupil numbers did not match up with their NHS number. AS felt that this was an area that could be developed as part of the ACO programme of work.

It was explained that local SEND data was gathered from many different organisations. There had not been any SEND data gathered nationally although the Department for Education was now producing outcome tools for this area. The SEND needs assessment (part of the Joint Strategic Needs Assessment) also made a series of recommendations covering strategic, service and technical issues.

AM felt that some key issues re SEND included immunisation, access to annual health checks and equipment. MP added that there was only a low number of occupational therapists available and it was important to use resources in the right way.

A question was asked about frequency of data being updated for SEND. MP clarified that data would be updated on an annual basis. A further query was raised about school exclusions for SEND. MP agreed to revise the Executive Summary to include reference to state schools.

Action: Revised Executive Summary to be circulated to Board Members.

19 TRANSFORMING CARE PARTNERSHIP - FOR SIGN OFF

BN explained that this was a national initiative supported by the Local Government Association and the Association of Directors of Adult Social Services , following the Winterbourne View review of incidents of abuse at a care home. The programme had led to the establishing of Transforming Care Partnerships (TCPs) in local areas.

Havering's TCP includes partnership working between the Council, NELFT, and NHS England which is responsible for specialist commissioning.

Locally, this work aimed to make respite care more readily available and provision across Havering, Barking & Dagenham and Redbridge would be looked at in order to get the maximum from community services.

It was noted that, as of March 2016, there were a total of 26 people receiving in-patient care services with 8 of these from Havering. These figures had increased slightly during 2016-17 but remained low overall. The aim of the TCP was to introduce facilities that would allow people to be discharged sooner and be supported in the community. The new Havering facilities at Great Charter Close were an example of this. It was uncertain at this stage why more people from Redbridge were placed in secure settings but this was being investigated in conjunction with NELFT. In-patient services consisted of 11 beds at Goodmayes Hospital. Private secure in-patient facilities were also used although these could be very expensive.

The TCP would have governance links to the three local CCGs as well as relevant partnership boards. The TCP work also sat within that of the STP but work would only be carried out at a regional or London-wide level where it was felt it would be advantageous to do so.

The TCP programme plan had several key domains including co-production and it was accepted that fuller engagement with service users was required. An organisation that was experienced with working with people with learning disabilities had been engaged to ascertain what service users required.

The programme also aimed to keep people out of hospital settings and the reduction in the number of beds required would fund the work of the TCP itself. Some specialist units would still be needed although work was in progress with NELFT to remodel the way beds were used and hence reduce the amount of out of borough placements that were needed.

The new 16-25 provision at the Avelon Centre would be used more and a Cabinet report had been drafted concerning a proposed special school for very high needs autistic children. This would be a unit for 20-25 children that would lead to better outcomes.

An estates workshop for Barking & Dagenham, Havering and Redbridge was due to be held shortly in order to consider what facilities would be needed in the future.

The Board:

1. Received the final TCP plan submitted to NHS England on 11th April 2016 (now assured by NHS England).
2. Noted the programme plan now underway to deliver the TCP plan.
3. Agreed to receive an update in six months on ongoing progress against the delivery of the programme.

20 CCG ASSURANCE FRAMEWORK AND RATING

AS explained that Havering CCG's assessment had been downgraded from 'good' to 'inadequate' due to the referral to treatment (RTT) issues. The issuing of legal directions to the CCG regarding RTT had led to a new assessment. The CCG was developing a plan for ensuring that the 18 week RTT target would be met and this was due to be finalised by the end of September 2016.The 1,000 people who had been waiting in excess of 52 weeks for treatment had reduced to approximately 200.

The assessment had indicated that the CCG was excellent in other areas such as primary care. The new assessment framework, which was related to work on the STP and Five Year Forward View had prioritised three areas – dementia, learning disabilities and diabetes. The assessment had said that the CCG was performing well on dementia but that improved outcomes were needed for diabetes. Work on this was in progress across the three local CCGs and it was hoped this would lead to a better quality of life for people with diabetes as well as increased funding. AS would bring an update on this to a future meeting of the Board.

It was agreed that the Board should receive regular updates from AS and FP on waiting times for treatment, particularly those people who had been waiting more than 52 weeks. It was noted that the Health Overview and Scrutiny Sub-Committee was currently reviewing this issue in conjunction with Healthwatch Havering.

21 FORWARD PLAN (TO BE TABLED)

It was agreed that the following items should be added to the Board's Forward Plan:

Area Inspection of SENDJoint Self-Evaluation.
TCP six monthly update.
Update on Looked After Children.
STP/ACO update
An update on Referral to Treatment delays

22 DATE OF NEXT HEALTH AND WELLBEING BOARD MEETING

The next meeting of the Board would be on Wednesday 16 November at 1 pm at Havering Town Hall.

23 EXCLUSION OF THE PUBLIC

It was agreed that the public should be excluded from the remainder of the meeting on the grounds that it was likely that, in view of the nature of the business to be transacted or the nature of the proceedings, if members of the public were present during those items there would be disclosure to them of exempt information within the meaning of paragraph 3 of Schedule 12A to the Local Government Act 1972.

24 STP UPDATE

The Board was informed that NHS England had recently advised that draft STPs could now be made publicly available. BN would confirm if there was any consultation or engagement on the STP document currently planned. This also included the ACO work that had been undertaken.

The revised STP document would have the same priorities and BN would seek to share a draft of this with the Board for comment.

Chairman

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Health and Wellbeing Board Action Log (following September 16 Board meeting)

No.	Date Raised	Board Member Action Owner	Non-Board Member Action Owner	Action	Date for completion	RAG rating	Comments
16.13	21 Sept 16	Susan Milner All members		Circulate to members by email the draft refreshed Joint Health and Wellbeing Strategy for comment by HWB members Comments to Susan Milner	31 Oct 16 By 7 Nov 16		
16.14	21 Sept 16	Tim Aldridge	Mary Phillips	The SEND JSNA Executive Summary to be revised to include information on exclusions from maintained schools as well as free schools and academies. This revised summary is to be circulated to HWB members	By 5 Sept 16		

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Refresh of Havering's Joint Health and Wellbeing Strategy
Board Lead:	Dr Susan Milner
Report Author and contact details:	Dr Susan Milner Susan.milner@havering.gov.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

The current Joint Health and Wellbeing Strategy (2015–2018) was signed off by the Havering Health and wellbeing Board in April 2015. It has been reviewed and refreshed in line with recent developments within the local health and social care economy to ensure it remains fit for purpose. The Board agreed the reframed themes and priorities for the strategy in May 2016. These have been reflected in the refreshed strategy document now presented to the Board for approval subject to discussion and any subsequent amendments. The actions required to deliver the themes and priorities within the strategy are contained within a number of other key strategic documents and actions plans. To avoid duplication of effort we have identified, for each priority, the key document(s) which sets out the agreed actions to deliver on that priority and who is responsible for ensuring those actions take place. In addition we have asked these leads to identify the key performance indicators to include in the HWB performance dashboard for the strategy. This will

provide the Board with assurance that the actions required to deliver the Joint Health and Wellbeing Strategy are being carried out and are leading to the specified outcomes.

RECOMMENDATIONS

It is recommended that the Board:

1. Provides feedback on the refreshed strategy to allow the final draft to be produced.

2. Provides feedback and input, as necessary, to identify the key strategic documents and actions plans already in place to deliver the strategy.

3. Agrees to receive and provide feedback by e mail on the performance dashboard for the refreshed strategy.

REPORT DETAIL

No further detail to add. Board members should note that this draft strategy document still requires significant editing to bring the presentation of the document up to the required standard. It is the content of the documents that Board members are asked to focus on.

BACKGROUND PAPERS

Draft refreshed Joint Health and Wellbeing Strategy attached

Havering's Health and Wellbeing Strategy 2015 – 2018

Refresh October 2016

Contents

(will need to be updated following refresh)

Executive Summary

Our Joint Health and Wellbeing Strategy (JHWS) has been developed by Havering's Health and Wellbeing Board and it is the overarching plan to improve the health and wellbeing of children and adults in our borough. The vision of the Havering Health and Wellbeing Board remains: *"For the people of Havering to live long and healthy lives, and to have access to the best possible health and care services."*

Informed by the Joint Strategic Needs Assessment and other needs analysis, we have identified the most pressing health and social care issues in the borough. By working collectively as a strategic partnership, we have prioritised the actions we need to take to deliver our vision and improve outcomes for local people. This refresh updates the strategy to reflect changes in the local health and social care economy. The refreshed strategy focuses on four overarching themes, each with underpinning priorities for action:

Overarching Themes	**Priorities**
Theme 1: Primary prevention to promote and protect the health of the community and reduce health inequalities. ***Healthy*** life expectancy can be increased by tackling the common socio-economic and behavioural risk factors for poor health:	-**socio-economic risk factors** 1. Getting people into work 2. Helping people to achieve (education and skills) 3. Ensuring people have a good home 4. Providing an environment in which it is easier for our residents to make healthier choices 5. Increasing community and individual ability to take control over the own health and care to reduce demand for services -**behavioural risk factors** 6. Promote good mental health 7. Reduce harm from tobacco 8. Reduce harm from alcohol 9. Improve nutrition and increase physical activity to promote healthy weight management 10. Improve sexual health 11. Increase uptake of immunisations 12. Increase uptake of screening programmes
Theme 2: Working together to identify those at risk and intervene early to improve outcomes and reduce demand on more expensive services later on.	13. Identify vulnerable children and families and intervene earlier. 14 Provide effective support for children with health needs. 15 Provide effective support for people with long term conditions (LTCs) and their carers so they can live independently for longer. 16 Provide effective support for people with learning disabilities/dementia and their carers so they can live independently for longer.

	17. Identify those with low level mental health issues and intervene earlier. 18. Improve secondary prevention for those with existing LTCs, e.g. identify those at risk of going on to develop CVD, diabetes, liver, renal failure etc. and clinically intervene to avoid worsening outcomes.• 19 Promote earlier presentation of signs and systems of major diseases, e.g. 'be clear on cancer'.
Theme 3 Provide the right health and social care/advice in the right place at the right time	20 Provide improved and, where appropriate, integrated care pathways especially for the major causes of morbidity and mortality, e.g. diabetes, CVD, cancer, mental ill-health. 21 Reduce avoidable A/E attendances, by changing 'health seeking' behaviour in our residents and providing alternatives. 22 Reduce avoidable admissions to hospital or long term care homes 23. Improve access to primary health care. 24. Promote self care
Theme 4 Quality of services and user experience	25 Ensure that services provided/commissioned are of good quality, are effective and provide the best possible service user's experience. 26 Reduce variations in quality and practice across primary and secondary care and social care. 27 Reduce variations in access to services

All member agencies of the Health and Wellbeing Board are facing significant budget pressures while operating in an environment where demand for higher quality services is increasing. This strategy needs to be one of demand management, with members of the Board working together and with communities and members of the voluntary sector, to:

- Keep people out of the health and social care system altogether wherever possible, by taking action to reduce the need for health care and improving the health and wellbeing of the local population;
- Support people to stay independent,
- Build community resilience and support people to manage their own conditions, by helping people and communities to look after themselves and each other wherever possible.

For those who absolutely do need to enter the health and social care system, the strategy sets out how members of the Health and Wellbeing Board will continue to work together to

integrate care across the sectors, both in order to improve patient and service user experiences and outcomes and also to secure enhanced value for money.

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

Foreword

Welcome to the refresh of Havering's second Health and Wellbeing Strategy. This strategy has been refreshed at its mid-point to reflect the work that has been undertaken across the Barking, Havering and Redbridge health and social care economy to address an unprecedented set of challenges between now and 2021.

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

We need to develop a new approach to service commissioning and delivery. Without a new service model demand for services will increase and service user experience will deteriorate, outcomes will be poor and the funding we currently have will not be enough to meet the health and social care needs of our population into the future. We are working together to create a new accountable care system which will allow us to better integrate health and social care services and use resources more efficiently and effectively.

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

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

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

By

Cllr. Wendy Brice Thopmson (Chair of the Havering Health and Wellbeing Board)
Dr. Atul Aggarwal (Chair of the Havering Clinical Commissioning Group and Vice Chair of the Health and Wellbeing Board)

1. Achieving our Vision

The vision of this strategy is:

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

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

Theme 1: Primary prevention to promote and protect the health of the community and reduce health inequalities. ***Healthy*** life expectancy can be increased by tackling the common socio-economic and behavioural risk factors for poor health:

Theme 2: Working together to identify those at risk and intervene early to improve outcomes and reduce demand on more expensive services later on.

Theme 3 Provide the right health and social care/advice in the right place at the right time.

Theme 4 Improve the quality of services and user experience

There are 27 priorities for action to deliver these themes and each has a jointly agreed plan as to how improved outcomes for local people will be delivered. Partnership working, joint commissioning and integrated working are fundamental to the delivery of this strategy. Tables that set out the themes, priorities and key actions can be found at Appendix 1 (to be produced once draft strategy signed off. They will be drawn from the existing strategies and plans in existence).

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

2. Scope and Purpose of the Strategy

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

This strategy replaced the first Havering Health and Wellbeing Strategy which covered 2012-2014. It focuses predominantly on health and social care related factors that influence health and wellbeing. It also reflects the wider determinants of health and wellbeing include factors such as housing, education and employment, and the environment though these are primarily addressed through other key partnership strategic documents. A list of such documents can be found at Appendix 2.(needs updating once strategy agreed)

3. Context

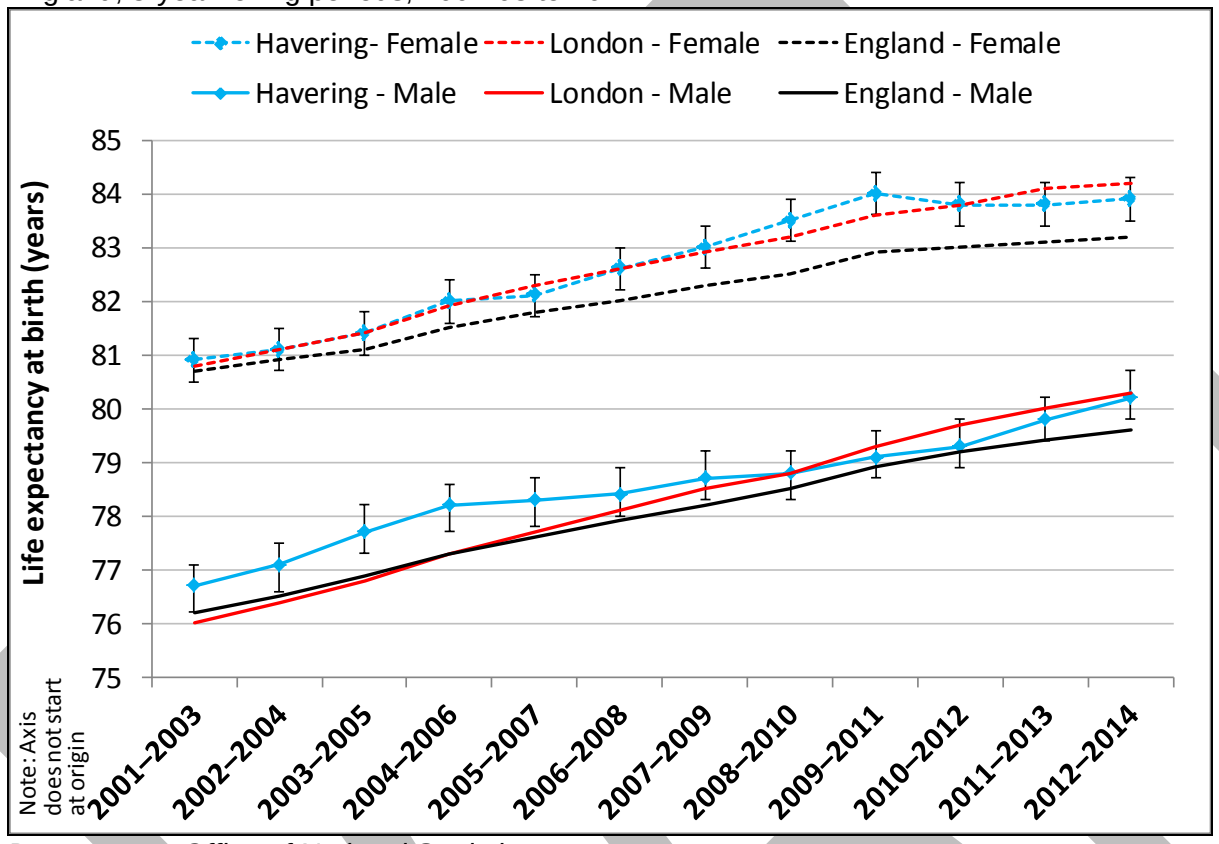
3.1 Our Population in Havering (updated on 30 Aug 2016)

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

There are about 249,085 people living in Havering[1]. 262,221 people are registered with a Havering GP though 22% of these (57,474) are not resident in Havering[2]. The population of Havering will grow from 251,618 (in 2016) by 6% (13,821more people) and 10% (26,509 more people) in five years (2021) and ten years (2026) respectively[3].

The life expectancy for people living in Havering is 80.2 years (for men) and 83.9 years (for women) from birth. Life expectancy in Havering has been mostly higher than the England average and has been on the increase over the last decade (see Figure 1).

Figure 1: Life expectancy at birth (years), by sex, Havering compared to London and England, 3-year rolling periods, 2001-03 to 2012-14



Data source: Office of National Statistics

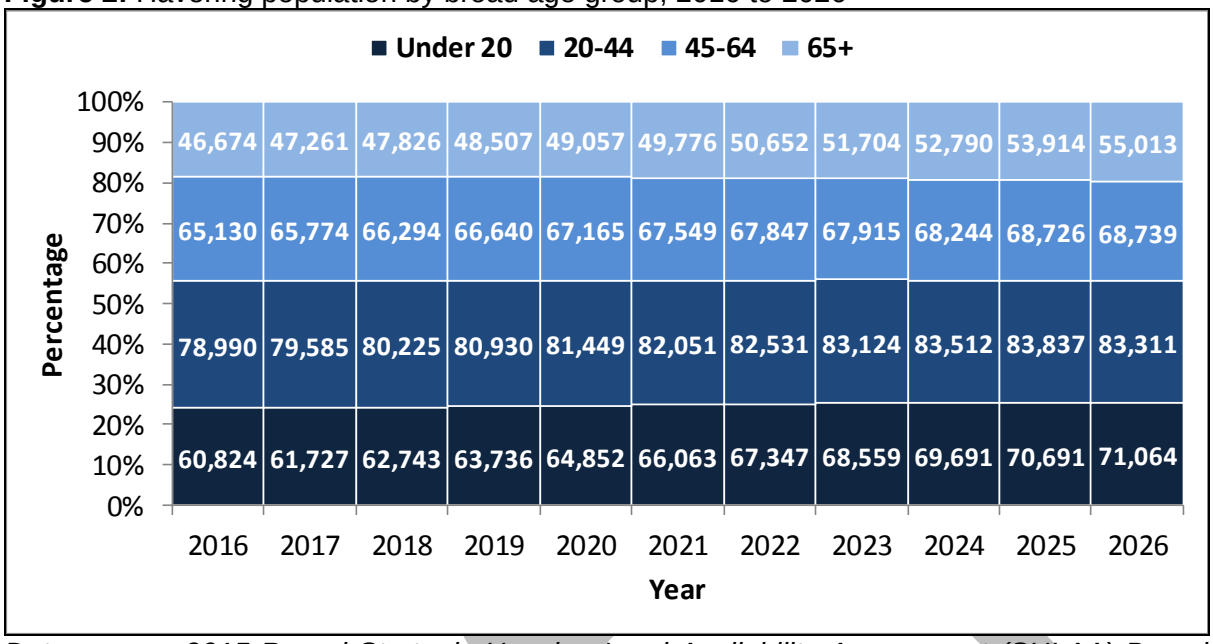
However, it is 7.9 years lower for men and 5.5 years lower for women in the most deprived areas of Havering than in the least deprived areas[4]. That is, life expectancy is particularly impacted by where people live and the circumstances of their upbringing.

Figure 2 presents the estimated population of Havering broken down by age groups in 2016. It suggests that:

[1] *Mid-year population estimates 2015; Office for National Statistics (ONS)*
[2] *Health Analytics (as of 31/06/2016)*
[3] *GLA 2013 Round SHLAA-Based Capped Population Projections (March 2014)*
[4] *Havering Health Profile 2014 (http://www.apho.org.uk/resource/item.aspx?RID=142312)*

- 24% of the population are children and young people (aged under 20 years)
- 31% are younger adults (aged 20-44 years)
- 26% are middle-aged (aged 45-64 years) and
- 19% are older people (aged 65 years and above)

Figure 2: Havering population by broad age group, 2016 to 2026



Data source: 2015 Round Strategic Housing Land Availability Assessment (SHLAA)-Based Projections; Greater London Authority (GLA)

Compared to England, London and other London boroughs, Havering has the largest older people (aged 65 years and above) as a proportion of the population (see
In addition, the growth in the 85+ age group increased by 43.6% (higher than for both London and England) between the 2001 and 2011 censuses, and the size of this age group is projected to continue to increase. The 85+ age group in Havering will increase (from 2016) by 14% and 26% in 5 years (2021) and 10 years (2026) respectively (see
Figure 4).

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

Figure 3). Havering has 46,674 older people resident in 2016 and this is projected to increase by 7% and 18% in 5 years (2019) and 10 years (2024) respectively (see

Figure 4).

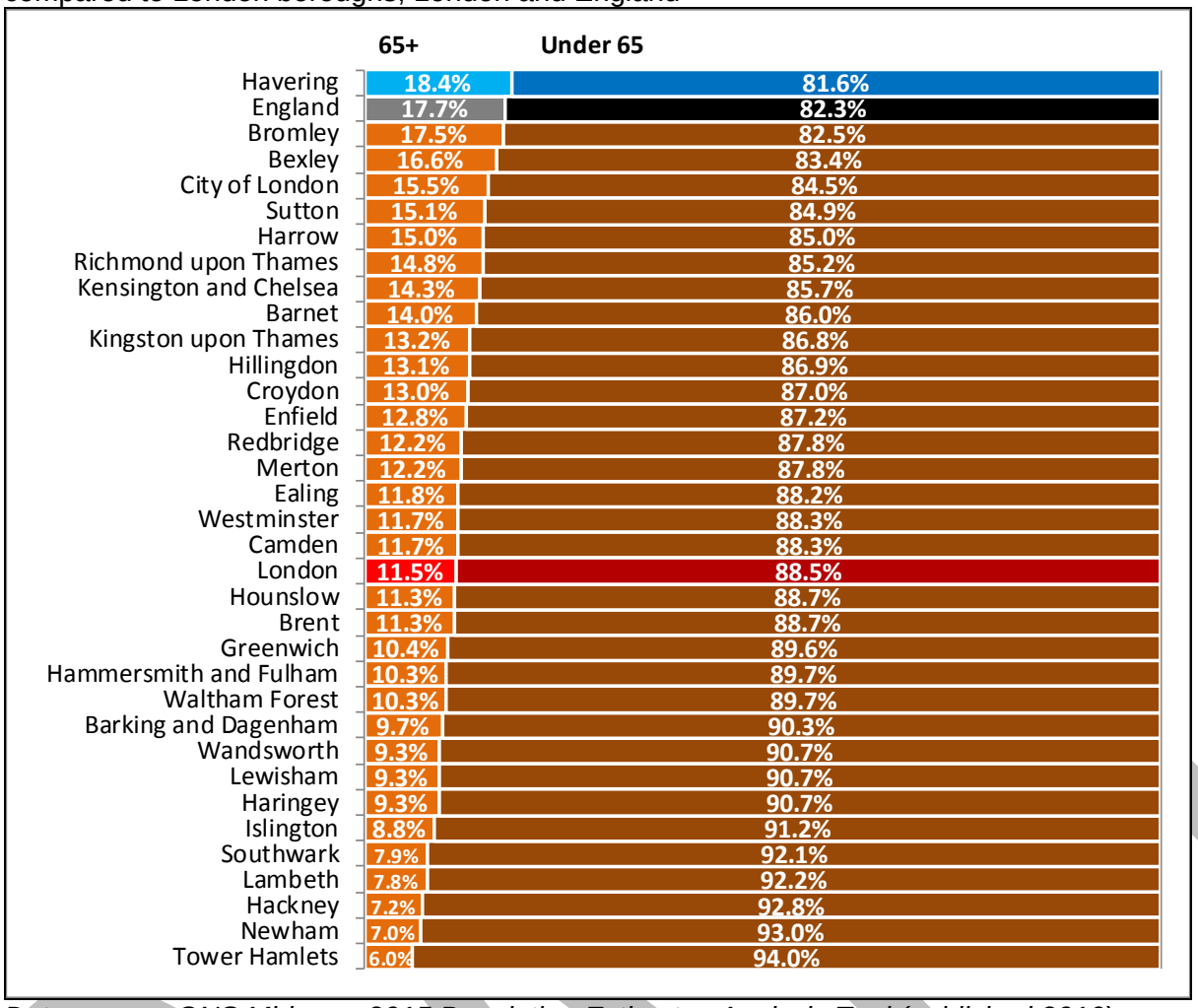
In addition, the growth in the 85+ age group increased by 43.6% (higher than for both London and England) between the 2001 and 2011 censuses, and the size of this age group is projected to continue to increase[5]. The 85+ age group in Havering will increase (from 2016) by 14% and 26% in 5 years (2021) and 10 years (2026) respectively (see

Figure 4).

[5] *This is Havering: A Demographic and Socio-economic Profile (http://www.haveringdata.net/jsna/)*

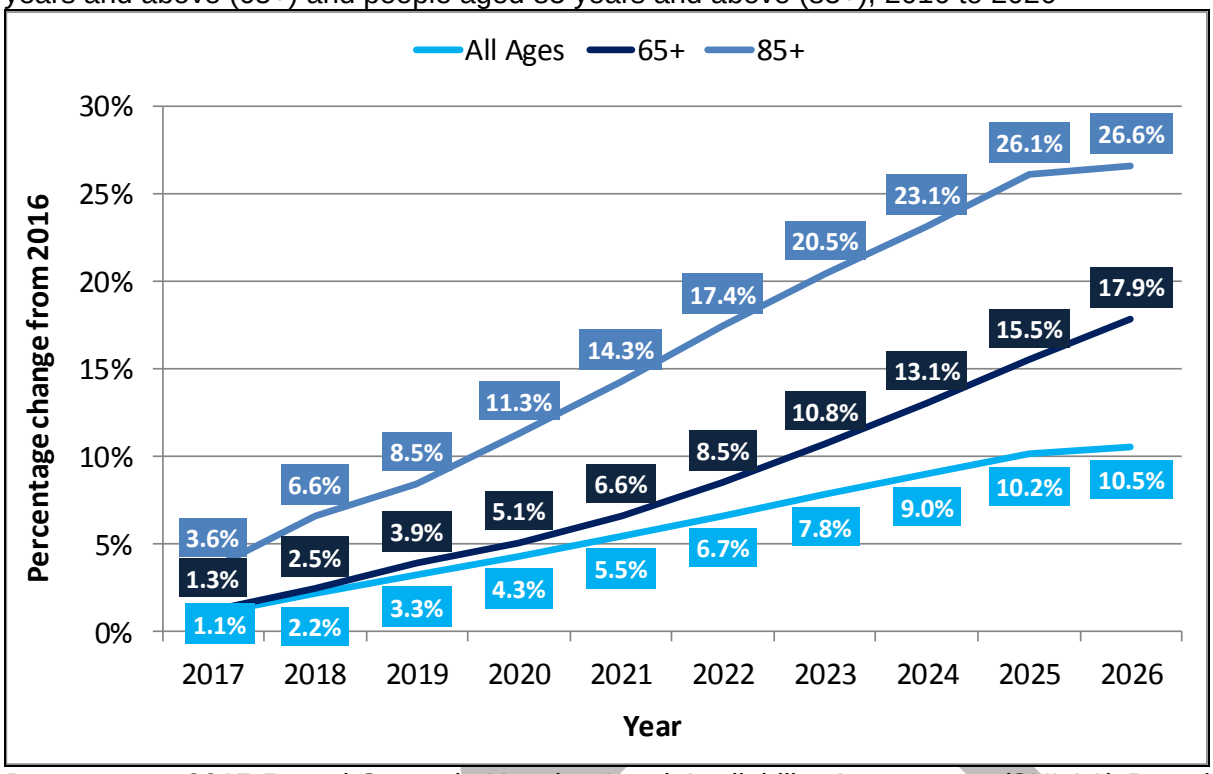
The projected increase in the older people population is likely to result in increases in numbers of residents suffering from cardiovascular disease (CVD), cancer, respiratory illnesses (e.g. bronchitis and pneumonia), dementia, osteoporosis, incontinence and hearing impairments.

Figure 3: Distribution of the population by under 65 and 65+ year age groups, Havering compared to London boroughs, London and England



Data source: ONS Mid-year 2015 Population Estimates Analysis Tool (published 2016)

Figure 4: Projected percentage change from 2016 for Havering population, people aged 65 years and above (65+) and people aged 85 years and above (85+), 2016 to 2026



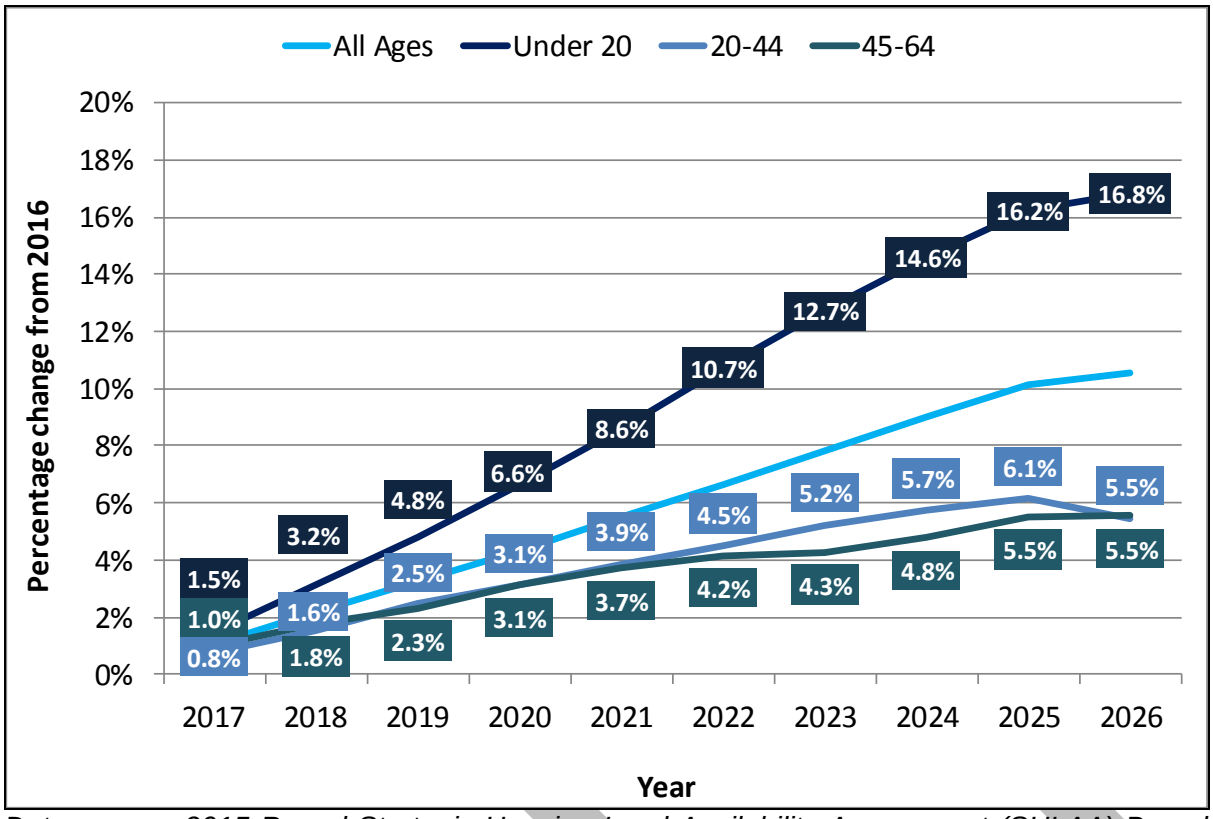
Data source: 2015 Round Strategic Housing Land Availability Assessment (SHLAA)-Based Projections; Greater London Authority (GLA)

The borough has a large younger population too. As earlier stated, around 24% (59,383) of the population in Havering are children and young people aged under 20 years (see Figure 2), which is similar to the England average of 24%. Future projections suggest that this group is estimated to grow by 8.6% by 2021 and 16.8% by 2026 (see Figure 5).

The borough is generally fairly affluent, being ranked 166th overall out of 326 local authorities for deprivation (1st being most deprived, 326th being least deprived), but has pockets of deprivation. Two small areas of the borough (situated in Gooshays and South Hornchurch) fall into the 10% most deprived areas in England and 8 small areas in Havering fall into the 10% most deprived areas in England[6]. When compared with other London boroughs, Havering has a relatively small proportion of children living in poverty, but this has risen in recent years (bucking the trend seen in most other London boroughs of declining levels of child poverty)[7].

[6] *This is Havering: A Demographic and Socio-economic Profile (http://www.haveringdata.net/jsna/)*
[7] *Children in Poverty Intelligence Update, Greater London Authority, released 2011*

Figure 5: Projected percentage change from 2016 for Havering population, children and young people (under 20 years), younger adults (20-44 years) and middle-aged 45-64 years), 2016 to 2026



Data source: 2015 Round Strategic Housing Land Availability Assessment (SHLAA)-Based Projections; Greater London Authority (GLA)

While the population is predominantly White British, it is becoming increasingly diverse. The ethnic minority population in Havering is 16.7% (39,617 people). This percentage is well below the London average (55.1%) and the average for England (20.2%).[8] However, the school census reported that nearly 23% of school pupils in Havering were from non-white ethnic groups.[9]

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

3.2 Key Achievements to Date **(need to update with any new developments over past 18 months since this was signed off)**

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

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

- Urgent Care Centres have been set up in the borough, with the aim of reducing A&E attendances and helping patient flow by seeing patients in the most appropriate setting. Hospital staff and local GPs can book non-urgent cases directly into these clinics.

[8] Ethnic minority is defined as all ethnicities apart from White British

[9] *This is Havering: A Demographic and Socio-economic Profile (http://www.haveringdata.net/jsna/)*

- An Integrated Care Strategy is in place and being delivered, which is helping to shift activity away from acute settings towards community and locality settings. As part of this, Integrated Case Management across health and social care has already been introduced.
- Residents of the borough now benefit from a Joint Assessment and Discharge (JAD) team, operating seven days a week, which provides a more collaborative approach across health and social care to ensure that planning for discharge takes place closer to the point of admission. This has played a large part in making Havering one of the best performing boroughs in London in terms of delayed transfers of care.
- In response to feedback from patients that they want to be supported closer to, or in, their own homes where possible, we have implemented Community Treatment Teams (CTTs) and the Intensive Rehabilitation at Home Service (IRS), and surveys indicate that most patients are very happy with these new models of care, with CTTs receiving a patient rating of 8.7 out of 10 and the IRS receiving a patient rating of 9 out of 10. In 2013/14, Havering's Intensive Rehabilitation Services received 159 referrals against a target of 69. During the same period, there were 1,576 referrals to the Queens Hospital hub of the new Community Treatment Team, 78% of which did not go on to be admitted to hospital. Within the community spoke of the CTT, 2,707 referrals were received during this time, 94% of whom were treated and maintained at home without the need for an acute admission.
- A Frailty Academy was launched across Barking and Dagenham, Havering and Redbridge in February 2014, to ensure that the lessons of various approaches and initiatives are learned and used to inform the development of mainstream services. As at May 2014, 34 participants had enrolled in the Academy, representing a range of agencies including the London Ambulance Service, NELFT, BHRUT and the Havering Care Association.
- The first stage of the new Community Health and Social Care Service (CHSCS) went live on 28 April 2014, with the reconfiguration of community nursing, Integrated Case Management, therapies and mental health services into locality based teams. We are now working towards the integration of partners outside of NELFT (e.g. social care and others) into this model.
- In June 2014, Havering became the first borough in London, and one of the first in the country, to expand its Multi-Agency Safeguarding Hub (MASH) to identify adults as well as children at risk. Alongside this, the Council and its partners developed a Community Multi-Agency Risk Assessment Conference (Community MARAC), to provide a multi-agency problem solving forum in respect of adults who do not meet the threshold for statutory services but who nonetheless require a multi-agency response in order to maintain them safely in the community. An independent evaluation is now underway, but anecdotal evidence and performance data suggests that both these initiatives are adding value to the partnership's work to identify and support vulnerable people and families.
- Havering has performed particularly well in the national Troubled Families programme. As at March 2014, the borough's initial target of identifying 415 "troubled families" to work with had been exceeded, with over 500 families having been identified. Havering's Troubled Families team is now closely involved nationally in the development and roll out of Phase 2 of the programme.
- Havering was awarded Dementia Friendly Borough Status in 2014, making the borough only the second London borough to receive this status.
- The stability of care placements for children looked after by the local authority has improved, with the percentage of looked after children with three or more placements during the year reducing each year.
- The percentage of LAC placements lasting two or more years has also steadily improved.
- Going forward, the recent successful bid to the Prime Minister's Challenge Fund will facilitate further improvements to the quality of and access to primary care services across the Clinical Commissioning Group by investing in improvements to complex care and facilitating access to services between 8am and 10pm seven days a week, as well as enabling technology to facilitate better information and data sharing.

3.3 The National Context

3.3.1 The Care Act 2014

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

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

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

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

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

3.3.2 Better Care Fund

The Better Care Fund (BCF) supports the transformation and integration of health and social care services to ensure local people receive better care. The BCF is a pooled budget that shifts resources into social care and community services for the benefit of the NHS and local government. The BCF is not new money but benefits in terms of better integrated working can be achieved from our combined budget.

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

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

3.3.3 The Children and Families Act 2014

The Children and Families Act draws together the support a child or young person aged 0-25 with special educational needs (SEN) requires across education, health and social care into a single Education, Health and Care (EHC) Plan which will replace the current statementing system. These will be gradually implemented over a two to three year period from September 2014 and will require plans to be outcomes, rather than outputs, focussed as well as requiring a co-ordinated, multi-agency assessment process.

The Act introduces a new legal requirement for the local authority to work with health to integrate services, as well as a requirement for joint commissioning arrangements across education, health and social care, and a mechanism to agree the levels of service required. The Act also strengthens the rights of young carers to an assessment of needs for support.

It is believed that the number of young carers in the borough is currently under identified and likely to increase. This in turn will increase the demand for assessments and services. This is recognised in the borough's BCF plan.

In addition, the Act requires children, young people and their parents or carers to be offered personal budgets to meet their care needs. This will require increased transparency, signposting and market development of "the Local Offer" within an increasingly competitive health and social care economy.

3.3.4 NHS 5 year Forward View and local Sustainability and Transformation Plan

The NHS Five Year Forward View sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on various public health measures, and on local service changes – will need explicit support from government.

The first argument made in the Forward View is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. Second, when people do need health services, patients will gain far greater control of their own care – Third, the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single disease

In December 2015, the NHS shared planning guidance 16/17 – 20/21 outlined a new approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England will produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.

To deliver plans that are based on the needs of local populations, local health and care systems came together in January 2016 to form 44 STP 'footprints'. The health and care organisations within these geographic footprints are working together to develop STPs which will help drive genuine and sustainable transformation in patient experience and health outcomes of the longer-term.

Havering is part of the North East London STP footprint and the aims of the NELSTP plan are

1. To measurably improve health and wellbeing outcomes for the people of NEL and ensure sustainable health and social care services, built around the needs of local people.
2. To develop new models of care to achieve better outcomes for all, focused on prevention and out-of-hospital care.
3. To work in partnership to commission, contract and deliver services efficiently and safely.

3.4 The Local Context and Delivery Arrangements

3.4.1 The Havering Health and Wellbeing Board

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

Recently updated terms of reference and membership of the Havering Health and Wellbeing Board is set out at Appendix 3. The governance structure (also attached at Appendix 3 – needs to be updated) illustrates how the Health and Wellbeing Board fits into the wider health and social care system and the other local governance structures which, whilst not all directly accountable to the Health and Wellbeing Board, provide the mechanisms through which the Board can receive assurance on progress against the priorities identified within this strategy.

3.4.2 Havering's Joint Strategic Needs Assessment (JSNA)

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

3.4.3 The Financial Landscape

Both the local NHS and the Council are facing a highly challenging financial position for at least the short to medium term. We are facing significant budget pressures while operating in an environment where demand for higher quality services is increasing. The implementation of the Care Act 2014 and the Children and Families Act 2014 has also put further financial pressures on the Council and its partners. The Health and Wellbeing Board's strategy going forward therefore needs to be one of demand management, with partners working together with one another and with the local community to:

- Keep people out of the health and social care system altogether wherever possible, by taking action to reduce the need for health care and improving the health of the local population;
- Support people to stay independent, and
- Build community resilience and support people to manage their own conditions by helping people and communities to look after themselves and each other wherever possible.

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

3.5 Implementation Plan

This JHWS sets out the Health and Wellbeing Board's 4 themes and 27 priority areas for action. Each priority has a jointly agreed action plan as to how improved outcomes for local people will be delivered. The JHWS Implementation Plan plan accompanying the strategy is set out at Appendix 1(to be developed but will be a composite from a number of other actions plans and STP/ACO documentation already in existence to avoid duplication). This includes a variety of interventions including individual, targeted and population-wide initiatives. Each intervention seeks to provide the most beneficial outcome for individuals, whilst being achievable within the constraints of health and social care budgets.

3.6 Monitoring and Review Arrangements

It is the responsibility of the Health and Wellbeing Board to oversee the delivery of this Joint Health and Wellbeing Strategy. Performance against the key actions and indicators set out in this Strategy will be monitored on a quarterly basis by the Board using a performance dashboard (in development based on the composite implementation plan).

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

4. Health and Wellbeing Themes and Priorities

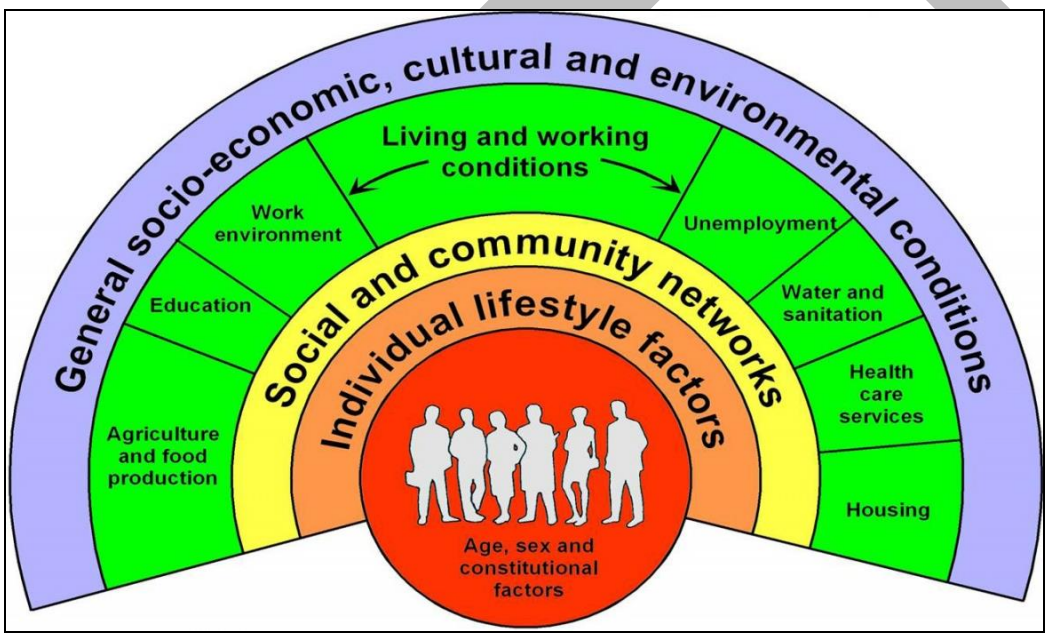
<u>Theme 1:</u> Primary prevention to promote and protect the health of the community and reduce health inequalities. Healthy life expectancy can be increased by tackling the common socio-economic and behavioural risk factors for poor health:

The factors that determine the health of a population are, broadly speaking, divided as follows:

- Socio-economic factors e.g. employment, income, education, housing, environment, etc.
- Lifestyle choices e.g. smoking, diet, exercise, alcohol, uptake of preventive services, etc.
- Health service provision (the contribution of health services to health differs by population subgroup).
- Genetics (although a relatively small contribution, its importance is increasing).

Dahlgren and Whitehead[10] have mapped the complex relationship between the factors that impact on the health of individuals and communities (see Figure 6).

Figure 6: Dahlgren and Whitehead's model of the determinants of health.



Source: Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health. Copenhagen: World Health Organization, 1992.

Individually and collectively, we can influence some of these factors in Havering and in so doing improve the quality of our lives.

What are health inequalities?

Health inequalities (sometimes called health inequities) are differences in health status between social groups. They exist in all countries – whether low, middle or high income. The lower an individual's socio-economic position, the higher their risk of poor health. Such

[10] *Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health. Copenhagen: World Health Organization, 1992.*

disparities in health are considered avoidable and modifiable and, therefore, unjust. There are health inequalities within Havering and between Havering and other local authorities.

Reducing health inequalities has been a longstanding national and local priority. There has been an increasing realisation (articulated in many Government documents over the past 30 years), that more effort needs to be put into preventing individuals and families from getting into situations where they require health or social care interventions. This would help to reduce health inequalities. There is also ample evidence that it is possible to prevent such situations from occurring. Therefore, there has been a strong national and local policy drive to shift more resources into prevention and early intervention and away from more expensive services that are required once problems have occurred.

This understanding informs the selection of our prevention priorities and shapes the things we can do in Havering to deliver these priorities. It allows us to engage all the resources at our collective disposal to create a more resilient economic and social environment in which individuals can make fully informed decisions about how to live their lives. It guides us to develop the circumstances in which it is easier for individuals to make healthier choices and to make best use of the services that are available to them to promote and protect their health and that of their family.

What is the current status of health in Havering?

Although health in Havering is better than a lot of other areas we have too many children who are overweight or obese because of poor diet and lack of physical activity. We also have too many adults who smoke, drink more than they should, and are overweight or obese

- The top 5 (underlying) causes of death in Havering (from 2012 to 2014) are: cancers, circulatory diseases, respiratory diseases, dementia & Parkinson's disease, and diseases of digestive system.
- Unspecified dementia comprises the biggest single underlying cause of death. Lung cancers comprise the largest proportion of deaths from Cancer.
- About 625 (29%) deaths each year occur prematurely (deaths that occur before a person reaches the age of 75 years). Cancer, heart disease and stroke are the main causes of premature deaths.

Long Term Conditions

- There is an increasing number of Havering residents living with long term conditions (LTCs) – this has a significant impact on daily lives including the use of urgent and emergency health and social care services.
- Havering CCG patients with five or more LTCs are 5 times more likely to attend A&E, 20 times more likely to be admitted for an emergency, and the average number of inpatient bed days will be 37 times greater compared to patients with no LTC.
- The prevalence of mental health problems in Havering (0.65%) is generally lower than both London (1.07%) and England (0.88%) but there is variation in how common it is across the wards in the borough.
- The prevalence of depression ranges from 53.6 per 1000 persons aged 17 and over in Upminster to 111.5 per 1000 persons aged 17 and over in Gooshays (i.e. more generally more common with increasing deprivation).
- In Havering, the number of people living with diabetes is on the increase. The prevalence of diabetes is lowest in Romford Town (47.5 per 1000 persons aged 17 and over) and highest in South Hornchurch (68.3 persons aged 17 and over).
- Dementia is more common in Havering than London but similar to England; and it will be an increasing problem for Havering because of its ageing population.

Disability

- Children and adults with a learning disability are at increased risk of having or developing physical and mental health problems. In addition, they are 10 times more likely to have serious sight problems.
- Havering was estimated to have 945 adults with moderate or severe learning disability in 2015, of which about 300 are estimated to be living with a parent. Additionally, about 1,850 people were estimated to have autistic spectrum disorders.
- Havering has a lower rate of people registered blind (205 per 100,000) compared to London and England.
- The number of children with special educational needs and disabilities is growing year on year, averaging increases of between 40 to 60%in all groups over the past 3 years.
- There is increasing demand for specialist help and schooling for children with autism (ASD) and for those with behavioural, emotional and social difficulties (BESD), including those with mental health issues.

Our priorities for action under this theme are:

Tacking socio-economic risk factors

- Getting people into work
- Helping people to achieve (education and skills)
- Ensuring people have a good home
- Providing an environment in which it is easier for our residents to make healthier choices
- Increasing community and individual ability to take control over the own health and care to reduce demand for services

Tackling behavioural risk factors

- Promote good mental health
- Reduce harm from tobacco
- Reduce harm from alcohol
- Improve nutrition and increase physical activity to promote healthy weight management
- Improve sexual health
- Increase uptake of immunisations
- Increase uptake of screening programmes

Theme 2: Working together to identify those at risk and intervene early to improve outcomes and reduce demand on more expensive services later on.

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

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

Of just over 30,000 families in Havering, it is estimated that nearly 400 of them are categorised as 'families with multiple complex needs' and over 2,000 are 'barely coping'. The level of poverty among children under 16 in Havering is slightly better than the England average with 20% of children in Havering living in poverty as at March 2014. However in some wards (e.g. Gooshays, at 35.2%) the percentage of children living in poverty is above both the London (26.5%) and England (20.6%) average, and the proportion of children living in poverty in the borough has bucked London-wide trends by increasing over recent years. Havering is one of only two London boroughs in which the rate of child poverty has increased. This is a concern to the Health and Wellbeing Board as children in poverty are more likely to report a range of poor health outcomes.

Our priorities under this theme are:

- Identify vulnerable children and families and intervene earlier.
- Provide effective support for children with health needs.
- Provide effective support for people with long term conditions (LTCs) and their carers so they can live independently for longer.
- Provide effective support for people with learning disabilities/dementia and their carers so they can live independently for longer.
- Identify those with low level mental health issues and intervene earlier.
- Improve secondary prevention for those with existing LTCs, e.g. identify those at risk of going on to develop CVD, diabetes, liver, renal failure etc. and clinically intervene to avoid worsening outcomes
- Promote earlier presentation of signs and systems of major diseases, e.g. 'be clear on cancer'.

What we want to see

- Seamless, integrated and people-centred health and social care services delivered to Havering residents.
- Greater co-commissioning across the CCG and local authority.

- The introduction of joint assessments of health and social care needs; interoperability between health and social care systems and the holding of single case records across the health and social care sectors.
- A vibrant primary care model.
- Services shifted out of secondary care and into the community and primary care
- A reduction in avoidable time spent in hospital.
- A higher proportion of older people living independently following discharge.
- Improved physical, social and psychological health across the looked after children population.
- Continue to provide intensive, bespoke support to families with multiple complex needs to avert the escalation of their difficulties.
- Reduce the numbers of children living in poverty in Havering
- Promote the physical, social and psychological health and wellbeing of children looked after by the local authority
- Improve transitions from children's to adults' care packages for young people with disabilities.
- Improve access to high-quality therapies for children and young people.

Theme 3 Provide the right health and social care/advice in the right place at the right time

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

The main health conditions responsible for avoidable admissions in Havering are chronic obstructive pulmonary disease, influenza and pneumonia and dehydration and gastroenteritis. There are pockets across the borough with particularly high rates of avoidable hospital admissions. There is a cluster of high rates around Brooklands and Romford Town as well as some areas within Rainham and Wennington, Heaton, South Hornchurch and Harold Wood .

There are wide variations between Havering GP practices in terms of avoidable hospital admissions, ranging from 7 per 1,000 population to 25 per 1,000 population.Readmission rates in Havering have risen by more than 4% over the last 10 years, in line with national trends. However, when emergency readmissions are analysed by age, Havering has consistently had a significantly higher (worse) percentage of older people (aged 75+) who are readmitted to hospital in an emergency within 28 days of discharge, compared with England

Our priorities under this theme are

- Provide improved and, where appropriate, integrated care pathways especially for the major causes of morbidity and mortality, e.g. diabetes, CVD, cancer, mental ill-health.
- Reduce avoidable A/E attendances, by changing 'health seeking' behaviour in our residents and providing alternatives.
- Reduce avoidable admissions to hospital or long term care homes
- Improve access to primary health care.
- Promote self-care

What we plan to do

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

Theme 4 Quality of services and user experience

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

The borough has two major service providers, these being the Barking, Havering and Redbridge University Hospitals Trust (BHRUT) for acute hospital services and the North East London Foundation Trust (NELFT) for community services (such as district nursing and mental health services). Community and mental health services are provided in clinics and hospitals as well as in people's own homes.

We are working in one of the eleven most challenged health economies in the country and with one of the most challenged hospital trusts in the country. While improvements have been made, there is still more needing to be done to improve quality of services.

Havering's patient experience of primary care and out of hours services is in the bottom quartile of London CCGs, while our patient-to-GP ratio (the number of patients to every GP in the borough) is very high. GP practices in Havering generally see lower levels of patient satisfaction with their GP than in most other CCGs nationally, and issues of patient access persist in some practices.

The Havering Health and Wellbeing Board remains concerned of the serious quality and patient safety concerns identified within some of the borough's providers. CQC reports identified specific concerns relating to BHRUT (the borough's major acute provider) and it was placed in special measures in December 2013. This meant that it had to make significant improvements in the way it provides patient care and operates as an organisation. The Trust now has a new leadership team in place and is working to a robust improvement plan – *Unlocking our Potential* - that members of the Health and Wellbeing Board were

instrumental in developing. Patient satisfaction has improved , with the Trust's Friends and Family Test inpatient score for June 2014 reaching 69, compared with 43 in June 2013. But while improvements have been made since, there is still more that needs to be done, and the Health and Wellbeing Board continues to have a vital role in scrutinising, challenging and supporting BHRUT to continue to make progress and improvements to benefit patients and their families.

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

Our priorities under this theme are :

- Ensure that services provided/commissioned are of good quality, are effective and provide the best possible service user's experience.
- Reduce variations in quality and practice across primary and secondary care and social care.
- Reduce variations in access to services

What we plan to do

- Ensure that the CQC's findings and recommendations for improvements in the quality of care and patient safety at Queen's Hospital continue to be addressed.
- Work across the health and social care sectors to make the best use of our combined estates and assets.
- Develop an integrated health and social care commissioning function
- Continue to develop effective care pathways both in and out of hospital and primary care
- Improve access to primary care, including in community settings
- Continue to develop Intermediate Care services
- Ensure that patient and public engagement actively informs service improvement.
- Improve communication of the activities of the Health and Wellbeing Board and its impact on local health and social care services.

5. System Enablers

The work streams below have been identified as essential to the successful transformation of the health and social care economy across BHR and relate directly to the successful delivery of this strategy. Although they are not specific priorities for the HWB per se, the Board will need to be kept updated on how this work is progressing.

- Intelligence and data sharing across the system – mapping hot spots
- Workforce transformation, e.g. clinical and social care workforce
- IT – to facilitate joint data sharing and working together across boundaries
- Estates transformation
- Innovation - new models of care and pathway redesigns
- Clinical engagement

Appendix 1: Outline Implementation Plan

Health and Wellbeing Board Strategy
2016-17 Implementation Plan

The Joint Health and Wellbeing Strategy (JHWS) will be delivered through a wide range of existing strategies, action plans and joint working arrangements led by the agencies that are represented on the Health and Wellbeing Board. These documents are not replicated here. This Implementation Plan signposts the reader to the relevant documents and identifies the subset of performance indicators, selected from the existing strategies and action plans, to provide assurance to the Board that the JHWS is being properly implemented.

Please note that as this is a working draft. Where further information is awaited this is described as a draft note (DN).

Themes	Lead organisation	Strategy/action plan name	Governance	KPIs
1. Primary prevention to promote and protect the health of the community and reduce health inequalities. ***Healthy*** life expectancy can be increased by tackling the common socio-economic and behavioural risk factors for poor health.				
Socio-economic factors				
1. Getting people into work	London Borough of Havering	[DN – awaiting confirmation that this document correct] Economic Development Service Plan 2015/16	[DN – to be completed]	[DN – to be completed]

		economic-developme nt-2015-16.pdf		
2. Helping people to achieve (education and skills)	London Borough of Havering	Education and Skills Delivery Strategy Education and Skills Delivery Strategy FIN	Document describes Education Strategic Partnership reporting to Children's Trust	[DN – to be completed]
		CME (Children Missing Education) Policy (DN awaiting document)	Part of CSE/Missing Policy monitored via LSCB	[DN – to be completed]
		LAC Education Policy (with Virtual School) (DN awaiting document)	Monitored by Corporate Parenting Panel	[DN – to be completed]
		Attendance Policy (with Attendance and Behaviour Service) (DN awaiting document)	[DN – to be completed]	[DN – to be completed]
		Fair Access Protocol	[DN – to be completed]	[DN – to be completed]

		(DN awaiting document)		
		Elective Home Education Policy (DN awaiting document)	[DN – to be completed]	[DN – to be completed]
		Commissioning Plan for Education Provision https://www3.havering.gov.uk/Pages/Services/School-organisation-place-planning.aspx	Monitored via IYFAP (In Year Fair Access Panel) Monitored via CSIB Approved by Cabinet, updated annually.	[DN – to be completed]
3. Ensuring people have a good home	London Borough of Havering	 Service plan 2016-17 FINAL v2, 26.2.16.dc Housing Service Plan- [DN Housing Strategy currently being revised – awaiting further information]	London Borough of Havering Senior Leadership Team	• Number of residents attending / referred to Apprentice Schemes • % of emergency care line/telecare call-outs responded to within 30 minutes of receipt of notification • % Estate inspection achieving excellent & good standard
4. Providing an environment in which it is easier for our residents to make healthier choices	London Borough of Havering	Local Plan [DN Local Plan currently being drafted – timescale to be inserted]	[DN awaiting first draft of Local Plan]	[DN awaiting first draft of Local Plan]

5. Increasing community and individual ability to take control over their own health and care	[DN: to be completed)	[DN: to be completed)	[DN: to be completed)	[DN: to be completed)
6. Mental health promotion	London Borough of Havering	Multi-agency Havering Mental Health Promotion Group focusing on delivering Five Year Forward View for Mental Health https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf	Reports to Havering Mental Health Partnership Board	• Increase access to Talking Therapies
Behavioural risk factors				
7. Reduction of harm from tobacco	London Borough of Havering	[DN: Multi-agency Havering Tobacco Harm Reduction Partnership Terms of Reference and Action Plan being developed and to be provided]	Reports to Havering Health Protection Forum	[DN – awaited]
8. Reduction of harm from alcohol	London Borough of Havering	2016 D & A Harm Reduction Strategy V	Reports to Health and Wellbeing Board and Community Safety Partnership	• Waiting times for drug treatment • Waiting times for alcohol treatment • Successful completion of treatment (opiate use) • Successful completion of

		2016-17 D & A Harm Reduction Action Plar		treatment (non-opiate use) • Successful completion of treatment for alcohol
9. Improve nutrition and increase physical activity to promote healthy weight management	London Borough of Havering	Prevention-of-Obesity-Strategy.pdf	Reports to health weight working group	• Healthy Schools London - Schools with a current award • Physically active and inactive adults – Percentage of active adults in Havering *(PHOF indicator 2.13i)* • Health Champions – Number of Health Champions trained
10. Improve sexual health	London Borough of Havering	No local strategy	No local strategy	• All new sexually transmitted infection diagnoses (exc chlamydia) • HIV prevalence • HIV late diagnosis
11. Increase uptake of immunisations	NHS England	Havering Immunisation Action Plan Havering Action Plan 201617v2.docx	Reports to Havering Health Protection Forum	[DN KPIs awaited]
12. Increase uptake of screening programmes	NHS England		Reports to Havering Health Protection Forum	• Breast screening – coverage • Bowel screening – uptake • Bowel screening - coverage

				• Cervical screening – coverage • Abdominal aortic aneurysms screening (AAA) • Retinopathy - uptake • Newborn hearing screening • Newborn blood spot • Uptake of Antenatal HIV tests
Theme 2: Working together to identify those at risk and intervene early to improve outcomes and reduce demand on more expensive services later on				
13. Vulnerable children and families – identify them and intervene earlier.	London Borough of Havering	Havering children and young people plan  Havering_Children_and_young_peoples_p	[DN: to be completed)	[DN: to be completed)
14. Provide effective support for children with health needs.	Clinical Commissioning Group	[DN: to be completed)	[DN: to be completed)	[DN: to be completed)
15. Provide effective support for people with long term conditions (LTCs) and their carers so they can live independently for	London Borough of Havering	[DN: to be completed)	[DN: to be completed)	[DN: to be completed)

longer.				
16. Provide effective support for people with learning disabilities/dementia and their carers so they can live independently for longer	London Borough of Havering	Joint Dementia strategy	Dementia Partnership Board reports to HWB, CCG Exec Committee & LBH Cabinet	• Early diagnosis
17. Identify those with low level mental health issues and intervene earlier	Clinical Commissioning Group	 -CCG-CAMHS-plat-v2 -December-2015.pdf	[DN: information awaited]	[DN: information awaited]
18. Improve secondary prevention for those with existing LTCs, e.g. identify those at risk of going on to develop CVD, diabetes, liver, renal failure etc. and clinically intervene to avoid worsening outcomes. (a) Health checks				
(b) Diabetes prevention programme	Clinical Commissioning Group	[DN: information awaited re Right Care Approach for Diabetes (across BHR)]	[DN: information awaited]	[DN: information awaited]

19. Promote earlier presentation of signs and systems, e.g."be clear on cancer"	Cancer Research UK	 Cancer comissioning strategy for London.p	[DN: information on Havering-specific governance arrangements awaited]	[DN: information awaited]
Theme 3 Provide the right health and social care/advice in the right place at the right time				
20. Provide improved and, where appropriate, integrated care pathways especially for the major causes of morbidity and mortality, e.g. diabetes, CVD, cancer, mental ill-health				
(a) Diabetes	See 2.6	See 2.6	See 2.6	See 2.6
(b) CVD	See 2.6	See 2.6	See 2.6	See 2.6
(c) Cancer	[DN: information awaited]	[DN: information awaited]	[DN: information awaited]	[DN: information awaited]
(d) Mental ill health	[DN: information awaited]	[DN: information awaited]	[DN: information awaited]	[DN: information awaited]
21. Reduce avoidable A/E attendances, by changing "health seeking" behaviour in our residents	Clinical Commissioning Group	[DN: information awaited]	[DN: information awaited]	[DN: information awaited]

and providing alternatives				
22. Reduce avoidable admissions to hospital or long term care homes	Clinical Commissioning Group	[DN: information awaited]	[DN: information awaited]	[DN: information awaited]
23. Improve access to primary health care	Clinical Commissioning Group	[DN: information awaited]	[DN: information awaited]	[DN: information awaited]
24. Promote self-care	[DN: information awaited]	[DN: information awaited]	[DN: information awaited]	[DN: information awaited]
Theme 4 Quality of services and user experience				
25. Ensure that services provided/commissioned are of good quality, are effective and provide the best possible service user's experience.	London Borough of Havering(John Green) Clinical Commissioning Group Healthwatch	[DN: information awaited on commissioning strategies]	[DN: information awaited]	[DN: information awaited]

26. Reduce variations in quality and practice across primary and secondary care and social care	London Borough of Havering Clinical Commissioning Group	[DN: information awaited]	[DN: information awaited]	[DN: information awaited]
27. Reduce variations in access to services	London Borough of Havering Clinical Commissioning Group	[DN: information awaited]	[DN: information awaited]	[DN: information awaited]

Appendix 2: List of key partnership strategic documents

Havering's Better Care Fund (BCF) submission
Children and Young People's Plan 2014 - 2017
Havering Joint Dementia Strategy 2014 - 2017
Integrated Care Strategy
Child Poverty Strategy
London Borough of Havering's Corporate Plan
London Borough of Havering's DRAFT Corporate Parenting Strategy
London Borough of Havering's DRAFT Looked After Children (LAC) Strategy
London Borough of Havering's DRAFT Voluntary Sector Strategy
Havering Clinical Commissioning Group's Commissioning Strategic Plan 2014/15 – 2015/16
Barking and Dagenham, Havering and Redbridge Integrated Care Coalition Strategic Plan Final Submission (June 2014)
Unlocking our Potential (BHRUT's improvement plan)
Culture and Leisure Strategy
Arts Strategy
DRAFT Violence against Women and Girls Strategy
Community Safety Strategy
Housing Strategy
Joint Strategic Needs Assessment (JSNA)
Economic Development Service Plan 2015/16
Education and Skills Delivery Strategy
Children Missing Education Policy
Looked After Children Education Policy
Attendance Policy (with Attendance and Behaviour Service)
Fair Access Protocol
Elective Home Education Policy
Commissioning Plan for Education Provision
Housing Service Plan
Local Plan
Tobacco Harm Reduction Partnership Terms of Reference and Action Plan
Drug and Alcohol Harm Reduction Strategy 2016-19
Prevention of Obesity Strategy 2016-19
Havering Immunisation Action Plan
Havering Children and Young People Plan
Joint Dementia Strategy
Havering Children and Young People's Mental Health Transformation Plan 2015

STP/ACO information to be included

Havering Health and Wellbeing Board
Terms of Reference

Purpose of the Health and Wellbeing Board

Health and Wellbeing Boards (HWBs) were established by the Health and Social Care Act 2012. Each top tier and unitary council (including London Boroughs), is required to have a board, established as a formal council committee. HWBs are strategic leaders and agents of change in the health, social care and wellbeing systems of their areas.

The Havering HWB is set up to

- improve the health and wellbeing of the residents of Havering and to reduce health inequalities.
- join up commissioning across the NHS, social care, public health and other health and wellbeing services in order to secure better health and wellbeing outcomes for the local population, better quality of care for patients/care users and better value for the taxpayer.
- build strong and effective partnerships

Responsibilities

The main responsibilities of the Board are to:

1. Agree the health and wellbeing priorities for Havering and oversee the development and implementation of a joint health and wellbeing strategy (JHWS).

2. Oversee the development of the Joint Strategic Needs Assessment (JSNA) and the Pharmaceutical Needs Assessment (PNA).

3. Provide a framework within which joint commissioning plans for the NHS, social care and public health can be developed and to promote joint commissioning.

4. Consider how to best use the totality of resources available for health and wellbeing e.g. consider pooled budgets. Also oversee the quality of commissioned health and social care services.

5. Provide a key forum for public accountability of NHS, public health, social care and other health and wellbeing services, ensuring local democratic input to the commissioning of these services

6. Monitor the outcomes of the public health, NHS and social care outcomes framework.

7. Consider the wider health determinants such as housing, education, regeneration, employment.

Membership

- Four elected members (as per LBH constitution)
    - Lead member for adults and public health (Chair)
    - Lead member for Children's Services
    - Leader of the Council
    - Additional member nominated by the Leader

- Director of Public Health
- Director of Adult Social Care
- Director of Children's Services.
- LBH Chief Executive
- CCG representatives x 4
- BHRUT representative
- NELFT representative
- Local Healthwatch representative
- NHSE (London) representative

All HWB members must be cognisant of potential conflicts of interest. Board members must declare such conflicts of interest and absent themselves from discussions and decision making where such conflicts of interest exist.

In attendance

LBH Head of Policy and Performance
LBH Public Health Consultant and/or Public Health Support Officer (to support DPH in their HWB lead officer function)

Reporting and Governance Arrangements

- The Health and Wellbeing Board is a committee of the Council.
- The Board will receive regular progress updates from all groups that report to the Board in the attached governance structure.
- The Health and Wellbeing Board will be held in public unless confidential financial or other information should prevent this (as per the Local Government Act, 1972)
- Chairing arrangements – the Leader of the Council will be required to nominate the Chair of the Board. Board members will nominate a vice Chair.
- All full members of the board will have voting rights. Where a vote is tied, the Chairman will have the casting vote.
- The Board is quorate when 9 members are present.
- Meetings will be held every other month. Special meetings may be requested by the Board at any time.
- Papers to be circulated at least 5 working days before a meeting
- The Board may co-operate with similar Boards in other locations where their interests align. This may include multi-area commissioning arrangements
- These terms of reference will be reviewed 12 months from the date of formal sign off by the Board.

Updated May 2016

Signed ……..
(Chair of the Health and Wellbeing Board)

Date: …….

Draft Appendix 1 v0.1 (Governance)

The Board wanted to confirm this underpinning group structure once the JHWS had been agreed (hopefully in Sept 2016)

Groups that will report to the HWBB *(to be put into structure chart once confirmed)*

Confirmed (May 2016):

- Health Protection Forum.
- JSNA Steering group.
- Local Children's Safeguarding Board and Adult Safeguarding Board *(changes due to safeguarding arrangements so will need to be reviewed)*
- Care Transformation Board

Could include the following plus any additional groups delivering the aims and objectives of the JHWS

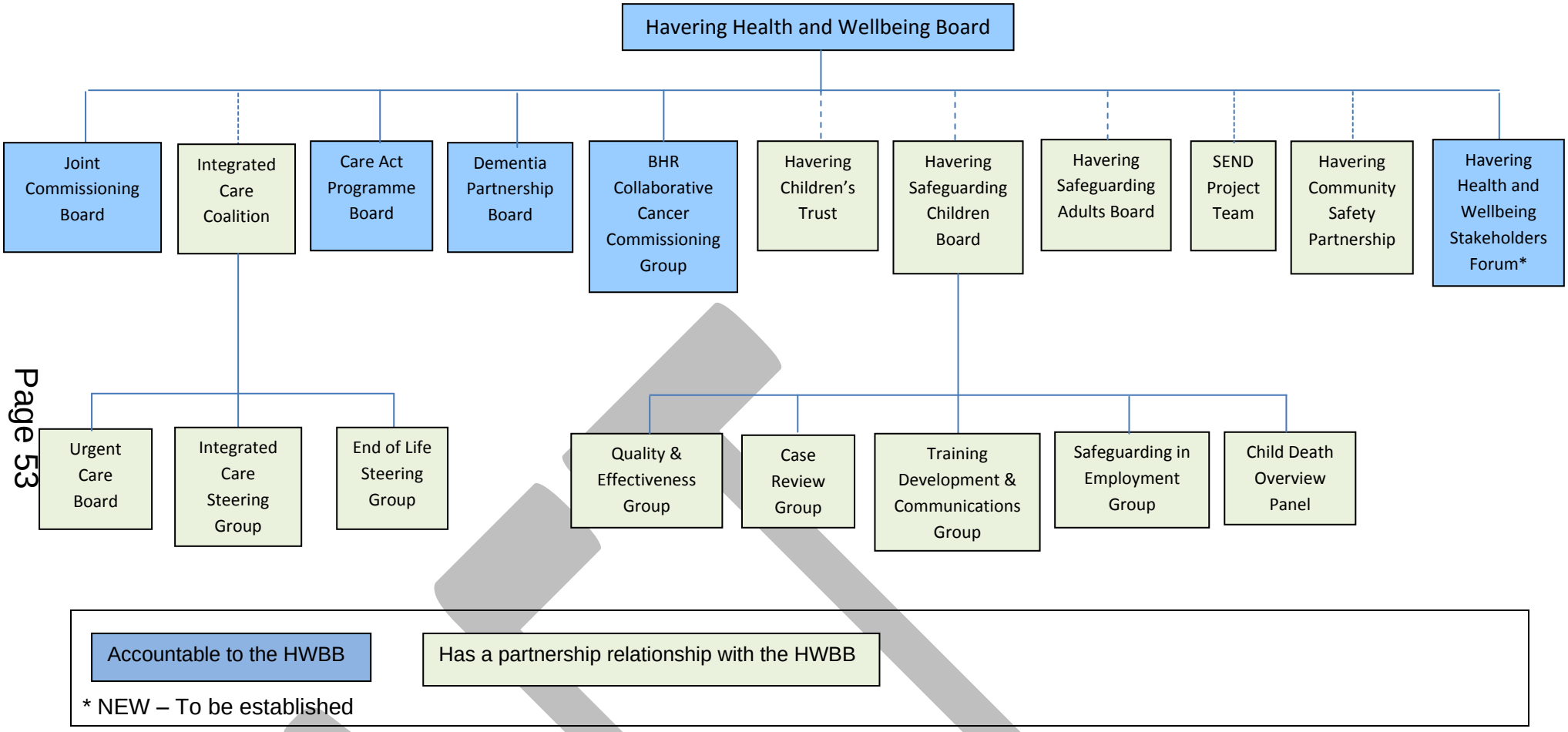
- Joint Management and Commissioning Forum.
- End of Life Strategy Group.
- Poverty Reduction Programme Executive (being reviewed – might not exist)
- Mental Health Partnership Board (?Dementia Partnership to be part of this board).

Once confirmed these groups will be asked to update their respective ToR for sign off by the HWB. They will be required to report regularly to the HWB on their agreed work programmes and KPIs, This will be built into the forward plan.

Groups that have a 'partnership relationship' with HWB *(to be put into structure chart once confirmed)*

- Integrated Care Coalition and/or ACO programme board (tbc)
- Community Safety Partnership
- Primary Care Transformation Board

The Health and Wellbeing Board's Governance Structure To be updated



Appendix 4: Glossary of Key Terms

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

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

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

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

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

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

Integrated Care Coalition (ICC) – Brings together senior executive leaders within the Barking and Dagenham, Havering and Redbridge health and social care economy to support the three Clinical Commissioning Groups and the three local authorities in commissioning integrated care and building a sustainable health and social care system. The ICC is responsible for developing recommendations for system wide integrated care for consideration by commissioners and the Health and Wellbeing Boards.

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

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

Intensive Rehabilitation Service (IRS) – A team consisting of nurses, occupational therapy staff, physiotherapy staff and rehabilitation assistants, with access to a geriatrician as

required via the Community Treatment Teams (see above). It aims to offer an alternative to admitting patients to an inpatient unit for rehabilitation by supporting people in their own homes where it is appropriate to do so. The in-home support provided is intensive and involves between one and four home visits each day, depending on the patient's needs. The service operates between 8am and 8om, seven days a week.

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

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

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

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

Abbreviations

A&E – Accident and Emergency Unit

BCF- Better Care Fund

BHRUT- Barking, Havering and Redbridge University Hospitals Trust

CAMHS- Child and Adolescent Mental Health Services

CCG- Clinical Commissioning Group

CHSCS – Community Health and Social Care Service

CIN – Child in Need

COPD – Chronic Obstructive Pulmonary Disease

CPP – Child Protection Plan

CQC- Care Quality Commission

CTT – Community Treatment Team

CVD- Cardiovascular Disease
DTOC – Delayed transfers of care

GP – General Practitioner

ICC – Integrated Care Coalition

ICM – Integrated Case Management

ICSG – Integrated Care Steering Group

IRS – Intensive Rehabilitation Service

JAD- Joint Assessment & Discharge Team

JCB – Joint Commissioning Board

JSNA- Joint Strategic Needs Assessment

LA – Local Authority

LAC – Looked After Child(ren)

LAS – London Ambulance Service

LBH – London Borough of Havering

LD – Learning Disability

LTC – Long Term Condition

MASH – Multi-Agency Safeguarding Hub

MARAC – Multi-Agency Risk Assessment Conference

NCMP – National Childhood Measurement Programme

NELFT- North East London Foundation Trust

NHS – National Health Service

NHSE – National Health Service England

PEF – Patient Engagement Forum

PHE – Public Health England

PPG – Practice Participation Group

SALT- Speech and language therapies

SEN – Special Education Need(s)

SEND – Special Educational Needs and Disabilities

UCB – Urgent Care Board

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	**Havering Safeguarding Children Board and Havering Safeguarding Adult Board 2015/16 Annual reports**
Board Lead:	
Report Author and contact details:	**Brian Boxall Chair HSCB and HSAB C/O Maria.Laver@havering.gov.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 the HWB with Havering Children and Adult Safeguarding Boards annual reports for 2015-2016.

RECOMMENDATIONS

For the HWB to consider the reports and take into account the issues raised when considering future planning of services for vulnerable adults and children in Havering.

REPORT DETAIL

The Havering Children and Adult Safeguarding Boards are both statutorily required to produce annual reports.

The reports highlight the strengths and weaknesses of the multi-agency safeguarding systems for adults and children as of the end of financial year 2015/16.

They highlight the work of the boards and the future challenges. They set out the work of the statutory partners including individual agency challenges.

BACKGROUND PAPERS

1. **Havering Safeguarding Children Board 2015/16 Annual Report**
2. **Havering Safeguarding Adult Board 2015/16 Annual reports**

Havering Safeguarding Children Board

Annual Report 2015-16

Havering Safeguarding Children Board Chair Forward

The HSCB continues to be well supported by both statutory and non-statutory partners and I would like to thank all members for their continued support and commitment.

This year has seen changes in the leadership within the Local Authority with the appointment of a new Chief Executive and Director of Children Services. I wish to acknowledge the help and support to the board provided by the former Director and Chief Executive Joy Hollister and Cheryl Coppell, both were committed to safeguarding the children and young people of Havering and their support has enabled the board to develop and fulfil its statutory requirements.

The Multi Agency Sharing Hub (MASH) is now well developed and contact to referral level has increased evidencing improved agency engagement and decision making when determining the level of service required to respond to identified needs. This has also led to a significant increase in the number of contacts being referred to Early Help. There is now evidence of early intervention with children and young people and families requiring support being signposted to the appropriate service.

The past year has seen continued activity in respect of the multi-agency service response to child sexual exploitation (CSE) and missing children. This work has built on the past two years improvement in awareness and response and has seen Havering become one the top London Boroughs for its identification and intervention in CSE cases.

The board has also started to work closely with young people from the Children in Care Council (CiCC), the youth parliament and young carers. This interaction is at its early stages but their input to date has been exciting and very insightful for the board and individual agencies.

The board continues to work closely with partners. The agency section 11 statutory requirement reviews reflect the work being undertaken and the willingness of agencies to continue to identify and address risks and challenges.

There have been major changes in a number of agencies including the separation of the Probation Service and the introduction of the Community Rehabilitation Company and Children Social Care will during 2016-17 be introducing and exciting new programme Face to Face for social workers to be able to respond.

The 'Wood' review findings, the removal of a statutory requirement to have in place a Local Children Safeguarding Board, have been placed in the new Social Care Bill. This Bill has major implications for agencies and specifically Children's Social Care. I will work with the Chief Executives and officers of the three statutory agencies, to ensure that Havering is in the best position to implement the new legislation.

The impact of austerity and budgetary restraints continues to be a challenge that must be a focus of the board during this next financial year.

I am pleased to be in a position to support the development of a strong and effective multi agency safeguarding offer to children and young people during the upcoming year.

Brian Boxall

HSCB Independent Chair

Introduction

The purpose of this report is to fulfil the statutory requirement set out in Working Together to Safeguard Children 2015, which states that all Local Safeguarding Children Boards must publish an annual report on the effectiveness of safeguarding in their local area.

Working Together 2015 asserts that LSCBs do not commission or deliver direct frontline services though they may provide training. While LSCBs do not have the power to direct other organisations they do have a role in making clear where improvement is needed. Each Board partner retains their own existing line of accountability for safeguarding.

Our Vision

The HSCB reviewed and amended its vision statement and strategic aims in January 2016**.**

Vision Statement

Keeping children and young people safe is the Havering Safeguarding Children's Board overarching priority. All partnership agencies are committed to raising safeguarding standards and improving outcomes for all the children and young people of Havering.

Our Six Strategic Aims

In order to meet our vision, the Havering LSCB has identified 6 strategic Aims

1. Ensure that the partnership provides an effective child protection service to all children and young people ensuring that all statutory functions are completed to the highest standards.
2. Monitor the effectiveness of the multi-agency early offer of help to children and young people in Havering.
3. Ensure that agencies work together to provide the most vulnerable children and young people with the correct help at the right time.
4. Ensuring an integrated multi-agency approach to respond to emerging themes and priorities identified by the Board and through national learning.
5. Assuring the quality of safeguarding and child protection to the wider community.
6. Ensure that partners learn lessons identified through local and national learning, and ensure that learning is acted upon and embedded in practice across all partner organisations.

This report will provide an overview of the following:

1. Summary of the HSCB response to 2014-15 annual report challenges
2. Overview of the 2015-16 safeguarding strategic aims.
3. Summary of the HSCB board sub group working and governance 2015-16.
4. Appendices: Each agency was asked to supply a summary of their responses to safeguarding in 2015-16. These reports are attached to the annual report in the appendix.

Summary Board Response to 2014-15 Challenges

The 2014-15 annual report identified a number of challenges for the HSCB. These were areas that needed to be addressed during 2015-16.
This section is a summary of progress made on challenges. The outcome of some of HSCB responses will be evidenced in the main report but the summary has been included here as it demonstrates how the HSCB has fulfilled its statutory responsibility to strengthen safeguarding of the most vulnerable children and young people over the past year.

Multi-agency dataset: The HSCB held a workshop in December 2015 to review its current dataset and consider the data required in order to

strengthen the Board's capacity to understand the level of need in relation to the safeguarding and protection of children and the effectiveness and impact of the multi-agency service response to this to children across the continuum of need. A revised dataset was presented to the Executive and Operational Boards in January 2016, and formally agreed. The end of year figures submitted in the new format will be analysed at the Quality and Effectiveness working group meeting in July 2016. Q1 figures will be presented to the Quality and Effectiveness meeting scheduled for discussed in September 2016. The HSCB dataset will be reviewed and revised throughout 2016 to 2017 in order to ensure the HSCB has the data that is required to assure itself of the effectiveness of the service offer to children and young people within Havering. During the transition period CSC data has presented data specific to the service to the Operational Boards and Quality and Effectiveness working group meetings to allow the Board to continue to maintain scrutiny, oversight and challenge of the service offer to children and young people in need of safeguarding and protection.

Multi Agency Safeguarding Hub (MASH): A formal review of the MASH was commissioned during 2015 and a report was published in June 2015 regarding the effectiveness of MASH, which included the impact of adult safeguarding processes to the children's MASH. Findings from this review have been taken forward by Havering Council Children and Young People services with the support of MASH partners, resulting in a further review of MASH processes and a restructure to make business progression within MASH more streamlined. A pilot of MASH processes was implemented between January and March 2016, which has resulted in improvements within decisions and an improvement in timeliness of assessments. This may suggest that fewer families are being drawn through a statutory process unnecessarily and MASH is identifying families that need services more effectively.

Workforce stability: This is being monitored at an organisational level with exception reporting and discussion during Executive / Operational Boards. Workforce data is an area captured within the HSCB dataset, which will be presented to the Quality and Effectiveness working group in July 2016. The impact of this is that strategic leads understand the importance of a stable workforce and are taking steps within organisations to develop processes that will lead to staff retention and stability within the workforce. A stable workforce has been found to improve worker satisfaction, which has been found to be more likely to deliver quality services to service users

Use of Police Powers: Havering continues to have a higher level of use of Police Powers in relation to national and statistical neighbour statistics. Meetings have been held between Children and Young People Services and Child Abuse Investigation Team Officers in order to address this. There was evidence of reductions in the use of Police Powers but Havering continues use this power at a higher level than statistical neighbours and nationally. This is being addressed at agency level between Police CAIT and Children and Young People Services.

LAC out of borough placements are appropriate and that the children are receiving good quality support: This action is held within the HSCB action plan and information will be submitted to the HSCB Operational Board in line with Children and Young People Services reporting schedule.

Timely completion of LAC health assessments: This action is being progressed within the HSCB risk register. The CCG put in place a new contract to ensure there is capacity to undertake initial health assessments. They have also made additional staff appointments to support the contract. This should ensure that there is capacity to respond to this statutory requirement in relation to LAC initial and review health assessments.

Private Fostering: CSC is leading and promoting awareness of this with simple messages. The Permanence Team has offered to provide briefings to multi-agency partners to develop awareness. To be included within safeguarding week October 2016

Early Help Assessments: The recently agreed dataset includes Local Authority data in relation to early help. 2015/16 saw a 13% increase in the number of Early Help Assessments completed, at 682 compared with 602 during 2014/15.

Engagement with Children and Young People: The Board has met with children and young people representing young carers, Havering Youth Council and the Children in Care Council. The information presented to the Board is being progressed and a plan to work with the young people on the issues the identified being progressed. The group will be participating within the Safeguarding week scheduled for 10-14 October. The Board will continue to develop the communication pathways between children and young people and the Board.

Disseminate local and national learning: The HSCB has developed and disseminated widely newsletters and briefing documents in relation to this Board challenge. The information is held within the HSCB website and is accessible to all.

Audit activity: The HSCB Quality and Effectiveness Working Group has undertaken an audit of MASH and an audit of LAC missing. The audits identified that significant information was not consistently captured across partner information systems and this is being addressed. There was not evidence of use of threshold when referring cases for a service. A further MASH audit will be carried out in October 2016 in order to ascertain how well the threshold document is understood and applied when referring cases to MASH.

LADO: The LADO annual report has been submitted for scrutiny during the Operational Board. Actions to improve the service response from the LADO have been taken following a SCR where gaps in the service were identified. These improvements are being implemented by the LADO overseen by the PSW and reported to the HSCB

HSCB Risk Register: The HSCB risk register is used to ensure areas of specific concern are known and action taken to mitigate risk at the earliest opportunity.

Board Challenge

The HSCB acknowledges that the challenges are not a quick fix and require partners to work collaboratively with a shared understanding of outcomes required so that improvements are achieved and sustained.

Section 1

2015/16 Strategic Aims

The Front Door

The front door to child protection services in Havering is the Havering Multi Agency Safeguarding Hub (MASH). This was designed to facilitate better decision-making and outcomes in respect of vulnerable people. The Havering MASH is a co-located, multi-agency team working in a single, secure hub that receives notifications about potential risk and need. The partners involved in the multi agency team include Police, Public Protection, Health, Housing, Probation, Adult Mental Health, Early Help Advisor, Missing Persons, and Independent Domestic Violence Advocacy.

Havering was one of the first London Boroughs to develop a MASH. It has developed and in June 2014 became the first borough to implement a joint children's and adult MASH.

MASH Referrals and Assessments		
Years	2014-15	2015-16
Contacts received.	6984	5856 (down 16%)
Contacts progressed to referral	1774 (25%)	1937 (33%)
Referrals progressed to Assessment.	1783 (95%)	1842 (81%)
Contacts progressed to Early Help.	964 (13%)	2156 (37%)
Contacts progressed to Early Help Assessment		391 (5%)
Repeat contacts to social care within a year (of total contacts received in Triage/MASH)		2045 (35%)

The aim of a MASH is to improve the quality of information sharing and decision-making at the point of referral. Whilst the MASH has been effective it was identified that it was a victim of its own success. It was receiving a high level of contacts that were MASH'ed and progressed to assessments with a high proportion of assessments being concluded with no further action required.

In order to address this a review of business processes (LEAN review) was undertaken between January and March 2016. The aim of the review was to:

- Reduce the number of referrals resulting in a statutory assessment.
- Create a joint front door with Early Help and MASH to target the most effective service to children and families at the earliest opportunity.

The review findings have been implemented and the impact in the early stages have included:

- 69% reduction of contacts that are MASH'ed
- Early intervention and Identification in harm.
- 28% reduction in assessments ending in NFA
- An average of 44% of contacts each month undertaken by Early Help Service.
- 70% reduction in the time taken to allocate Early Help cases to family Support Workers.

Impact

Is the MASH making a difference?

Whilst the number of contacts have reduced the number of contacts progressed to referral have increased by 8% indicating an increased quality of contacts being submitted.

What needs to be highlighted is the significant increase in the number of contacts progressed to Early Help. This would indicate that more children and families are receiving early intervention and receiving the support they required at an earlier stage, reducing the possibility of requiring critical intervention at a later point in time.

A multi-agency audit of the MASH was undertaken in March 2016. The agencies that participated were North East London Foundation Trust (NELFT), Barking, Havering and Redbridge University Hospitals Trust (BHRUT), Havering Clinical Commissioning Group (CCG) and Children's Social Care (CSC).

Main findings

- The MASH decision was considered appropriate in all but one case reviewed.
- There was no evidence of the outcome of the referral being fed back to the referrer or Partners.
- There wasn't clear evidence of the threshold document being applied to evidence decision making / feedback to partners.
- Discussions between Management and Social Workers are not always clearly recorded even though they are taking place. Further streamlining of CCM is also required as many cases were difficult to navigate as information had been stored in several places.

These finding have been fed back to the team and performance will be reviewed during future audits of MASH which will continue throughout 2016 to 2017. Findings will continue be presented to the HSCB Operational group.

Contact Sources.

The source of the contacts/referrals has remained consistent to previous years with the Police being the main referral source at 44 per cent (a drop from 65 per cent % 14-15). Schools have increased to 13% from 7 per cent 14-15 which is a good change of direction.

Health partners, comprising of acute and community settings, midwives, GPs and the London Ambulance Service, account for 8 per cent. This is a significant increase from the 3 per cent % 2014/15. Whilst this is to be welcomed this is an area of work that needs to be further examined to better understand why this is taking place.

In order to assist agencies identify and evidence referrals, The HSCB Threshold document was

revised (March 2016). It is now much shorter and easier to use with regards to multi-agency involvement. The early indications are that it is being used by staff as this is being reflected in the MASH contacts.

Board Challenge

- To continue to monitor and audit the MASH to ensure that it is continuing to identify and provide early intervention and appropriate signposting.
- To ensure that the multi agency support currently within the MASH continues in the light of reducing budgets and agency restructuring.

Child Protection

Whilst the MASH acts as the front door and provides the initial direction, it is the effectiveness of the multi-agency response to referrals that impacts on the life of the child.

Category	2014-15	2015-16
Average Number of children on CP plan at the end of March.	178	290
Average Number of Children on CIN plan	171	193
Average Number of other LA children on CP plan	37	16
Average Number of new section 47 investigations	841	597

Does the intervention improve the child's life?

It was highlighted in the 2014-15 annual report that the introduction of the MASH directly impacted upon the significant increase in the number of section 47 investigations and the number of children who subsequently become subject to a Child Protection Plans. The past year has seen a decrease in the number of section 47 investigations. The previously identified work in the MASH will improved the multi agency information available in the initial referral, assisting effective informed decisions making.

Category	2014-15	2015-16
Emotional abuse	24%	31%
Neglect	55%	52%
Physical abuse	16%	8%
Sexual abuse	6%	5%

The monthly average of children on a CP plan has increased by 63 per cent although at the end of the year there are indications that this number is decreasing

Timeliness

The number of Initial Case Conferences has increased during the year from 131 in 2014-15 to 184 in 2015-16. The number of case conferences being held within the required fifteen day timeline has increase from 50 per cent 2014-15 to 58 per cent 2015-16.

Completion of assessments with 45 days is an area where CSC are still underperforming. The target for 2015-16 was 90% but by the end of March 2016 the figure was 49% for the whole year. There are indications that at the latter end of the year the % was increasing, with 83% and 86% of assessments being completed within timescale during February and March respectively, following the introduction of new ways of working as a result of the Lean Review and the successful development, piloting and roll out of a new, streamlined single assessment template. What needs to be noted is that there was a 65% and increase of the number of assessments. This provides evidence of continued pressure on the workforce and the need to ensure that referrals to CSC are appropriate.

86 per cent of active CPPs during 2015 – 16 had been in place for twelve months or less and only 1% where in place over 18 months.

	0-6	7-12	13-18	19-21	over 21
Total children	**103**	**168**	**40**	**2**	**0**
%children 2014-2015	**29%**	**50%**	**14%**	**0%**	**7%**

%children 2015/16	**33%**	**53%**	**13%**	**1%**	**0%**

The continued use and development of the Family Group Conferences in the more complex and high need cases has proven to be an effective mechanism to facilitate better family engagement. This includes the identification of risks and the actions required to reduce them. This is helping to achieve positive outcomes for children and young people with improved family engagement.

Child in Need (CIN)

CIN plans have continued to increase over the year with March 2016 numbers being 80 per cent higher than the same month 2015. It is of note that that there has been an increase in the number of white British children from 48% to 63% whilst children " of any other mixed background " have dropped from 14% to 6%.

The percentage of CIN cases that are linked to the "Toxic Trio" (Mental Health, Domestic Violence and substance abuse), has increased by 5% with the highest increase in cases related to domestic violence.

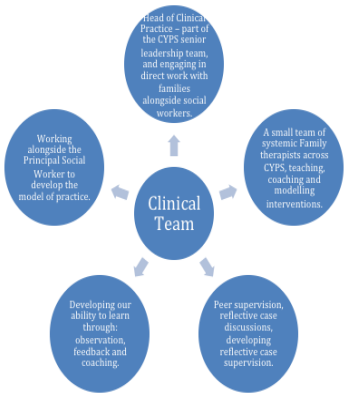
Children's Social Care

During 2015-16 Havering Children's Social Care under its new director formulated a new way of working.

The new *face-to-face* programme was launched in April 2016 and aims to support practitioners to spend more time working directly to support children and their families in Havering.

The programme features three key elements:

- A Systemic practice team to model and support evidence-based practice;
- A training programme for practitioners and their managers in an accredited Systemic Family Therapy course;



- And a set of measures to transform the environment in which practice takes place – removing system conditions that get in the way.

Audit and Performance Monitoring.

The board has been fully consulted on the new process, supported the launch seminars and fully supports the new exciting approach to working with and helping children and families. It is important to be able to identify the impact that the new Face to Face programme has on improved outcomes for children. The HSCB Q&E Group will deliver a 'tracking framework' to assess the effectiveness of the new programme by tracking twenty five families over a two year period. Each quarter, five cases will be sampled; these will be cases that have progressed through assessment team to social work allocation (CIN / CP / LAC) or are held by Early Help services. A sub group will be assigned to undertake a deep dive into these five cases.

During 2015-16 the CSC improvement board and the HSCB continued to audit and review cases.

This included the introduction of a 'Practice Week' during which CSC with involvement of staff reviewed 100 cases.

A number of issues were identified and placed on the HSCB risk register. They included:

- Health Visitors and School Nurses attendance at Core Group meetings.
- Non-attendance of police at ICPC and RCPC
- Lateness of CP reports to Conference.

The CSIB board identified some risks and challenges that were monitored over the year

and will continue to be monitored over the coming year. In common with the observations outlined above, these include:

- Delays in completion of assessments (see above)
- The need to improve the quality of planning processes.
- The need to ensure a robust response to all CSE cases (see page 18)
- The need to improve outcomes for LAC (see below)
- Financial and resource pressures – The need to make significant savings coupled with rising numbers of LAC and child protection cases.

Board Challenge

To support the new programme and ensure that all agencies also aware of the programme and actively become involved.

In addition, multi-agency thematic audits will be conducted as and when required by the Board.

Staffing

One of the biggest impacts on effective responses to child protection is agency staffing levels and workloads. This continued to be of concern in 2015-16.

The HSCB has during 2015/16 monitored the work force across the agencies. Agency staffing levels now forms part of the HSCB data collection.

Social work staffing continues to be the most challenging with 29 % of the establishment covered by agency staff. This is being monitored and managed by the Local Authority through its Recruitment and Retention Strategy. In response to increasing demand on the service the Local Authority has employed a further 24 agency staff over the agreed establishment.

Whilst this is to be welcomed, the use of agency staff continues to be of concern: of the 517 cases open for a year or more 153 children had at least 3 changes of social worker over the year, 8 had 5 or more changes of social worker. Whilst this may be for legitimate reasons instability in the work force does not help the development of meaningful relationships between children and their workers.

Board Challenge

- For the board to continue to seek information regarding workforce stability and assurance that staffing levels do not have an impact on the provision of services, and to challenge when necessary.

Looked after Children (LAC)

Looked after Children are vulnerable and the HSCB needs to be continually satisfied that they are in receipt of timely support in a stable environment.

LAC		
	2014/15	2015/16
Male	56%	54%
Female	44%	46%
0-4 Years	15%	16%
5-10 Years	26%	24%
11-15 Years	31%	36%
16-17 Years	29%	24%

The end of year statistics March 2016 showed that there were 229 LAC, this is 11 lower than same period last year. There have been some changes in the spread of ages of our LAC population. The 5-10 age group has dropped from 26% to 24% with the 11-15s increasing from 31% to 36%. The older age group are more difficult to place and this may impact on the LAC placement budget.

In terms of ethnicity White British children have reduced to 61% from 70% with Black Caribbean and Black African showing a slight rise.

The levels of children starting to be looked after on Police Protection have shown a significant decrease with an end of year figure of 55 compared to 84 the previous year. This is a welcome reduction and is in response to the work undertaken by the CSC and the local police

command and CAIT. It still remains higher than the statistical neighbours.

This was an area that has been reviewed regularly within the Havering Quality and Effectiveness (Q&E) working group.

During 2015/16, the local authority developed and agreed a new Corporate Parenting Strategy. The Council's "Pledge" to looked after children and care leavers has also been reviewed and an updated version has been co-produced with children in care.

Legal Status

The use of section 20 –still remains high. The use of section 20 will be subject of audit to ensure other forms of care order are not more appropriate for the LAC. This was an area of concern highlighted in one of our Serious Case Reviews.

	S31 Care Order	S38 Interim Care Order	S20 Voluntary Accommodation	S21 Placement Order
2014-2015	81	26	115	17
2015-2016	87	28	96	18

Placement Stability

Placement Stability meetings bring professionals from relevant agencies together to agree the most appropriate support package and placement for each LAC. The meeting predominantly focusses attention on children and people that are in long-term care.

All children require stability and continuity if they are to be given every opportunity to reach their potential. LAC have not experienced stability or continuity of care and it is crucial to provide this to them to help them to heal and to provide them with the best opportunity to achieve their potential. Significant effort has been put into placement stability and the 2014-15 position has been maintained. Year-end data evidenced that 10 per cent (23) of LAC experienced three or more placement moves within the year. Although this is an improving picture, this remains an area of concern for the HSCB.

LAC placement lasting two years or more has decreased from 83 per cent for 2014/15 to 70%. Whilst this is a reducing it is still above the national average of 68%.

The number of LAC who are placed outside the local authority area and more than 20 miles away from where they used to live has increased again for a second year to 16% against a target of 10%.

Missing

LAC children represent a high number of the missing reports taken and LAC children are more likely to be vulnerable and at risk of CSE. The board required assurance that the response to missing children and LAC in particular was appropriate and effective.

To that end a multi-agency audit session focusing on LAC Missing Children was held in November 2015. Agencies in attendance were Children Social Care (CSC), Barking, Havering and Redbridge University Hospitals Trust (BHRUT), North East London Foundation Trust (NELFT) and Havering Clinical Commissioning Groups (CCG).

Common themes identified during the audit meeting:

- ✓ A variety of support had been offered to young people in a timely way, although in most cases the young people were hard to engage and did not take up the services and support offered to them.
- ✓ When visits took place, in the majority of cases the young person's views were implicit.
- ✓ The placement was considered appropriate in all but one case reviewed by CSC. The other agencies did not hold enough information on the young person to be able to assess this.
- × Return Home Interviews had not taken place at the required frequency.
- × The quality and robustness of care plans needs to be improved.
- × There is a clear need for earlier, targeted intervention to improve engagement.
- × Evidence of multi-agency working across different systems in use needs to be improved.

- The robustness of audits completed by NELFT needs to be improved

In order to address the highlighted issue of RHI the responsibility has now been returned to the Children Social Care. The initial findings on this development appear to show an improvement in timeliness. The board will continue to monitor this.

Health

There is a statutory requirement for all children to undergo a health assessment within 20 working days of becoming 'Looked After'. Thereafter children under 5 require review health assessments every six months and over 5 require review health assessments annually. In last years annual report this was identified as a risk as there were a significant % of LAC that were not in receipt of timely health assessments. Significant work has taken place during 2015-16 to rectify this situation and by the end of the year 91% of all LAC had an up to date medical recorded.

Education

LAC generally achieve more poorly within education than their peers. In response to this Havering council has established a LAC Education Panel to oversee the drive to improve educational amongst this group: HSCB will monitor the stability of education placements for LAC matched to their educational achievements during 2015 -2016. This will support the HSCB to identify whether an increase in educational placements impacts negatively on attainment.

Each LAC should have in place an up to date Personal Education Plan (PEP). By the end of the year there were 189 LAC of school age of which 121 have an up to date PEP (64%).

This was identified as an area of concern by the board. During the year the electronic version of the PEP was introduced which has enabled schools to update the PEP. The virtual head has reported that the up to date PEPs are now around the 80% mark.

A new measure is the number of former relevant young people aged 19-21 who were in higher education. It is currently 5%. The numbers are low but the aim is to increase this over time with the work being provided to current LAC.

Non-Havering LA LAC

By the end of 2015-16 there were 329 LAC placed in Havering from other areas. They were placed by 35 different authorities across the country with biggest single placing authority being Newham with 47 placements. This is a high number and far more than Havering's own LAC.

Whilst Havering is informed of placements, when Havering requests more detailed information from the placing authority, this is not always provided. The HSCB chair has requested that he is supplied with details of these authorities so that he can escalate to the appropriate LSCB.

This large number of LAC children also places additional pressure on health and schools in Havering to complete the required assessments.

Board Challenge

- To continue the monitor use of Police Protection to ensure that its use is consistently applied and appropriate
- To ensure LAC out of borough placements are appropriate and that the children are receiving good quality support
- To continue to monitor the completion of LAC health assessments to ensure they remain timely.
- To continue to monitor the response to missing children and to ensure that RHI interviews are improved following the withdrawal of the Children Society.
- The Board will continue to monitor the LAC Improvement plan and the LAC education plan, which focus on placement stability, improving outcomes and increasing the numbers of LAC placed in family placements within the borough

Independent Reviewing Service

The Independent Reviewing Service is responsible for discharging the following statutory functions:

(i) Child protection – chairing child protection conferences and monitoring of the progress of child protection planning.

(ii) Looked after Children – chairing reviews and monitoring the performance of the local authority in discharging its responsibility in the child's journey through care.

(iii) Providing Business support for the above services.

The IRO is an essential element for ensuring that children and young people are safeguarded and as such their input to the board is essential.

Independent Reviewing Officers (IROs) in Havering

- Undertake the dual function of chairing child protection conferences and carrying out their responsibilities towards looked after children.
- IROs represent the Safeguarding & Service Standards Unit at the Looked after Children Panel within children's services, Multi Agency Risk Assessment Conference (MARAC) and Multi Agency Public Protection Arrangement (MAPPA) Panels.
- IROs discharge their duties in relation to the revised Care Planning Regulations and Guidance which were introduced in April 2011. The responsibility of the IRO has changed from the management of the Review process to having a wider overview of the progress of a child's case including regular monitoring and follow-up between statutory Reviews. The IRO has a key role in relation to the improvement of Care Planning for Looked after Children (LAC) and for challenging drift and delay.

There has been a significant increase in the number of child protection conferences taking place and therefore an increase in the numbers of children being made subject to child protection plans during 2015-6.

- The decisions made to convene a child protection conference and commence a plan are appropriate and in line with Working Together thresholds. This needs continued monitoring
- Havering has a changing demography. Continued analysis of this is underway due to this continued and sustained increase in numbers of children subject to CP plans. This will need to be monitored
- Timeliness of reports received continues to be an area requiring improvement during 2016.
- Ensuring permanence plans are in place for LAC by the second review is a priority area to be promoted by IRO and monitored through audit and practice discussion.
- Developing links with teams which are collaborative while challenging and critically appraising of practice is a key priority for the coming year.
- Developing meaningful partnerships with parents & carers to gain their views on the service we deliver and their input to making changes to service
- Ensure that children and young people participate in meetings and contribute to the plans made for them
- Supporting the move to a systemic model of practice in CYPS

Board Challenge

To ensure that agencies are represented at conference.

To ensure that agencies provide timely relevant information for conferences.

Private fostering

Private Fostering is still a major challenge. The number of registered privately fostered children remains low and has reduced over the past year despite extensive publicity and training. Action is being taken to address this situation and is led by Children Social Care. This remains a priority for the HCSB.

Board Challenge

- For the board to ensure that partners continue to promote and raise awareness of Private Fostering in order to ensure that such arrangements are identified and registered.

Early Help

Early help is the bedrock to improving outcomes for children and young people. Effective early help will improve outcomes and help reduce the need for more serious child protection processes.

Early help is crucial in the 'step down' from child protection to child in need and child in need to early assessment processes. Thresholds for services must be fully understood and embedded if step down or step up transitions are to be smooth and supportive to families.

'Early help is better for children: it minimises the period of adverse experience and improves outcomes for children'

Eileen Munro March 2011

The Early Help Service offers some of Havering's most vulnerable families support in the following areas:

- Family intervention and support – under 12s and over 12s
- Children's centres
- Targeted Youth Support
- Employment Advice
- Adult mental health assessments
- Opportunities to volunteer with the LA
- Housing support and advice
- Support for victims of Domestic Abuse
- Family Group Conferencing
- Parenting Support – surgeries and programmes

There has been a 64% increase in the total number of 0-4 year olds that have registered within Havering in 15/16 compared to the same stage last year (March 14/15 - 1,382). This shows that Early Help are reaching a larger amount of families within Havering which is a positive outcome.

From January 16 all of the children centres within Havering received extra admin support at front of house; this has proved effective and there has been a large increase in the total number of registrations since.

Early Help has seen a 56% increase in the total number of contacts received by the Early Help Service in 15/16 compared to 14/15. Of which 73% were given Advice and Signposting. However, we have seen a 33% increase in the total number of cases that have progressed to an Early Help Assessment. This is good for the Early Help Service as it shows that we are working with and reaching more families. Of the contacts received in 15/16 over 41% of these cases related to Domestic Violence (25.4%) and Socially Unacceptable Behaviour (16.1%) compared to 35.8% received in 14/15. The main concern however relates to Domestic Violence which has tripled in 15/16 compared to the previous year.

The Early Help Service has seen an increase in the total number of Assessments completed by 13% compared to last year (14/15). This indicates that they are reaching out to more families which is a sign of improvement. We have seen a slight decrease in the total number of assessments that have been completed by schools (1%) however this may be due to the nature of recording.

Team Around the Family (TAF) reviews are broken down into Internal and External reviews, Internal TAFs are completed by the family support workers within the Children's Centres, External TAFs are completed by the schools and sent through to Early Help.

There has been an 11.3% decrease in the total

number of TAF reviews completed in March 16 compared to February 16, however there has been a 220% increase in the total number of completed TAFs as at the end of 15/16 (768) compared to 14/15 (240).

During 2015 – 16 303 cases were stepped down from Children Social Care to the Early Help Service, with 59 cases being stepped up. This provides some evidence that Early Help services is helping to reduce the unnecessary escalation of early need.

Early Help Board Challenge

- ***To continue to monitor and be assured that early help is intervening at the earliest opportunity to improve the outcomes for children and their families.***

Community Safety Team

This team is responsible for the development and implementation of work to reduce crime and

disorder, as well as the fear of crime, within the borough. It achieves this through both direct work and by co-ordinating strategic partnership working with the wide range of public, private and voluntary sector partners represented on the Havering Community Safety Partnership (HCSP) and the Safer Neighbourhoods Board. The following is a summary of the current situation in Havering.

Serious Group Violence:

- At present 93 individuals are being monitored under SGV, of which 45 are on the Police Trident Matrix and 6 are in custody.
- Following on from the Peer Review and the Local Assessment Process, Havering ran its first Serious Group Violence Conference on the 9th March 2016. The key speakers for the conference (Home Office, St Giles Trust, Spark2Life & CRC) are setting the pace in London and the UK in relation to SGV and Gangs. Its aim was to raise awareness around gangs, county lines and to make the links between Gangs, CSE and MISPERs very clear. The conference went very well. 90 people attended, 94% would attend again and 97% would like to attend further gangs training.
- The conference also provided a platform to promote the new Police Partnership Intel Sharing Form. This document gives the Police the opportunity to get valuable information from stakeholders and onto the Police Computer System (Crimint).

SGV Schools and Mentoring Projects

- The 1:1 Mentoring programme hit its target of 300 sessions. A total of 357 Sessions were carried out amongst 17 Nominals.
- The Schools Programme achieved its target of 88 sessions. A total of 89 Sessions were carried out amongst 12 schools. 6,811 school children were given gang prevention/ awareness advice in the form of an assembly, small class work or 1:1.

SGV Gangs Awareness Training

In 2015-2016 82 frontline workers attended the basic Gangs Awareness Training. A good variety of services have been represented, and all have shown an increased confidence in identifying individuals at risk/ involved in a gang.

Level 2 gangs training is currently being designed, and we hope to start running these in Quarter 1 of 2016/2017. (Trying to source appropriate training venue). This will only be available to those professionals who have already been through the basic awareness training.

Havering DV MARAC

- There have been 250 referrals to the MARAC in the financial year 2015/16, a rise from 240 for the previous year 2014/15. There were 77 repeat cases in 2015/16, an increase of 51% from 51 cases in 2014/15.
- There has been a significant rise in the volume of children in the households referred, which may reflect the volume of referrals coming from Children's Social Care. There were 351 children in the household for the last year, up from 292.
- In terms of diversity data for 2015/16 compared to 2014/15,
- BME cases increased from 29 to 45
- There were 3 LGBT cases, whilst there were none in the previous year.
- Disability cases increased by 1 to 5.
- There were 13 male victims, with 10 in the previous year.
- There were 4 victims coming to MARAC aged 16-17.
- In terms of referrals data for the past 12-months,
- IDVA's made the most referrals at 82 which is 14% up on 2014/15
- Police made 59 referrals, a decrease from 72.
- Children's Social Care, which includes Early Help, made 48 referrals, a 140% increase compared to two years ago (2013/14) when there was just 20.
- Referrals from Housing have declined by 80% from 18 in 2014/15 to 10 in 2015/16

DV Champions training

Currently we have a total of 89 trained DV champions working across organisations in the Borough

PREVENT

- Section 26 of the Counter-Terrorism and Security Act 2015 (the Act) places a duty on certain bodies ("specified authorities" listed in Schedule 6 to the Act), in the exercise of

their functions, to have "due regard to the need to prevent people from being drawn into terrorism". This guidance is issued under section 29 of the Act. The Act states that the authorities subject to the provisions must have regard to this guidance when carrying out the duty. This short report gives details of what provisions the Council and other bodies have taken to ensure compliance with the Act.

- A multi-agency PREVENT plan has been developed and implemented
- PREVENT training (Workshop raising awareness of PREVENT, WRAP 3) is now run for all agencies through the LCSB hub that can be found at www.havering.gov.uk/lcsb. These are run once a month by Havering's Community Safety and Development team. So far about 300 staff across all agencies have been trained through this method. The Health Authority also runs regular PREVENT training and again many hundreds have been made aware of PREVENT. The workshops take the form of one hour workshops
- Workshops were also delivered at the Safeguarding Conference in October to raise awareness of PREVENT. This included WRAP3 training and an improvised 'ACT NOW' event where staff decided what actions to take in a simulated terrorism scene.

Junior Citizen

The London Borough of Havering's second Junior Citizens event was held at the Territorial Army centre in Romford in June-July 2015. The project was funded by MOPAC in order to provide safety advice to Primary School leavers the summer before they start secondary school.

A number of partners from the local authority and across partnership agencies came together to provide 2 weeks of scenarios aimed to providing a hands on approach to safety in situations they may encounter. The following agencies took part:

- KD Safer Schools Officers, Metropolitan Police
- Safer Transport Team, Metropolitan police
- Road Safety, London Borough of Havering
- StreetCare, London Borough of Havering
- Public Health, London Borough of Havering
- Community Safety Team, London Borough of Havering
- London Ambulance Service
- London Fire Brigade
- Youth Service, London Borough of Havering

Each partner provided a 10 minute scenario on a range of different topics. Within this report are breakdowns of each scenario, and how safe the participating students felt afterward.

The event hosted 1400 school children in 2015/16.

Board Challenge

To continue to monitor and react in Havering of VAWG especially in respect of children and young people of:

- Female genital Mutilation
- Forced Marriage
- Honour based violence.
- Child Sexual Exploitation and Trafficking.

To continue to increase awareness and understanding of the level of make-up of the gang structure in Havering.

Local Authority Education

Local Authority colleagues have continued to provide substantial and significant support to schools and early years providers as part of both their traded and statutory work. This includes support and training for governors, designated safeguarding leads, head teachers, provider leadership teams and education staff more generally. Additionally this year the focus has intensified around the PREVENT agenda, including CSE and CME and all providers have had specific input on FGM.

For the first time our School Improvement Team benefits from an officer devoted entirely to schools' safeguarding training and support. The officer is a qualified social worker who works alongside our school improvement officers to support schools with policy and practice issues. We regularly develop best practice advice based

on national cases, so that policy is made live through understanding practice.

School safeguarding policies have been revised to include the requirements of Keeping Children Safe in Education 2016. There is regular training for schools and schools are using a variety of training sources, including online training from the NSPCC. All schools have had whole staff training within the 3 year period. As this requirement becomes annual in the next academic year, a range of training courses have been developed to meet this need, including FGM, CSE, online safety, WRAP, DV.

Schools continue to use a section 175 audit document; this covers the statutory elements of Section 175 Education Act 2002, Section 11 Children Acts 2004 and Keeping Children Safe in Education, May 2016. All schools audited are compliant, many have very well developed in school processes which support high quality recording of child protection issues, enabling timely and detailed referrals and on-going. Recommendations are made for developing best practice. These action plans have been commended by Ofsted in several inspections.

- 35 schools have had audits this year, a 26% increase on 2014/5
- 65 school training sessions have been delivered to 2000+ delegates

Briefing notes have been issued to schools on specific topics such as

- The LADO
- MASH and referrals
- Breast Ironing
- Online safety in Safeguarding

A resources page on www.haveringeductaionservices.co.uk will host these briefing documents, policy templates and further information from September 2016.

Early Years and school leaders report that the training provided to support them has been very helpful and they feel well supported. The new draft policies sent to providers have been adopted. The child protection conferences are well run and chaired by individuals with a high level of skill and knowledge. Our early years advisors have audited all providers and followed up with targeted support where there are identified weaknesses.

Areas for development identified by education leaders within Havering's provision include improving the consistency of advice given by the MASH Team, better match with social workers' skills and the level of complexity of individual costs, handover agreements when social workers leave, and a more sensitive approach when police and social workers arrive to remove children.

Views of Children &Young People

There are number of process across agencies that capture the views of the children, young people and families.

LAC views are accessed via View point; the views of children subject to CP plan are also captured via View point.

Of the 623 looked after children/young people aged 4 or over that had a statutory review between 1st April 2015 to 31st March 2016, 611 (98%) communicated their views using a range of mechanisms including personal participation, written or electronic communication or independent representation.

The challenge is to ensure that each agency utilises the feedback so that services are improved to better meet the needs and requirements of children and young people.

The re-launch of the Children in Care Council provided an opportunity during 2015/16 to engage LAC young people in the work of the board. In November 2015 the HSCB chair attended a meeting with representatives from the Children in Care Council, the Youth Parliament and Young Carers. He spoke to them about the board and asked them to help inform the board by working together to identify the major issues in their lives that impact on them in respect of feeling safe.

They agreed to help and worked as a group during the first part of 2016 to prepare a presentation. The presentation to board members and members of the LA corporate parenting panel took place in May 2016.

Board Challenge

To improve the use of feedback to better inform board future board strategy.

Section 2

Learning and Improving Framework

Case Reviews

Local Safeguarding Children Boards (LSCBs) should maintain a local learning and improvement framework which is shared across local organisations that work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result

Summary of Work Group Purpose

The purpose of the HSCB Case Review Working Group is to ensure that the statutory requirements contained in Chapters 3 and 4 of Working Together to Safeguard Children 2015 are embraced and delivered. The main statutory requirement is for the group to implement a learning and improvement framework where partner agencies are clear about:

- Their responsibility for contributing to the learning and improvement processes.
- Effective dissemination of learning.
- Making sustainable changes to services.

The local framework should cover the full range of reviews and audits including:

- Serious Case Reviews.
- Child Death Reviews.
- Management review of a child protection incident which falls below the threshold of a SCR to provide useful insights about the way organisations work together to safeguard and promote the welfare of children.
- Review or audit of practice in one or more agencies.
- Identify and drive improvements to safeguard and promote the welfare of children.
- Translate the findings from reviews into programmes of action to bring about sustainable improvement and prevention of future deaths/harm.

Activity 2014/2015

Serious Case Reviews.

Two serious case reviews have been progressed during 2015-16.

The overview report written in response to each review will be published once all processes have completed.

Learning Reviews

2015/16 saw the completion of one learning reviews. The recommendations from this review were added to the action plan being progressed in response to learning reviews completed previously. Implementation of actions has been overseen by the case review working group.

The case review working group reported concerns to the Operational Board in relation to the drift in implementing action plans developed following serious case reviews and learning reviews. This was addressed through the establishment of a biannual Executive Board Learning and improvement meeting. The purpose of the meetings will be to ensure that each organization is held to account for the way in which actions are implemented and how this has impacted on improved outcomes for service users.

Board Challenge.

- To incorporate national and local learning into briefings and to ensure that this is disseminated widely and understood by practitioners.
- To continue to ensure multi agency learning impacts on service delivery through focused audit and feedback

Child Deaths: The Child Death Overview Panel (CDOP) and Serious Case Reviews

Working Together 2015 states:

The LSCB is responsible for ensuring that a review of each death of a child normally resident in the HSCB's area is undertaken by a CDOP
The CDOP will have a fixed core membership drawn from organisations represented on the LSCB with flexibility

The Havering CDOP is responsible for reviewing the circumstances of all child deaths within the borough.

Whilst the CDOP aims to complete its work as quickly as possible there are often delays due to factors such as securing post-mortem reports. This leads to some death reviews not being completed in the year (financial) that they occur.

Nine new cases were reported in 2015/16. THis is consistent with the previous year. Four cases were closed in 2015/16 only 2 of these deaths occurred in year. The remaining 7 deaths reported to CDOP in 2015/16 remain open.

Concerns have previously been raised that some deaths may not have been reported to the CDOP. However, an audit has shown that the CDOP process in Havering identified all deaths known to the ONS (primary Care Mortality Database).

Due to the small numbers a view of deaths occurring over a 3 year period provides a better picture.

When considering deaths 2013 to 2016 a third of deaths occurred within a month of birth; a half within the first year of life.

70% concerned White British Children which is a similar proportion of White British children in Havering school.

For the purposes of CDOP, an unexpected death is defined as-

'*the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death'*.

The final decision lies with the Designated Paediatrician. Just under half of child deaths where unexpected during this period.

Number of expected and unexpected deaths by category of death

	2013 - 2016			
	Expected	Unexpected	Total	%
Acute medical or surgical condition	0	2	2	7%
Chromosomal/genetic/ congenital anomalies	3	3	6	20%
Chronic medical condition	1	0	1	3%
Infection	0	3	3	10%
Malignancy	4	0	4	13%
Perinatal/neonatal event	8	0	8	27%
Sudden Unexpected Death	0	3	3	10%
Trauma	0	3	3	10%
Grand Total	16	14	30	

Neonatal death or a known life limiting condition was recorded as cause of death in 2/3rds of cases. The next most frequent cause was 'other' including 3 case of infection/sepsis and Sudden Unexpected Death of an Infant (SUDI). There was also 1 case of drowning and two deaths as a result of a traffic accident.

Safeguarding issues

None of children considered by CDOP over the period 2013/14 to 2015/16 was the subject of a serious case review.

No deaths were categorised as deliberately inflicted injury, abuse or neglect.

The CDOP didn't identify safeguarding issues as a modifiable factor in any case.

One child had been the subject of child protection arrangements at some point, but not at the time of their death.

Board Challenge

- To review the future arrangements of the CDOP in light of the recommendations in the Wood Review.
- **To work with neighbouring boroughs and in order to provide a greater picture over and increased population size.**

Safeguarding in Employment

Working Together 2015 Chapter 2

Local authorities should put in place arrangements to provide advice and guidance on how to deal with allegations against people who work with children to employers and voluntary organisations. Local authorities should also ensure that there are appropriate arrangements in place to effectively liaise with the police and other agencies to monitor the progress of cases and ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process.

Local Authority Designated Officer (LADO) Role

The role of the LADO or 'Designated Officer' is set out in Working Together to Safeguard Children (2015) and is governed by the Local Authority's duties under section 11 of the Children Act 2004.

Chapter 7 of the London Child Protection Procedures outlines the process for managing allegations against all paid or unpaid staff and volunteers, including foster carers and approved adopters.

The LADO's role is to co-ordinate information sharing with the right people and monitor and track investigations with the aim to resolving them as quickly as possible in an independent, fair, proportionate and reasonable manner for all parties with a focus on ensuring the protection of children.

The role gives all agencies, whether from the statutory, private or voluntary sector a central point of contact to discuss and refer concerns falling within the above criteria. The LADO is involved from the initial phase of the allegation through to the conclusion of the case, whether or not a police investigation continues.

The LADO will provide advice, guidance and support for organisations in meeting its obligations under the relevant legislation where an individual has:

- behaved in a way that has harmed, or may have harmed a child;
- possibly committed a criminal offence against or related to a child; or
- behaved towards a child or children in a way that indicates they may pose a risk of harm to children

From April 2015 to March 2016, the LADO received 274 contacts which resulted in 194 referrals. This represents a 71% conversion rate from contact to referral. Comparatively with other neighbouring LA data such as Redbridge (23% conversion rate from 211 contacts for the same year), this indicates a better understanding of thresholds.

Feedback from Users of the Service

Year	Number of cases	Percentage increase/decrease year on year
2012/13	106	71%
2013/14	160	51%
2014/15	121	**(24%)**
2015/16	194	

Towards the end of this year, feed-back forms have been developed in order to better quality-assure the LADO process for users of the service. General feedback over the year has been mixed with agencies requesting more availability of the LADO for general enquiry and this has notably improved from the figures in the final quarter as outlined above. It is hoped that with the more formal request for targeted information from those agencies involved with the LADO process, accurate analysis of the information will be possible in the coming quarters.

Moving Forward

The following areas of focus areas for development in the coming year for the LADO are as follows:

- Further outreach to low enquiry/referral sectors including faith, sports, private education providers.
- Continued links with LSCB to promote training and awareness.
- On-going work with BHRUT and NHS England to support LADO Process adherence.
- Further joint working with OFSTED Inspectors working in the borough to assist with Early Years settings.
- Improvement of resolution of cases where possible, minimising drift in cases.
- On-going positive work with CAIT Police and CYPS.
- Securing an amendment to the Child Protection Procedures as outlined above which will provide clarity of lead LADO role within the region with a view to expanding it nationally.
- Analysis of feedback from involved agencies.
- Data Protection issues to be explored with the relevant teams (Information / Legal). This may result in changes to LADO recording / notification practice.
- Referral Template and Database to be reviewed – this will ensure data capture is pertinent to on-going LADO need and referrals are succinct with the salient information required to progress referrals in a manner which is not laborious for referrers. This to be done in conjunction with feedback analysis.
- Close working in conjunction with Safeguarding in Education Lead to continue as a support for Educational Settings.
- Close working with Early Years Quality Assurance teams to support these settings including child minders.
- LADO to be regular attendee to the Schools Monitoring Group
- The development of a generic LADO training toolkit in conjunction with regional LADOs.

Board Challenge

- To monitor the LADO action plan and ensure that it receives multi agency support.
- To continue to highlight and challenge areas of concern.

Training & Development

HSCB has offered a range of training courses for the borough's multi-agency partners. This training is available to all agencies and individuals in the borough who work to protect children and young people.

During 2015-16 this period there were a total of 55 courses scheduled with a total of 1210 places available. Of these places available, 729 participants attended courses equating to 60% of capacity reached. The non-attendance fee that was implemented during the year generated £1,760.

Courses

In addition to the scheduled HSCB courses, a one hour Prevent Strategy course was introduced. This ran twice every month from September. During this period 21 separate courses were scheduled.

The most attended course was Introduction to Safeguarding with 93% attendance rate. This is the only level one course offered by HSCB and is accessible to a much larger delegate base who maybe non-specialist frontline staff for example, GP receptionists to SENCOs who are in need of a refresher course. This course will continue into the new year and will run four times.

The lowest attended course this year was Effective Supervision with a 20% attendance rate. This is the only two day course run by HSCB and a reason as to why the number is so low could be due to the fact it's over two days and finding availability for candidates could be an issue. This training was added to the programme as one of the Board priorities is to improve supervision processes across all agencies1. A consideration needs to be given as to whether organisations are accessing this training within their own agencies or do Board members need to push this course within their organisations to encourage attendance. The impact of ineffective supervision is highlighted within a number of SCRs locally and nationally.

2016-17

The money generated through non-attendance fees will help finance the Safeguarding Week planned for October 2016. A training fee will also be attached to agencies who wish to attend training that are not based within Havering and do not work directly with Havering children.

October 2016, will see the first annual Safeguarding Week. A series of events will provide safeguarding advice and awareness to professionals working with both adults and children. The annual Safeguarding conference will be held during the week and will include themes emerging from both adults and children safeguarding.

Havering has agreed to take part in the development of the London Training procedures that will form part of the London Safeguarding Procedures. The task and finish group will aim to develop the procedures that will be adopted by all London boroughs ready for 2017-18.

All training courses during 2016-17 will include information on escalation and threshold policies and where appropriate, how professionals respond to issues of disguised and partial compliance.

Introduction of Impact Analysis Process

During this year we introduced the process to evaluate the impact of training. Each candidate is required to complete the post-course evaluation 4-8 weeks post training to evaluate how the training has impacted the way in which they work with children and families. 158 evaluations have been received for this period to date, which is 22% of attendees. The drop in responses is likely to be due to the fact participants no longer receive a deadline reminder and are solely responsible for returning their evaluations within the allotted timeframe.

HSCB Newsletter

The HSCB newsletter is produced and distributed termly and held within the HSCB website, which was redesigned during this year.

SECTION 3

Board Sub groups Groups

Child Sexual Exploitation and Missing (CSE) Working Group

The HSCB CSE and missing working group has been in place since 2009 with a remit to understand the prevalence of CSE within Havering Borough; to raise awareness of CSE and missing across the Borough; and to develop a consistent response to CSE within Havering.

Late in 2014 Havering participated within a London wide CSE peer challenge; the outcomes from this were used to drive the CSE and missing agenda forward from strategic direction to frontline practice.

A CSE briefing document was produced, which set out the next steps for Havering around CSE, and detailed a proposal to establish a 6 month pilot to develop a consistent and informed service response to CSE:

- To set up a small children social care CSE pod to receive referrals that evidenced CSE themes;
- Establish a multi-agency virtual team to consider cases referred to the CSE pod and agree multi-agency actions;
- Establish a CSE steering group to oversee the implementation of the pilot and report to the CSE working group.
-

The pilot was set up to improve the identification of CSE at the front door; develop a shared understanding of CSE categories across the partnership; improve understanding of agency responsibilities; improve information sharing processes across partnership agencies; improve the knowledge base of practitioners in place to identify and respond to CSE; and better understand the effectiveness of the service response to children and young people at risk of or suffering CSE.

Further activity was to strengthen the Multi-Agency Sexual Exploitation (MASE) Panel and review the Missing Panel processes to begin to establish a framework that would allow the partnership to understand the prevalence of CSE and target resources to consistently respond to CSE activity, emerging priorities and themes. This process was supported through the completion of a CSE problem profile, which was updated in November 2016.

Points to note

- The activity that has been progressed since early 2015 has seen a significant shift in CSE understanding.
- CSE data indicates that CSE is identified within MASH/ triage: this was also confirmed through the CSE peer challenge
- Disruption tactics are used to deter CSE activity within Havering
- A problem profile is in place to support the development of services and inform front line practice responses.
- A body of expertise has been established within CSC and across partnership agencies, which has led to a shared understanding of CSE categories and a better understanding of agency responsibilities as it relates to CSE and missing.
- Missing processes have been strengthened and children missing are discussed during weekly CSE and missing virtual team meetings to enable a multi-agency response to risk and need.
- Data within the HSCB dataset includes CSE and will be reported to the board quarterly from April 2016.
- RHI have been identified as an area of risk and this is being responded to by children social care: RHI interviews remain on the HSCB risk register
- MASE is not yet in a position to provide strategic oversight of CSE within Havering: this is being addressed activity to improve process is reported to the CSE and missing WG.

CSE and Missing Prevalence

Over the past couple of years the HSCB has firstly raised the awareness for all agencies of CSE and then looking at the identification and responding to vulnerable young people

During 2015-16 there were 183 recorded CSE Contacts relation got 166 young people. This represents an 86% increase in the number for the previous year. Havering consistently in the top 2 London Boroughs for reports.

Of the 183 18 young people also appeared on the Missing register.

None of the CSE contacts related to LAC although 7 have now become LAC.

There were 1065 missing episodes recorded relating to 282 children and young people 209 where Havering residents. 32% had episodes of missing for more than 24 hours.

The Return Home interview (RHI) were conducted during 2015-16 by the Children Society. 34% of children had an independent RHI within 72 hour.

The RHI has now been transferred back to in house.

Quality and Effectiveness Working Group

1. Summary of Work Group Purpose

Working Together (2015) sets out the requirement for each LSCB to have in place processes to monitor and challenge the effectiveness of the safeguarding offer to children across the spectrum of need:

In order to fulfil its statutory function under regulation 5 a LSCB should use data and, as a minimum, should:

- assess the effectiveness of the help being provided to children and families, including early help;
- assess whether LSCB partners are fulfilling their statutory obligations set out in chapter 2 of this guidance;
- quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and
- monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

Working Together 2015

CYP Quality & Effectiveness sub group

The working group provides overview and scrutiny to the work undertaken by the HSCB partners to safeguard children within Havering. The objectives of the group as set out within the HSCB Business Plan 2015-2018 are:

- Monitor and analyse performance against defined HSCB targets and objectives utilising learning from key strategic drives including

MASH, Early Help processes, Alcohol reduction strategy, HWBB, JSNA, CSP, VAWG strategy, Serious Youth Violence strategy, CSE strategy.

- Collate data to inform HSCB priorities
- Monitor safeguarding practices and systems through an annual self-assessment audit of s11 (CA2004) compliance.
- Identify and provide robust evidence for performance improvement
- Develop a multi-agency audit programme and undertake multi-agency audits and report findings to Havering LSCB
- To receive reports on single agency audit activity and scrutinise findings.
- Report on the effectiveness of inter-agency working re safeguarding

The group has been extremely active in promoting the objectives identified above. A highlight of the group's activity is set out below:

Audits completed by multi-agency partners:

CSE audit following the peer review: the findings from this supported the direction of CSE activity within Havering

LAC missing audit as previously discussed.

MASH multi-agency audit

Some observations / questions from the audit activity were:

- Is feedback sent to the referrer and is this recorded? CSC noted that feedback had been given however for the two cases where the GP had completed the MARF, CCG noted that feedback had not been received.
- There was no evidence of the outcome of the referral being fed back to the referrer or Partners.
- There wasn't clear evidence of the threshold document being applied to evidence decision making / feedback to partners.
- SW making the MASH decision and Group Manager reviewing Discussions between the Managers and Social Workers are not always clearly recorded even though they are taking place.

The audit of MASH was undertaken prior to changes that were made to MASH processes following the lean review and the subsequent MASH review. The audit was a helpful benchmark to assist the partnership to better understand the impact of changes made within MASH on improved processes when delivering services and working effectively with partners. A further audit of MASH to include the uptake and application of threshold when referring cases to MASH will be undertaken in September 2016

Group activity

A dataset workshop was held in December 2015 and a HSCB dataset was agreed by the partnership: this will be implemented in April 2016 and reported biannually. All partners have agreed to contribute to the agreed performance pack. The Q&E group will oversee implementation of this and ensure all agencies provide data as required.

The group has focussed on Child Protection processes and how best to ensure the correct practitioners attend conferences and core groups to ensure that all information known about the child is discussed, and that professionals do not attend with little knowledge of the family. This continues to be a focus for the group and updates are provided by NELFT and the Principal Social Worker regarding the impact on improved outcomes in relation to changes made.

Self-Harm has been an area of scrutiny for the group: The group requested BHRUT provide information regarding children and young people that present to A&E with symptoms of self-harm. This is on-going and is being progressed by BHRUT and CCG.

LAC children medicals has identified as a risk and action to address this is being led by CCG with support from C&YP services

Priority areas for the group over the next six months

Develop and agree an audit programme for 2016-17 that is achievable and is focused on the key priorities of the HSCB in order to support the Board to understand the effectiveness of the partnership in safeguarding children and young people.

To continue to oversee the effectiveness of CP processes, identifying areas of strength and areas that require change / further scrutiny to improve the process so that it is meaningful and effective.

To receive and analyse data in relation to safeguarding and report to the Board regarding the effectiveness of the partnership in safeguarding children and young people in Havering

To progress the actions identified within the HSCB action plan 2016-17 on behalf of the HSCB Executive.

Three positive achievements since last report.

- New HSCB dataset agreed
- Health participation within CP processes streamlined
- Performance reports and data used to challenge and support partners in improving safeguarding processes. This has included A&E activity and LAC health assessments.

Long and short term risks and priorities

The group is extremely busy with all delegates balancing competing work pressures and demands. In order for the group to be effective, the work plan must be achievable and focused on themes that will provide meaningful and relevant information to partners in order to assist to understand the impact of services on outcomes. Once agreed, partners must commit time and resources to progressing the audit programme

- The revised HSCB dataset will require information from all partners to ensure that the data agreed as relevant and necessary by partners is submitted in a format that can be understood with clear narrative to assist the group to understand and analyse the information.
- Balancing national and local priorities in an environment that can at times be politically driven**, so that any change in direction is not reactive but considered and thought through.**

Future action to address these.

- The work plan will contain four multi-agency audits plus one audit that is longitudinal to follow families through child protection processes. This will be embedded within usual business processes of organisations to limit the impact of additional workloads.
- Open and transparent discussion will assist to identify gaps or pressures that may impact on the timely submission of data so that action can be taken to address this in a timely way.
- The group must be led by the Operational and Executive Boards whilst reporting information to assist the board to agree the direction of travel. Emerging themes and priorities must be considered by the Executive and Operational to reduce the likelihood of the group reviewing vast amounts, which may reduce the level of positive impact on the outputs from the group.
- **There will be a concerted effort to agree realistic timeframes for audits and requests for data with partner agencies and an agreement that these will adhered to.**

Timescale.

Exceptions due to competing priorities will be taken into account

Section 4

Agencies statutory responsibilities

Section 11 statutory requirements

Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

Working Together 2015

Havering Safeguarding Children Board (HSCB) during 2015 undertook an audit of section 11 compliance.

Each agency completed a section compliance report covering each statutory requirement. These were supported by comprehensive single agency action plans that will be subject to regular monitoring by the board.

The following are the overarching conclusions and actions.

Submissions evidenced that there was good strategic understanding of section 11 responsibilities across the partnership. All submissions identified some elements within standards that were not fully met: these have been included within agency action plans. Although some elements within some standards were not fully met, overall all standards were being complied with.

Agency actions have been amalgamated and are set out within the action plan held at the end of this report.

The previous S11 report identified a need for a co-ordinated response to S11 across Havering council's services: the 2015 submission provided a thorough understanding of the council's compliance with S11 responsibilities across all services of the council.

The HSCB received three submissions from the Health Economy covering the commissioning, community and acute health areas: Clinical Commissioning Group (CCG); North East London Foundation Trust (NELFT); and Barking Havering Redbridge University Hospital Trust (BHRUT). The CCG is responsible for commissioning services within BHRUT and NELFT. The three reports evidenced clarity of roles across the organisation that provided consistency in response when reporting on s11 compliance. This evidenced a good understanding of role and responsibility across the health economy in relation to S11.

HSCB did not receive a submission from NHS England, which has responsibility for the commissioning of General Practitioners. This was identified as a gap within the last S11 self-assessment audit of compliance and will be formally addressed by the HSCB chair.

Since the last s11 self-assessment was undertaken the London Probation Trust has experienced significant organisational changes. Probation service responsibilities are now served through two separate bodies:

London Community Rehabilitation Company LTD (CRC)

National Probation Service (NPS): London Division

Both services evidenced that s11 responsibilities had been understood and included within usual business processes.

Standard 1: Senior Management have commitment to the importance of safeguarding and promoting children's welfare

This standard was fully understood by all partners with each response evidencing that there was a clear line of accountability within the organisation that was held within job descriptions and understood throughout the organisations.

As within the previous S11 self-assessment audit, agencies referenced internal audit processes as evidence of compliance with S11 standards. This audit activity has not been consistently submitted to the HSCB Quality and Effectiveness working group for challenge and scrutiny.

Action from Standard 1: all SCB partners to submit reports and actions regarding single agency activity to the HSCB quality and effectiveness group once the reports have been formally signed of by agency quality assurance business processes. Each agency to submit their safeguarding audit programme to the quality and effectiveness group annually so that there is a thorough understanding of each agency's quality assurance processes.

Standard 2: There is a clear statement of the agency's responsibility towards children and this is available to all staff

Each submission evidenced that processes were in place to ensure that all staff at all levels of

each organisation were aware of their safeguarding responsibilities.

The returns provided evidence of the growing importance of working together to strengthen the multi-agency response to safeguarding. This included MASH processes, multi-agency audit processes and multi-agency meetings. The submission from Havering Council noted that better processes had allowed agencies to identify more accurately the families in need of services, which has allowed a better targeting of services. This was identified to have led to a reduction in the number of families being subjected to agency scrutiny unnecessarily.

All s11 returns noted that S11 requirements were embedded within contracts if commissioning was undertaken by the agency.

The 2013 S11 returns identified a need to continue to strengthen the work being progressed in relation to capturing and responding to the views of services. This area continues to be a focus of organisation business so that the views of services users are utilised to support the development of services.

Standard 3: There is a clear line of accountability within the organisation for work on safeguarding and promoting welfare

All s11 returns identified that this standard was met despite an increase in the workload of all agencies in relation to safeguarding. Each agency has clear lines of accountability within their organisational structures and these are freely available to staff.

As previously stated, agencies provided assurance that staff were aware of their responsibility to act if a safeguarding concern was identified regardless of their role or core responsibility.

Supervision processes have been embedded across all organisations and additional supervision capacity is being added to meet the increasing demands of staff.

Standard 4: Service development takes into account the need to safeguard and promote welfare and is informed, where appropriate, by the views of children and families

There was evidence of considerable activity across partnerships in improving the multi-agency service response to this standard. All s11 returns provided assurance that the views of service users were sought and taken in to account when developing and delivering services.

The change to probation service process has allowed more autonomy when developing a service response: this has led to a more 'think family' approach to service delivery.

The returns from both NELFT and Havering Council discussed a number of new and emerging activities that had been developed to provide processes to assist in capturing the views and opinions of children, young people and their families.

The CCG noted that both NELFT and BHRUT provided the CCG with evidence that this standards was understood and implemented.

Standard 5: There is effective training on safeguarding & promoting the welfare of children for all staff working with or, depending on the agency's primary functions, in contact with children & families

All agencies reported that an induction programme was in place for staff joining the organisation. Each s11 response referenced a single agency training programme that was in place to ensure that staff were provided with the correct level of training to support them in their role within the organisation.

All audit returns provided assurance that each organisation understood the importance of training to equip staff to identify and respond to possible signs and symptoms of harm.

Evidence of the impact of training on improved outcomes was the identified increase in reporting of concerns notably in relation to CSE, FGM and domestic violence.

Standard 6: Safer recruitment procedures include vetting procedures and those for managing allegations are in place.

a. Organisation has safer recruitment & selection procedures in place in line with statutory guidance.

All agency returns provided assurance of compliance with this element of the standard.

b. Organisation can demonstrate that agencies commissioned to provide services have safer recruitment in place

Havering Council provided assurances that commissioning processes included a requirement for service to provide evidence of compliance with all s11 standards. Compliance with contract requirements is monitoring by Havering Council within usual business processes.

The CCG response provided a level of assurance that services commissioned directly by the CCG were required to comply with the standard and to provide evidence of this. The CCG does not have oversight of management use of recruitment agencies: there is an expectation that the recruitment agencies used by BHRUT and NELFT are part of the NHS Buying Solutions Framework with an expectation that they comply with s11 standards. Although not explicitly noted within S11 returns, both NELFT and BHRUT confirmed that they comply with CCG expectations when using recruitment agencies.

c. Safer recruitment training is in place for managers involved in recruitment

All returns provided assurance that training was available to all relevant staff to ensure compliance with this element of the standard.

d. Organisation has managing allegations procedures in place

All returns provided assurance that processes were in place to respond correctly when a safeguarding allegation was made against a professional.

e. A senior manager has been identified for the managing allegations process & knows who the LADO is and when to contact them

All s11 submissions provided assurance that a designated professional was in place to manage allegations and to support staff through this process: This was not explicitly stated within the LCRC return; however written confirmation of compliance with this standard was submitted separately.

f. Support is available for staff who are subject to allegation

All s11 submissions confirmed that there were appropriate services in place within the organisation to support staff when an allegation is made against them.

g. Audit processes are in place to monitor safer recruitment & managing allegations

All returns provided assurance that processes are in place to monitor processes at an organisational revel.

Standard 7 the response to this standard evidenced a commitment to ensure effective multi agency working across the continuum of need. The evidence supports a commitment to multi agency safeguarding hub processes, information sharing and embedding early assessment processes.

The number of early help assessments completed in year 2014-15 was 396, which is an increase on previous years but still suggests a low take up when considering the high level of tier 4 CSC assessments completed that result in no further action.
Uptake and completion of early help assessment processes will be required to be reported quarterly to the HSCB Quality and Effectiveness working group for scrutiny and challenge. The newly implemented early help service will help to improve take up of early help assessments and will provide support to those initiating early help processes.

Standard 8 returns from all agencies and service areas evidenced a good understanding of information sharing processes and protocols. Single and multi agency training was identified as a key to embedding good practice.

<u>Conclusion</u>

There is evidence of a strong commitment across HSCB partners to ensure section 11 standards are complied with. The s11 audit has provided

assurance to the HSCB that all agencies required to comply with S11 understand their duty and are committed to ensuring compliance with processes.

The returns indicated that there was a comprehensive audit programme embedded across all services reporting with the exception of the Metropolitan Police: Metropolitan Police quality assurance processes are progressed through daily 'Grip and Pace' where senior managers review cases and determine timelines as appropriate. KPIs are scrutinised during regular performance meetings. Risks are escalated through agreed internal escalation pathways and, when necessary, escalated to the HSCB.

The quality assurance work undertaken at single agency level is not routinely reported into HSCB quality and effectiveness group. Audit reports including actions to address emerging issues should be reported quarterly to the HSCB Quality and Effectiveness working group for challenge and scrutiny.

The impact of training on improved outcomes has not always been easy to determine. The impact of learning on improving knowledge and understanding is evidenced within post course analysis: an increase in referrals regarding CSE and FGM may also be indicative of improved understanding of this area of work.

The s11 self-assessment audit provided the HSCB with assurance that S11 requirements have been priorities across statutory partners during structural and transformational organisational changes. Partners have identified gaps within standards and identified action to ensure that each element within the standards are embedded.

The section 11 audit tool requires agencies to report on compliance biennially. The HSCB will need to determine whether an annual self-assessment audit of compliance should be completed to allow the HSCB to fully understand agency commitment to these standards during this time of austerity and shrinking resources.

Recommendations:

1. Each agency to implement their agreed action plan and report to the quality and effectiveness group quarterly and by exception.

2. Single agency audit activity to be reported to the HSCB Quality and Effectiveness group at quarterly intervals.

3. HSCB to consider whether to initiate a further section 11 audit in 2016

Education

Section 175 Education Act 2002 requires the governing body of a maintained school to make arrangements for ensuring that their functions relating to the conduct of the school are exercised with a view to safeguarding and promoting the welfare of children who are pupils of the school.

The Havering Education Services conducted a 175 self-audit. The audit tool was shared with all 92 Havering schools- LA Maintained, Academies and Independent Schools.

This was backed up if requested by a supported audit undertaken by the HES Quality Assurance Inspector. The findings were reported to the HSCB in February 2016.

36 schools requested a supported audited in 2015 compared to 7 the previous year. These audits showed that:

- All schools were 95% compliant most 100%.
- All schools had whole staff training within last three years. Some schools now have annual training.
- All schools had up to date Safeguarding policies and Managing Allegation policies.
- Head teachers' present a safeguarding report to the full governing body of the school

The HSCB did intervene on behalf of the HSE with one Academy School in respect of DBS checking of staff. As a result the Academy agree to comply with Havering requirements re 3 year checking.

Board Challenge

To continue to work with schools to improve their knowledge.

Board Governance and structure and finance

Governance

The HSCB is chaired by an Independent Chair; the appointment was made by a panel of HSCB members, which was chaired by the Chief Executive. The Independent Chair holds regular meetings with the Lead Member for Children Safeguarding , the Chief Executive and the Director of Children, Adults and Housing. The purpose of each meeting is to hold the Independent Chair to account for the effectiveness of the HSCB and to provide space to ensure open and honest discourse between the Director of Children Services and the Independent Chair regarding the service activity as it relates to children's safeguarding within Havering.

The Nurse Director, Barking & Dagenham, Havering & Redbridge CCG is Vice Chair to Havering SCB; regular discussion is held between the Independent Chair and the Vice Chair.

All statutory partners are represented at the HSCB at an appropriate level and actively participate within the business of the Board.. There has been difficulty in securing / maintaining regular attendance from NHS England and CAFCAS. The impact of this has meant strategic insight in to NHS England priorities and direction of travel specifically in relation to GPs is missing from Board discussion. CAFCAS is significant because of its work with the most vulnerable children within Havering and the knowledge it holds from both local and national perspective.

The structure of Havering's SCB was reviewed during 2015 in order to strengthen governance processes to support the Board to manage business priorities more effectively as the Board's responsibilities increased.

Structure

Executive Board

The Executive Board is chaired by the Independent chair; it has a small membership consisting of the strategic leads from all statutory partners and holds ultimate responsibility for the effectiveness of the multi-agency safeguarding offer to children and young people in Havering.

The Executive Board formally agrees

- Business priorities of the board and the business plan
- The annual report
- Final overview reports and recommendations from SCRs
- Action plans to respond to SCR / LR recommendations
- Actions to respond to Board risks and the responsible working group / partner organisation to progress the actions.

Operational Board

The Operational Board is chaired by the Independent Chair and has senior staff with links to practice within the membership. All members actively participate within the discussions and this is evidenced within minutes of meetings. The Operational Board's agenda includes both children and adult priorities to ensure that cross cutting priorities are considered by both strategic boards.

The Operational Board is in place to provide overview and scrutiny of the progress of HSCB / SAB Business plan priorities and to provide assurance to the SA / SC Executive Boards in relation to the progress of business plan objectives. Concerns that are identified by the Operational board and HSCB working groups in relation to the effectiveness of the safeguarding offer are added to the HSCB /SAB risk register, monitored by the Operational and reported to the Executive Boards.

Progress of the HSCB action plan is monitored by the Operational Board. The Operational Board drafts the Executive Board agenda to ensure that it is appropriately focused on relevant areas of business.

Operational Board minutes are circulated to Executive Board to allow for scrutiny and challenge of business activities.

Working group activity is overseen by the Operational group

- Quality and Effectiveness Working Group
  The Q&E group is chaired by a member of NELFT's SMT and all organisations except CAIT are represented. All members participate fully within meetings, identifying areas of risk and areas that require further scrutiny. These are progressed by the group and also raised at the Operational / Executive level
- Case Review Working Group
  The Case Review Working group is chaired by a member of NELFT's SMT and all partner organisations are represented at the meetings. The group has considered and progressed SCRs and LR and overseen the implementation of action plans. Drift in progress of actions has been escalated to the Executive and a decision made for the Executive leads to hold responsibility for the progression and implementation of action plans.
- CSE working group
  This group is chaired by the Director of Children and Young People Services and has representation from all key partners who actively participate within discussion and decision making.

HSCB risk register

The HSCB risk register holds the areas identified by the Board as requiring oversight in order to progress actions quickly to reduce risks. The risk register is owned by the Executive and activity progressed through the working groups and operational board. The risk register is rag rated to include impact of activities agreed to mitigate risk and is a standing agenda item at every HSCB group meeting and is used by the Independent chair to inform discussions held with the lead member and meetings with senior strategic leads from the partnership.

Annual report

The HSCB publishes an annual report. The report is presented to the Havering H&WBB and Overview and Scrutiny by the Independent Chair. The report is sent electronically to MOPAC, Chief Executive and London Councils and held on the HSCB website.

Multi-agency training programme

The annual training programme is developed by the Training and Development officer with engagement and oversight from the all working groups . The training programme is agreed by the Executive board each year.

Points to note

- The HSCB structure was revised to allow partners more time to provide overview and scrutiny of partner activity to assure the board of effectiveness
- The Independent Chair is held to account by senior leads within Havering Council at regular meetings.
- The HSCB Executive and Operational Board considers performance information as well as information emerging from the JSNA / Problem Profiles / Annual reports to ensure that local needs are considered within the activities and priorities of the Board.
- The Independent chair has developed a culture of openness and challenge during all Board business, which includes activities progressed within working groups
- The structure has enabled the partners to be open and regarding organisational issues, identify risks and to work together effectively to resolve / mitigate the risks posed.

LSCB Financial Contributions

HSCB is funded under arrangements arising from Section 15 of Children Act 2004. The contribution made by each member organisation is agreed locally. The member organisations' shared responsibilities for the discharge of the HSCB's functions include determining how the resources are provided to support it.

During the financial year 2014-2015 the largest proportion of the budget was spent on:

Staffing £108,519

Havering's independent chair £17,835.

Multi-agency training programme £25,000, which included classroom based learning and a conference.

The budget agreed for 2015/16 was comprised of contributions from the key partner agencies represented on the Board and in all cases except Havering Council, which increased its contribution, is the same as the previous three years.

Name of Agency	Contribution 15/16
Havering Council	£121,640.00
Police	£5,000.00
CCG	£28,706.49
BHRUT	£4,778.33
NELFT	£4,778.33
National Probation Service	£1,000.00
The London Community Rehabilitation Company LTD	£1000.00
CAFCASS	£562.15
Totals	**£167,465.30**

The projected contributions from partner agencies total £167,465.30. This budget excludes the additional contribution required to finance The Child Death Overview Panel (CDOP) statutory requirements. The CDOP was funded by contributions from Health and Children Social Care and covers all CDOP processes. CDOP costs for the year were £44,465

The HSCB had a carry forward from the previous year of £10,000.

Staffing and support

Board staffing has remained stable over the year. A business manager, training and development officer and an administrator are in place to assist the board in achieving agreed priorities. The Board is chaired by an independent person.

APPENDIX

Single agency successes and areas for further improvement

In preparation of this annual report each agency represented on the board except Havering Council Children and Young People Services, which is intrinsically incorporated throughout the body of this report, were requested to submit a report setting out their individual successes and areas for future improvement.
This section will set out the agencies identified risks and challenges and their actions and priorities for the year 2015 to 2016

Metropolitan Police Child Abuse Investigation Team (CAIT)

1. Introduction and Summary of Service Provided

The Metropolitan Police Service (MPS) has a dedicated Sexual Offences, Exploitation, Child Abuse Command (SOECAC). The Child Abuse Investigation Team (CAIT) functions are crime prevention, crime detection & to provide risk assessments. Whatever the function, **THE WELFARE OF THE CHILD IS PARAMOUNT'** is always the primary consideration in any decision or action undertaken.

All allegations of crime within the scope of 'child abuse' (victims under 18) are recorded & investigated in co-operation with Local Authorities and other appropriate agencies.

Intra-familial abuse - This includes family and extended family defined as aunts; uncles; cousins; siblings including step, fostered, half brother and sister, grandparents, step grandparents, step mothers/fathers, long term partners in established relationships.

Professional abuse - Working in a child focused environment who abuse paid positions (e.g: teachers; sports coaches; youth workers; ministers; caretaker of a school; school cleaner; prison staff).

Other carers - Act as a carer with some responsibility for a child at the time of the offence (e.g: babysitters; voluntary groups like scouting, unpaid sports coaches, close personal family friends).

Non recent allegations - Adult victims if the abuse occurred whilst a child (under the circumstances described above).

Parental Abduction - Outlined in Section 1, Child Abduction Act 1984.

SUDI investigations - Sudden Unexpected Death in Infancy (children under 2 years old).

2. Review of Safeguarding Activity

The MPS has standing operating procedures that dictate how CAIT deal with safeguarding concerns. Havering CAIT has a strong working relationship with other safeguarding partnership agencies (Child Social Care, Education, Health etc). They

also have a dedicated team of Police Staff deployed to represent the MPS at child protection case conferences and to produce reports for them.

All investigations are subject to risk assessments with comprehensive research conducted. This ensures any direct or potential risk to children can be managed and strategies implemented.

The Metropolitan Police Service attends and supports relevant Serious Case Reviews. This ensures any potential agency failings and any organisational learning is disseminated to all staff.

The Continuous Improvement Team & Professional Standards Champion continues to evaluate the Command's contact with children, parents & carers to inform best practice and service delivery. Listening to children culminated in every MPS interview suite being upgraded in regards to the equipment installed and them being furnished in a child friendly way. All suites now minimise any anxiety experienced by young people whilst furnishing their evidence & also optimise the quality of evidence recorded.

Havering CAIT are set MPS key performance indicators to prioritise safeguarding as core to their business. The figures below relate to Havering and Barking/Dagenham as this is a brigaded team.

1st April 2015 to 31st March 2016

	Offences	Detections
• All Offences	984	239 **(24.3%)**
• Rape	54	13 **(24.1%)**
• Serious Sexual Offences	90	21 **(23.3%)**
• Violence with Injury	235	45 **(19.1%)**
• Neglect	263	112 **(42.6%)**

- The crimes not listed above include less impact offences such as common assaults and other crime related incidents.
- Initial Child Protection Case Conferences - **66%** attended.
- Review Child Protection Case conferences - **16%** attended.
- Strategy Discussions - 1028 of which 650 were conducted within 24 hrs **(63.2%)**

A further 49 offences resulted in Community Resolutions being administered as positive outcomes.

The Detection rate for all offences and individual offences exceeded the targets set.

Over this reporting period there has been an 11.6% annual increase in offences.

This is largely attributed to a spike in Havering's population. This also illustrates the public's increased confidence to report current & historical offences in light of high profile cases such as the Saville Inquiry.

3. Havering SCB Vision Statement & Strategic Aims

1) CAIT staff are required to complete the Specialist Child Abuse Investigators Development Programme (SCAIDP) and Achieving Best Evidence (ABE) training. All non detectives are required to pass a national exam & complete the nationally

accredited Initial Crime Investigator Development Programme (ICIDP) to develop their skills and confidence. This ensures staff are knowledgeable regarding legislation, current policy and procedure. All investigations and child conferences are monitored and supervised by Detective Sergeants. More serious investigations are also reviewed by Detective Inspectors to ensure an exemplary service is being delivered.

2) Agency referrals to CAIT require a strategy discussion between Police Sergeants & Children's Social Service (CSC) managers. Police always respond in tandem with an approved social worker when conducting home visits or speaking to children. Such joint investigations are underpinned by strong working relationships between both agencies. The effectiveness of multi-agency working is scrutinised at various SCB Sub Groups and the strategic SCB. This is further monitored within various audits conducted which CAIT support. CAIT supplied a comprehensive Section 11 audit in June 2015 to enable all partner agencies to hold the MPS to account.
3) Initial strategy discussions are timely and actions are set to match the risk accordingly. The most vulnerable children will be protected by Police Officers taking them into Police Protection. CAIT ensure the best interests of the child are considered which includes asking the child their wishes. If the risk is significant, children are placed into foster care to protect them. These decisions are continually reviewed. Police will always arrange intermediaries to further support very vulnerable victims.
4) Police have implemented Operation Limelight involving officers from CAIT, aviation & security, and Border Agency staff. This is to tackle the emerging prevalence of FGM. Staff engages with passengers travelling to & from countries with a high incidence & culture of FGM. This is to target suspects involved in this practice, protect children at risk and to raise awareness about FGM.
5) CAIT has a dedicated Partnership Team which is centrally based. They visit schools, agency professionals, faith groups and community groups. Their aim is to inform, educate and engage with hard to reach communities. This ensures the wider community are aware of legislation regarding issues such as FGM & forced marriage and further seek to prevent these crimes occurring.
6) CAIT tailors it's response from any learning disseminated from local & national Serious Case Reviews. All relevant agencies engage in these reviews which ensure agencies' priorities and procedures are adapted when necessary. Any change in policy then becomes part of our standing operating procedures which staff are held accountable to.

4. Risks & Priorities

Priorities in both the long & short term are set by the Command for all pan London CAIT's. These targets are set to ensure children are safeguarded. These are centred on detection rates, adhering to the Victim's Code of Practice, strategy discussions, case conference attendance & acquiring Sexual Harm Prevention Orders.

Risks continue to also be the same in both the short and long term. This is to meet the challenge of acquiring additional staff to cater for the year on year rise in reported offences.

5. Actions to Address the Risks & Expected Impact on Outcomes

Priorities are scrutinised during daily 'Grip & Pace' meetings to ensure resources are devoted to the most serious investigations and vulnerable children. There are also monthly performance meetings where all Detective Inspectors & Detective Chief

Inspectors are held to account by the Senior Leadership Team. MOPAC monitor CAIT performance in all areas of core business.

Risks are currently being addressed with a recruitment campaign to fill vacancies. A SOECA review is currently being conducted regarding workloads & staff numbers within all areas of business. Once this is completed a further review is expected regarding the distribution of staff within each CAIT to cater for current workloads and anticipated demand.

A key area for Havering CAIT is to develop case conferencing by phone link to improve CAIT input within conferences. CAIT and partnership agencies have seen a marked increase in demand of their services. CAIT continue to try and meet the challenge of case conference attendance by finding an effective way to improve CAIT input and engagement.

6. Example of an Effective Emerging Practice

Operation Limelight has identified various items used to perpetuate witchcraft/spirit possession. These operations have also identified various words and language used within communities when referring to this practice. This has enabled the MPS to better assess intelligence when information is reviewed. This has in turn led to various addresses being searched throughout London to safeguard children at potential risk of this practice. Project Violet is SOECA's continued commitment to tackle spirit possession.

Barking, Havering & Redbridge University Hospitals NHS Trust (BHRUT)

Work Undertaken/Developments in Safeguarding Children

Barking Havering & Redbridge University Hospitals NHS Trust (BHRUT) continues to ensure that it is doing everything it can to fulfil its requirements that as a Local Safeguarding Children's Board (LSCB) partner agency member, in meeting its commitment as required under Section 11 of the Children's Act 2004 and Working Together 2015.

BHRUT has established robust systems and processes to ensure there is a timely and a proportional response when safeguarding concerns are raised when a child/children are considered to be at risk or likely to be at risk of "Significant Harm".

This has been achieved as follows:

Safeguarding Team

The Safeguarding Children's Team was fully established during the reporting period, and comprises of:

Full time Named Nurse
Full time Named Midwife
Named Doctor for Safeguarding Children (3 PAs)
Full time Paediatric Liaison Nurse/Child Death Co-ordinator
Full time Team Secretary

The Deputy Chief Nurse, Safeguarding and Harm Free Care line manages the Named Nurse Safeguarding Children, on behalf of the Chief Nurse, who is the Trust's Executive lead for safeguarding.

Safeguarding Children's Training

Safeguarding Children's Level 1, 2 and 3 training compliance is monitored at the Trust's Safeguarding Children's Operational and Safeguarding Strategic & Assurance Groups. Compliance levels are reported quarterly at the Havering Local Safeguarding Children Board meeting.

A Safeguarding Children's Training Needs Analysis (TNA) and Strategy for 2015/16 was approved at the Trust's Safeguarding Children's Operational Group on the 27th April 2015. The TNA reflects the legislative changes as per Working Together to Safeguard Children (2015).

In addition, all staff requiring Level 1 training have the option of either completing training via e-learning, or reading an information flyer and confirming in writing that have received this. In March 2016 a Safeguarding Children flyer was included in all staff's payslips, thereby ensuring 100% Level 1 training compliance for all relevant staff. The Corporate Safeguarding Team deliver a mandatory session of 30 minutes on the bi-monthly Registered Nurse Induction programme which includes Prevent awareness. An e-learning Level 2 training programme was developed in March 2016, and will be launched in April 2016.

Safeguarding Children's Policies & Procedures

The Trust's Safeguarding Children's Policy Version 2 was approved at the Safeguarding Children's Assurance Group on 27th April 2015 and was accessible to all staff during the reporting period. This has been published and disseminated to various departments/wards and is accessible on the Trust intranet and website and relevant information remains available in folders in the clinical areas for ease of access. The Safeguarding Named Nurse, Named Midwife and Named Doctor continue to promote awareness of Safeguarding issues via the Trust communication portal, and at the Safeguarding Children's Operational and Safeguarding Strategic & Assurance Group meetings.

The following policies have been implemented/reviewed during the reporting period:

- A Child Sexual Exploitation Policy was devised and ratified in June 2015
- A Female Genital Mutilation Policy was devised and ratified in March 2016
- A Prevent Policy was approved in February 2015 and ratified in March 2015
- Managing Allegations against Staff/Volunteers who work with Children & Young People Policy was revised in March 2016
- A Child Protection Pathway for Emergency Department (including all specialities) was devised in March 2016, and is due for approval in April 2016
- A Safeguarding Children Escalation Protocol was devised in March 2016, and is due for approval in April 2016
- A Domestic Abuse Policy was developed in January 2016 and approved in March 2016

Safeguarding Children's Supervision

The Trust's Safeguarding Children's Supervision Policy (Version 3) has been revised and was approved at the Safeguarding Children's Operational Group in June 2015.
Safeguarding Children's Supervision has been embedded in the Trust in Paediatric, Midwifery and Reproductive and Sexual Health Services since June 2013. Progress on compliance is monitored at the Safeguarding Children's Operational and Safeguarding Strategic & Assurance Groups.

Safeguarding Children Audits

A rolling programme of Safeguarding Children audits has been in place during the reporting period.

Audit results are presented at the Safeguarding Children's Operational Group and exceptions are reported to the Safeguarding Strategic & Assurance Group.

Section 11

The Trust is compliant with Section 11 requirements, as set out in Working Together (2015). The Trust provides quarterly updates to Havering Local Safeguarding Children's Board.

Partnership Working

BHRUT continues to be an active member of Havering Local Safeguarding Children's Board and related sub groups.

A Liaison Social Worker and an Early Intervention Worker (EIW) from Barking & Dagenham are based within the Safeguarding Children's Team at Queen's Hospital, providing advice and support for Emergency Departments, Maternity and Paediatric Inpatient areas.

Maternity Partnership meetings are held monthly, to share information and ensure pre-birth plans for vulnerable families are in place and updated prior to birth. The meetings are chaired by the Named Midwife and are well represented by Health Visitors and Social Workers from the three local boroughs.

Psychosocial meetings are held weekly to discuss children with safeguarding concerns and families with vulnerabilities that attend through the Emergency Departments or other areas, where children are admitted to Paediatric wards/NICU, during the preceding week.

The purpose of the meeting is to ensure that all children/young people who have accessed BHRUT services have been referred or supported appropriately where there are identified concerns. The Group is chaired by a Named Safeguarding Professional. In attendance at the meetings are Consultant Paediatrician/Named Doctor Child Protection, Named Nurse, Safeguarding Children, Children Social Care representatives from B&D, Havering and Redbridge; CAMHS (represented by Interact), Out Reach Drug and Alcohol Teams from B&D and Redbridge, NELFT Health Visiting Liaison Service and from relevant BHRUT medical and nursing staff.

In this reporting period BHRUT has worked in partnership with the London Borough of Barking and Dagenham, London Borough of Redbridge and London Borough of Havering to implement the Child Protection-Information Sharing (CP-IS). The Trust has established a Task and Finish Group and has developed a CP-IS Protocol and trained staff in utilising the CP-IS system, in readiness for when the Trust's three local boroughs 'go live'.

Serious Case Reviews (SCR)/Individual Management Reviews (IMR)

During the reporting period BHRUT has been involved in three Serious Case Reviews for the London Borough of Havering and one Case Review which the Threshold for Serious Case Review was not met (May 2016).

Safeguarding Annual Work Plan

During the reporting period the Trust's Safeguarding Annual Work Plan (2015-2016) workstreams where monitored at the Safeguarding Children's Assurance Group. All actions were delivered within the agreed timeframes.

Common Assessment Framework (CAF)

The CAF is now in use within the Midwifery Department and is also used by Sexual Health and Paediatric staff.

Trust staff are provided with CAF training as part of Level 2 and 3 Safeguarding Children's training. BHRUT continues to be supported by an Early Intervention Worker from a neighbouring Local Authority who contributes towards provision of tier two services and supports staff in completing CAFS with carers consent. The Early Intervention Worker also assists Social Workers where a case is linked to the hospital.

Safeguarding Children Multi Agency Referrals (MARFs)

The Trust has a process in place for the collection of information regarding child protection referrals made by BHRUT staff. This process was implemented in April 2014. Multiagency Referral Forms (MARFs) are used to refer child protection concerns to Children Social Care.

Child Sexual Exploitation (CSE)

The Trust's Named Nurse, Safeguarding Children is the Trust's Champion for Child Sexual Exploitation. The Trust continues to have quarterly CSE Lead meetings to advance this agenda.

Child Sexual Exploitation awareness is incorporated within the Trust's Level 1, 2 and 3 Safeguarding Children's training programmes. In February 2016 the Level 2 and 3 training programmes were updated with case scenarios on CSE. Initial feedback from staff has identified that this approach is useful and aids learning

All staff have access to a new Intranet Child Sexual Exploitation Web page which contains key information relating to this subject. The Trust's Named Nurse Safeguarding Children attends Tri-borough Multi Agency Sexual Exploitation (MASE) meetings, and supports information sharing for children identified at risk of CSE. The Named Nurse, Safeguarding Children is an active member of the Havering Child Sexual Exploitation Steering Group.

The Trust has endorsed the Pan London Child Sexual Exploitation Operating Protocol (March 2015 2nd Edition) within a newly developed Trust Child Sexual Exploitation Policy.

Since 1 January 2016 the Named Nurse Safeguarding Children maintains a confidential log of all children discussed at Tri –borough Multi Agency Sexual Exploitation (MASE) meetings and this is cross referenced against cases discussed at Psychosocial Meetings. This enhances detection of children who may frequently present to the Emergency Departments and admitted to the Paediatric Wards.

Female Genital Mutilation (FGM)

Mandatory reporting for FGM is undertaken by the Trust in all relevant areas.

The Trust's Named Nurse Safeguarding Children is the Trust's FGM Champion, and as such holds quarterly FGM Divisional Lead meetings.

The Trust's FGM Policy was approved in March 2016.

FGM audits are undertaken as per the Trust's Safeguarding Children's audit schedule.

Maternity Services

Maternity Services have a clear process in place to ensure that vulnerable families are identified; risk assessed and referred promptly in pregnancy and that appropriate support and pre-birth planning is implemented. Care plans are monitored and entered on the electronic system (E3).

Main Achievements and Areas of Strength

- **Staff Awareness of Vulnerable Groups**

The Trust has seen an increase in staff's awareness of vulnerable groups i.e. Children and Young People affected by Domestic Violence (DV), Child Sexual Abuse (CSA), Looked After Children (LAC). In Quarter 4 2015 - 2016 there was a 50% increase in completion of Multi-Agency Referrals identifying risk to children and young people. The Trust actively promotes awareness of vulnerable groups i.e. Children at risk of Sexual Exploitation, against Women and Girls including Female Genital Mutilation, Modern Day Slavery and Trafficking.

There is also an increased awareness of DV in key clinical areas with additional training and posters, and visibility, supported by Independent Domestic Violence Advocate (IDVA) based at Queen's Hospital.

The Trust has produced a Domestic Violence Policy during the reporting period which replaces the Maternity DV Guideline.

- **Implementation of Child Protection Information Sharing System (CP-IS)**

In this reporting period the Trust established a Task and Finish Group to oversee the implementation of CP-IS. The Trust is ready to 'Go Live' at the point that all three local boroughs that it serves are ready to implement the system.

- **Safeguarding Policies and Procedures**

All related Safeguarding Polices have been updated during the reporting period in line with National Changes. In addition, three new policies (FGM, CSE and Domestic Abuse) have been developed and implemented.

- **Safeguarding Supervision Compliance**

The Trust achieved 85% compliance in implementing Safeguarding Supervision in Maternity, Sexual Health and Home Care Team. Safeguarding Supervision has also been embedded within the Emergency Departments at Queen's and King George Hospitals.

- **Redesign of the Child Protection Web Pages** (internal and external).

All safeguarding topics of interest are available for staff to access via the intranet and internet.

- **Children and Young People are Valued as partners**

There is evidence to demonstrate that staff consult with children so their views are heard and included in care provision.

During the reporting period audits have identified that:

- More children & young people will recommend BHRUT
- Evidence that BHRUT is providing a calming and comfortable environment for children
- Evidence of BHRUT providing more information to children, and reducing the elements of fear and worry
- Evidence that BHRUT is better with our provision of pain relief
- Evidence that BHRUT is better about providing more information about tests and results during hospital admissions
- Evidence that BHRUT has improved on providing information about medication side effects
- Evidence that with help of play specialists, children say their non-clinical time has been more enjoyable during their stay in hospital

- **Learning Lessons**

Learning lessons from Serious Case Reviews and safeguarding children cases is undertaken in a number of forums which include the Trust's Safeguarding Children's Operational and Safeguarding Strategic & Assurance Groups. Shared learning also takes place at the Trust's muti-professional Patient Safety Summits.

Examples of BHRUT's Contribution to HSCB Six Strategic Aims

Strategic Aim	Contribution / Evidence
Ensure that the partnership provides an effective child protection service to all children and young people ensuring all statutory functions are completed to the highest standards.	Section 11 compliance - quarterly progress reports are presented at the Havering Local Safeguarding Children's Board.
Monitor the effectiveness of the multi-agency early offer of help and young people in Havering.	The number of Pre CAFs that are completed are reported at the Trust's safeguarding groups.
Ensure that agencies work together to provide the most vulnerable children and young people with the correct help at the right time.	Members from partnership agencies are members of the Trust's Safeguarding Children's Operational and Safeguarding Strategic & Assurance Groups. The Trust's Safeguarding Team attend 'professionals' meetings, strategy meetings, LADO meetings, core group meetings, pre-discharge planning meetings, Local

	Havering Safeguarding Board meetings and related sub-group meetings. The Trust contributes in multi-agency audits.
Ensuring an integrated multi-agency approach to respond to emerging themes and priorities identified by the Board and through national learning	Representation at relevant meetings include: Multi Agency Child Sexual Exploitation (MASE), Violence against Women and Girls (VWAG), Multi-Agency audit meetings, Case Review meetings/Serious Case and External Training Events.
Assuring the quality of safeguarding and child protection to the wider community	The Trust's compliance against Section 11 (Children's Act, 2004) is reported regularly at the Trust's Safeguarding Children's Operational and Safeguarding Strategic & Assurance Groups.
Ensure that partners learn lessons identified through local and national learning , and ensure that learning is acted upon and embedded in practice across all partner agencies	Learning lessons from Serious Case Reviews and safeguarding children cases is undertaken in a number of forums which include the Trust's Safeguarding Children's Operational and Safeguarding Strategic & Assurance Groups. Shared learning also takes place at the Trust's muti-professional Patient Safety Summits.

Example of Effective and Emerging Practice

In January 2015 the Trust held a tri-borough meeting, to discuss collaborative working, and to assist in the development of a tri-borough pathway for responding to FGM. It was agreed that routine referrals to Children Social Care in the three boroughs should be made where there is a maternal disclosure of FGM and were there are girls under the age of 18 years in the household.

In April 2015 a meeting was held with Services Leads in Sexual Health, Obstetrics and Gynaecology, and Urology to review data collection and recording to ensure the Trust is supporting the work of the Department of Health on FGM, by submitting an Information Standard (1610 FGM Prevalence Dataset). All Division complete a proforma and submit data of cases to the Trust's Information Department which in turn submit UNIFI returns to the Health and Social Care Information Centre.

An FGM Policy was devised to replace the Maternity FGM Guidelines.

All women booked for maternity care at BHRUT are asked about FGM and this information is recorded electronically.

In addition to the above Integrated Sexual Health Services also routinely screening for FGM and this is embedded within an Integrated Sexual & Reproductive Health Proforma

A quarterly Divisional FGM/CSE Leads meeting has been established by the Trust's FGM Champion (Named Nurse, Safeguarding Children).

BHRUT has also supported the development North East London Foundation Trust FGM Multi-Agency Strategy.

Key Areas for Development

During 2016/17 the following will be implemented:

- Continue to embed the Female Genital Mutilation, Child Sexual Exploitation, and Domestic Violence agenda locally
- Establish Safeguarding Children Summits, whereby learning relating to children's cases and serious incidents will take place
- Develop a Safeguarding Children's Dashboard
- When launched in the three local boroughs, the Trust will implement and embed the new Child Protection Information System

Conclusion

The Safeguarding Children's Team continues to make significant progress in ensuring that the Trust executes its duties and safeguarding responsibilities and maintains focus on the welfare of children. This is evidence based by interagency working and improved inter-hospital and external working relationships with Havering Local Safeguarding Children Board members and related subgroup members.

North East London NHS Foundation Trust (NELFT)

1. **Brief summary of service as it relates to safeguarding children: S11 compliance will be drawn from the S11 audit of compliance and resultant action plan completed June 2015**

- *NELFT provides an extensive range of mental health and community health services for people living in the London boroughs of Waltham Forest, Redbridge, Barking & Dagenham and Havering, and community health services for people living in the Basildon & Brentwood and Thurrock areas of Essex. It also provides an Emotional Wellbeing Mental Health Service for the 0 – 18 year olds across Southend, Essex and Thurrock.*
- *NELFT has Named Doctors and Named Nurses who provide advice, guidance and support to staff across the Trust on safeguarding children issues. Roles and responsibilities for these roles are clearly outlined in the job descriptions.*
- *All of NELFTs individual employee's responsibility for safeguarding vulnerable children are stated in the "Safeguarding the welfare of children policy" and outlined in all job descriptions at appraisals and in all safeguarding training.*
- *In accordance with the obligations of the children Act 2004, NELFT (Havering) has completed a Bi-annual Section 11 Audit and Action plan that is monitored locally by Havering Directorate Integrated Safeguarding Group.*

- *NELFT is registered as a provider with the Care Quality Commission (CQC). As part of the CQC requirements an NHS provider compliance assessment in relation to Outcome 7 (Regulation 11) has been completed and evidence collated.*
- *The Chief Nurse & Executive Director of Integrated Care Essex is the executive lead and board member for safeguarding. The Chief Nurse has Board level responsibility for safeguarding adults and children, LAC and Prevent.*
- *The Safeguarding Team acts on the Chief Nurses behalf to ensure that the Board is assured that all necessary measures are taken to safeguard adults and children at risk. The Director of Nursing, Patient Safety is the Strategic Lead for Safeguarding and together with the Associate Director of Safeguarding and LAC supports the management oversight of safeguarding issues in relation to vulnerable adults and children.*
-

2. Review of Safeguarding Activity 2013-2014

- What has your organisation done in terms of your own agency safeguarding priorities?

- *Safeguarding children priorities are highlighted in the NELFT safeguarding children annual report. NELFT has an overarching Safeguarding Strategy action plan and safeguarding services work plan that has been progressed over the year 2015/2016.*

This report:

- *provides an overview of the progress of the safeguarding agenda within the Trust in relation to children and adults with care and support needs over the past 12 months; 1st January 2015 to 31st December 2015. It sets out the key developments and progress both internally and with NELFTs partners and also describes the progress and current position in relation to the Looked After Children (LAC) Service.*
- *Outlines NELFT's response to key national and local safeguarding priorities including Child Sexual Exploitation (CSE) and Female Genital Mutilation (FGM). It also highlights activities in relation to our response to the Harmful Practices of Honour Based Crime, Forced Marriage and Modern Day Slavery which impact on the safeguarding of adults and children.*
- *Has described the implementation of the new safeguarding service delivery model, including the introduction of the safeguarding children enquiry duty desk in July 2015.*
- *Has taken account of the serious case, domestic homicide and other learning reviews which were commenced during the reporting period.*

- How has your agency utilised the views of children, young people, parents and carers to improve services?

- *Listening to and responding to the voice of child is integral to practice and embedded in training and audit processes. NELFT has a service user engagement programme in place which includes seeking the views of children, young people and their families in relation to their experience of our services. Their views are considered and used to inform improvements in service delivery.*
- *The extension of young people's forums to actively engage and seek the views of a cross section of children and young people receiving both targeted and universal Children services is an area of service development across NELFT. Further to this, it is anticipated that there will be a CAMHS user group progressed within Havering*

3. How has the organisation contributed to the Havering SCB vision statement and strategic aims?

Vision Statement

- Keeping children and young people safe is the Havering Safeguarding Children's Board overarching priority. All partnership agencies are committed to raising safeguarding standards and improving outcomes for all the children and young people of Havering.

Six Strategic Aims

1. Ensure that the partnership provides an effective child protection service to all children and young people ensuring that all statutory functions are completed to the highest standards.
2. Monitor the effectiveness of the multi-agency early offer of help to children and young people in Havering.
3. Ensure that agencies work together to provide the most vulnerable children and young people with the correct help at the right time.
4. Ensuring an integrated multi-agency approach to respond to emerging themes and priorities identified by the Board and through national learning.
5. Assuring the quality of safeguarding and child protection to the wider community.
6. Ensure that partners learn lessons identified through local and national learning, and ensure that learning is acted upon and embedded in practice across all partner organisations.

- *There has been NELFT representation at all the Local Safeguarding Children Board meetings and sub-groups in the last year.*
- *The Case Review Working Group of HSCB has been chaired by the Named Nurse Safeguarding Children from November 2014 to date and the AD Children's Services is deputy Chair of the Quality and Effectiveness subgroup. NELFT's on-going involvement in the sub groups has ensured that safeguarding actions are pertinent across the partnership and that any potential obstacles are identified and reduced.*
- *The LSCB's multiagency audit programme forms part of NELFT's systematic programme of quality assurance. The Safeguarding Children Team and members of operational services, from both Community Health Services and Mental Health services, have participated in the LSCB Multi-agency audit programme. Outcomes from these audits are communicated back to the organisation through the safeguarding governance arrangements and integrated into training delivered by the Safeguarding Children Team.*
- *The Safeguarding Children Team and NELFT practitioners have actively participated in both SCR and Learning Together reviews. NELFT has worked in partnership with HSCB to look at lessons learned from the cases and implement actions arising from these reviews.*
- *The early identification of emerging needs of children, young people and their families is embedded in practice. This is further supported by safeguarding children supervision, training and audit.*
- *NELFT monitors and reports on the number of Early Help referrals. Performance improvement in relation to the number of NELFT generated Early Help referral continues to be a challenge. Practitioners continue to support other services, for example children Centre and schools to make their referrals. Staff then support the integrated response to identified needs.*
- *The implementation of the Safeguarding Children duty desk has further supported practitioners to understand thresholds and make early help referrals as appropriate.*
- *NELFT as a provider of both community and mental health services is well placed to ensure that the THINK family approach is embedded in practice to ensure a coordinated approach to domestic violence , mental health and drug and alcohol abuse across children's and adults services. The Safeguarding adults and children's teams work collaboratively to identify risk and to protect adults with care and support needs and children.*

4. **Long and short term risks and priorities**

- *The Health offer to 0-19 (Health visiting / School nurse provision) has been identified as a risk. The transfer of commissioning responsibilities from Health to Public Health held no reduction in funding, but no increase either. The availability of this early help provision is not considered to be sufficient to meet the needs of Havering residents. NELFT is complying with contract obligations; however there continues to be a gap between need and service availability.*
- *There was a backlog of LAC Initial Health Assessments (IHAs), which has been raised as a risk by CSC, CCG and NELFT. The position at the end of Q4 was that there are no outstanding IHA's In Havering and they will be carried out by a paediatrician, as opposed to by GPs ,going forward.*
- *There is need for formal audit evaluation of the duty desk and user satisfaction survey by the end of June 2016.*
- *The Safeguarding children team will strengthen the arrangements for agile working to support a further increase in the visibility of safeguarding team members in frontline staff settings by June 2016.*
- *The Safeguarding children team will undertake an evaluation of training provided by the safeguarding team in order to assess the impact on practice and outcomes for children /young people and adults with care and support needs by September 2016*

5. **Actions to be taken to address the risks and the expected impact on outcomes**

- *NELFT to continue to review and challenge its arrangements to support safe and consistent practice to ensure that children and young people are appropriately safeguarded.*

6. **Example of Effective/Emerging Practice (can be a sentence or two.)**

- *The implementation of the new service delivery model which included the safeguarding children's enquiry duty desk was introduced July 2016 and has resulted in an increase in Safeguarding enquiries from practitioners working in Havering services.*

Named GP Safeguarding report for the Havering LSCB annual report

2015-16

Dr Richard Burack Named GP for Safeguarding children

Introduction and description of area of work

Context

The Assurance Framework (2013) acknowledges the critical role performed by the Named GP in local leadership and early family engagement. Safeguarding children training has been a compulsory requirement (since 2010) for all General Practitioners and, as such, has to be included within all appraisal / re-validation documentation by all individuals. The Named GP is available for advice and support to general practice to help them meet their responsibilities to safeguard children. The Named GP works alongside the Designated professionals and the strategic lead for safeguarding children across the area they serve.

(i) Role: Leadership & Advice

- To work closely with the organisation's Board (governing body) executive lead for safeguarding and support and to advise the organisation about safeguarding/child protection in general practice.
- To advise on safeguarding children practice guidance, policies and audit, to advise and support local GP practices and Lead GPs, ensure advice is available on the day to day management of children and families where there are safeguarding concerns. This includes signposting, legal processes, key research and policy, preparation for inspection by regulators.
- Offer advice and support on the development and provision of safeguarding children training for GPs and their staff
- Support local GP practices and CCGs on establishing and monitoring governance, planning and strategy
- To advise on practice guidance and policies in relation to the assessment, treatment and clinical services for all forms of child
- To work with the Designated Professionals to advise CCGs and Area Teams on deficiencies and vulnerable areas, priorities and areas of risk
- To support the Designated Professionals to actively engage in multi-agency strategic partnerships for Child Protection and Looked After Children within the CCG areas to influence the multi-agency agenda
- To participate in serious case reviews/case management reviews/significant case reviews, and individual management reviews/ individual agency reviews in relation to primary care / out of hours services.
- To participate in and support General Practices in the child death review process

(ii) Role: Governance

- To support and have oversight of general practice safeguarding/child protection policies and procedures in line with legislation, national guidance, and the guidance of the Havering LSCB
- To encourage case discussion, reflective practice, and the monitoring of significant events at a practice level

(iii) Role: Policies & procedures

- To contribute to the development and review of policies and procedures relevant to safeguarding children, including implementation of new government or agreed local policies and recommendations across GP practices.

(iv) Role: Training

- To work with specialist safeguarding/child protection professionals across the health community and with the training sub-groups of the Havering LSCB to agree and promote training needs and priorities
- To contribute where possible to the delivery of training for health staff and inter-agency training
- To evaluate training and adapt provision according to feedback from participants
- To tailor provision to meet the learning needs of participants
- To work with the CCG to identify training needs for the Named GP and GP Practice Leads through appraisal, reflective supervision and audit
- To take part as appropriate in the design & delivery of multidisciplinary & multi-agency training programmes for health professionals and professionals in other relevant agencies.

6. Safeguarding support to and by Primary Care: April 2015 – March 2016

i. All GPs are encouraged to achieve their expected Level 3 Safeguarding through a blended learning scheme of training which will include Large group protected time initiatives (PTI) at monthly CCG sponsored educational events; smaller local group workshops; local Havering LSCB training opportunities; London and/or national based conferences and meetings; IT and e-based learning platforms and from self directed reading and learning
ii. In 2015-16, specific topics covered during Havering PTI sessions included Child Sexual Abuse (CSA) and Exploitation (CSE); Female Genital Mutilation (FGM) and the recognition of Radicalisation (PREVENT).
iii. Since 2014, Havering practices have had a local Safeguarding Primary Care Handbook for use and reference. This has compiled key information and combined latest National guidance with local implementation flowcharts and provided further information and resourced references to enable local practitioners to remain active and current in their management of safeguarding concerns and their statutory responsibilities and duties. This is updated annually and presented to Havering practitioners (January 2016) and disseminated to every practice / practitioner for their use.
iv. Further guidance about e-learning opportunities, Mandatory FGM reporting and PREVENT training updates and initiatives, produced by NHS England, have been circulated to all practices.
v. Training is also provided by the Havering LSCB for multidisciplinary training in a variety of topics associated with the safeguarding children spectrum and is offered to all practices and health staff. Access is via the Havering LSCB website.
vi. The Named GP has made himself fully and unconditionally available by phone or e-mail for any local GP for advice and support on safeguarding and child protection. Several GPs have made use of this over the year for advice and individual support.
vii. The Named GP has produced supportive documentation / policy templates for all GP practices to help them prepare for their personal CQC inspections. This will hopefully assist practices with regards to having in place all necessary Safeguarding processes and pathways and assuring CQC of robust safeguarding practices.

7. Quality and Effectiveness of Safeguarding Arrangements and Practice

i. The Named GP is commissioned to provide services for an average of two sessions weekly with flexibility required to vary the weekly time commitment as and when required, to cope with IMR or SCR chronology tasks and deadlines as and when required. Effective time management and an ability to prioritise from the large list of required skillsets.
ii. The availability and ability to contact the named GP is 24/7 by e-mail or phone.
iii. Through on-going training, the Named GP has attended several Level 3 & 4 training events and has exceeded the number of hours required to fulfil obligations for personal professional development and accreditation requirements.
iv. The Named GP is also the Honorary Secretary of the Primary Care Children's Safeguarding Forum (PCCSF), an independent National body providing on-going support and a network for over 100 other Named GP's within the UK.
v. The Named GP attends safeguarding meetings with the other named and designated clinicians (nurses and doctors) facilitated by the CCG nursing Directorate and via the Local safeguarding assurance network and committee.
viii. The Named GP attends the NHS England (London) Named GP forum (quarterly) and receives all minutes and correspondence from their meetings and actively participates in the on-line fora and support.
ix. The Named GP has robust links with the local Havering LSCB CDOP team and the MASH unit to ensure effective on-going communications.

x. The Named GP meets bi-monthly with the CCG's leads responsible for children's services, including the newly appointed Director of Children's services to ensure Safeguarding priorities are addressed and triangulated effectively.

xi. The Named GP attends operational board meetings of the Havering LSCB to support local safeguarding triangulation, sharing and discursive networking.

xii. A directory of GP safeguarding leads, their deputies and the practice manager associated with each and every practice has been compiled. This will also be shared (and used) with other local safeguarding agencies / organisations including Children's Care, MASH and NELFT.

8. Main achievements and areas of strength

i. Good communication network between Named and designated professionals and GP practices and better communication and collaboration between all named and designated health professionals through quality assurance meetings facilitated by the CCG and Nursing Directorate.

ii. Responsive training and education provision for GPs, based on surveys and feedback and including case histories and interactive and reflective discussions.

iii. Updated register of named leads in SG for each practice with contact numbers to ease prompt and correct contacting of personnel at each of the Havering practices.

iv. Excellent attendance and feedback from GP's at PTIs when the named GP has lead Safeguarding training, assisted by the Designated Nurse.

v. Improved communication between GP and MASH units for information sharing, both in what information is shared and the timing of responses.

vi. A comprehensive, annually updated, Primary Care Safeguarding handbook as a resource for all practices and associated staff, with local and national priorities and information available, including contacts, report templates etc.

vii.

9. Main areas of concern and issues for development in relation to safeguarding

i. Continued challenges for timely and regular communication between social care and primary care.

ii. Reporting to aid case conference discussions and attendance by GPs at conferences remains low.

iii. Sporadic cases of GP practices not fully responding or delayed responses to statutory reporting requests on safeguarding requests.

iv. Explain the action being taken to address these and militate against any risks

v. No administrative support for the named GP to carry out any contact or dissemination of updates, information or mailshots to all GPs / practices.

vi. More emphasis on engaging and involving practices in SG audit, collaborative audit and work and the dissemination of SCR/IMR outcomes and recommendations for Primary Care to hear, acknowledge and reflect and implement.

10. Key areas for development and future action

i. Consideration of forming a practice GP Safeguarding leads forum to develop SCR/IMR feedback, reflection and impact plus to gain further feedback on areas of priority support from other lead GPs

ii. Discuss and come up with a proposal to improve reporting and attendance (where possible) for case conferences and Child Protection review meetings where GPs are invited or asked to submit an update paper.

iii. Consider a local audit on report submission and Case Conference attendance.

11. Key messages / recommendations for the HAVERING LSCB

i. This report demonstrates that GPs remain engaged and aware of the safeguarding agenda in their day-to-day work and priorities.
ii. That the named GP has a wide remit of opportunity and challenge to keep children's Safeguarding firmly on the agenda and high in the awareness radar of all practices
iii. More collaboration between Primary Care and other services, health and non-health related to develop a better understanding of everyone's key role in the Safeguarding growing agenda.

Havering Clinical Commissioning Group (CCG)

1. Brief summary of service as it relates to safeguarding children: S11 compliance will be drawn from the S11 audit of compliance and resultant action plan completed June 2015

1.1 Since Havering Clinical Commission Group (CCG) was established on 1 April 2013, there has been developmental work to; establish systems and processes for safeguarding children, establish clear lines of safeguarding accountability, have robust safeguarding governance arrangements and secure the expertise of designated safeguarding professionals. The Section 11 audit was used as a benchmark for improvement.

1.2 In 2014/15, the CCG continued with the development and embedding of safeguarding systems and processes, but the focus was on maintaining and strengthening partnership working with the Local Safeguarding Children Board and informally through our local safeguarding professionals' networks. Work continued to ensure progress made is embedded within the CCG business plan in discharging their duty to safeguard children and young people residing in Havering.

1.3 Therefore in April 2015 – March 2016 the report covering this period will show the CCG developmental work on safeguarding systems and processes is now embedded and that partnership working with the local safeguarding children board is firmly established.

1.4 The overall accountability for safeguarding remains with Barking and Dagenham, Havering and Redbridge (BHR) CCGs' Accountable Officer and the responsibility for adherence and delivery of our statutory functions is discharge through the Nurse Director who takes overall leadership responsibility for BHR CCGs' safeguarding arrangements. The Nurse Director is supported by the Head of Safeguarding and the BHR CCGs' designated safeguarding professionals. The Chief Operating Officer for Havering CCG remains the operational lead for ensuring the implementation of safeguarding functions and is supported by the Havering CCG designated safeguarding professionals. This model of matrix working across our central and borough teams enables us to have a strong system where there is a culture that supports staff in raising concerns regarding safeguarding issues.

1.5 BHR CCGs have explicit and defined governance arrangements that are made up of internal safeguarding governance arrangements, external systems and provider compliance monitoring arrangements and formal partnership structures.

1.6 There are four specific functions within the internal governance arrangements; 1) to provide assurance to the CCG governing body that the health commissioning system is working effectively to safeguard children at risk of abuse or neglect, 2) to provide assurance that the CCG is compliant with safeguarding training and that safer recruitment processes are adhered to, 3) to have robust processes in place to learn lessons from serious case review and 4) to have clear policies that set out the CCG commitment and approach to

safeguarding, including arrangements for dealing with allegations against people who work with children and young people. All these functions are delivered within the Safeguarding Assurance Committee that meets monthly and the minutes and reports from the meetings are submitted to the CCG Quality and Safety Committee for scrutiny.

1.7 External assurance of safeguarding arrangements is carried out through scrutiny of compliance with the safeguarding NHS standards contract with our commissioned health care providers using key performance indicators. The clinical quality review meeting (CQRM) is the CCG's formal contractual monitoring meeting where the CCG obtains assurance on compliance with the contract. CQRMs take place every month with our two main providers Barking, Havering and Redbridge University NHS Hospitals Trust (BHRUT) and North East London Foundation NHS Trust (NELFT). Safeguarding is firmly on the CQRM agenda and both providers are required to produce reports / audits to provide assurance. The CCG also conducts assurance site visits and scrutinises providers' section 11 audits, ensuring action plans are carried out and embedded within their organisations.

1.8 The CCG participation in the formal partnership structures led by Havering Safeguarding Children Board provides a platform where partners, including the CCG, are held to account for each other's safeguarding arrangements, that they are effective and in place, in order to discharge their safeguarding duties.

1.9 BHR CCGs' safeguarding arrangements were scrutinised by an NHS England deep dive exercise in Nov 2015. Evidence was provided against the key line of enquiry and a small but strong team headed by the Nurse Director was interviewed by NHS England. Evidence submitted included Havering CCG section 11 audit and the actions taken to ensure compliance, the CCG safeguarding structure, safeguarding policies and an example of good practice. The example shared demonstrated how the CCG promoted and supported the implementation of the national programme for Child Protection Information Sharing (CP-IS) for BHR CCGs. The outcome for Havering CCG safeguarding children arrangements was reported as good and the report was shared with Havering Safeguarding Children Board.

2. Review of Safeguarding Activity 2014-2015

What has your organisation done in terms of your own agency safeguarding priorities?

2.1 The Havering CCG safeguarding team was fully established in this reporting period. There is a full-time designated nurse for safeguarding children, a designated doctor for safeguarding children, a Named GP, a designated doctor for LAC (BHR CCGs) and a designated nurse for LAC (BHR CCGs). This team participates and contributes to the BHR CCGs' safeguarding assurance committee process.

2.2 The BHR CCG Safeguarding Assurance Committee (SAC) process is firmly embedded within the CCG business process. The SAC has met monthly chaired by the Nurse Director or the Head of Safeguarding. Reports submitted by the designated safeguarding professionals contain information of their work with their local area, highlighting issues on serious incidents, serious case reviews, child deaths, safeguarding training, providers Section 11 action plans, commissioning matters and risks. The outcome of discussions including action plans are recorded and the minutes are submitted to the Quality and Safety Committee for monitoring. Risks and safeguarding issues identified at SAC against the two main providers are also escalated via the CQRM process.

2.3 Havering CCG has participated and contributed to establishing strong partnership working with Havering Safeguarding Children Board. The CCG is represented in the Executive and Operational Safeguarding Children Board and participated in appropriate working groups such as quality and effectiveness, case review, child death overview panel, child sexual exploitation and missing and Local Authority Designated Officer (LADO) process, providing

the health safeguarding expertise support to these groups. In particular, the LADO process for managing safeguarding allegations staff working with children and young people was undergoing change of personnel and the designated nurse had work closely with each LADO to help achieve closure for some cases.

2.4 There were two serious case reviews (SCRs) in this reporting period and the Designated Nurse was a member of both SCR panels. The SCR of the neglect case was completed and the action plan for the two major healthcare providers involved were to embed the escalation process within their safeguarding process. NELFT had an additional action to develop a policy for managing Faltering Growth which is not completed. The CCG is monitoring this delayed action via the SAC process.

2.5 There were two multi-agency audits carried out within this period, Missing/CSE and Multi Agency Safeguarding Hub (MASH) referrals. The CCG had participated in both audits through collating information from individual GP practices to complete the audit and sharing outcome at audit meetings. These audits provided an opportunity for the designated nurse to build working relationships with GP practices and to raise the GP profile.

2.6 The Havering CCG arrangements for the provision of the designated child deaths doctor function is discharged through the BHRUT paediatric consultants (shared between two consultants). These consultants chair the rapid response meetings that take place after a Havering child death and are members of the ***Child Death Overview Panel*** (CDOP). To provide an additional level of scrutiny and expert support at the rapid response meetings, the designated nurse has attended all the Havering rapid response meetings held within this reporting period and has carried out this function effectively.

2.7 In 2015 NELFT had proposed a new streamlined safeguarding team and support structure which had raised concern. The CCG discussed their concern with NELFT and NELFT agreed to facilitate monthly safeguarding CCG/NELFT meetings providing a forum to review progress and share learning/success from this new structure. Following some initial hiccups, these meetings continue to take place and have helped to build a stronger working relationship with NELFT. The new safeguarding structure appears to be working well and there are audits conducted to support this. Anecdotally, the Named Nurses seem satisfied with this process and seem well supported.

2.8 The designated nurse continued to provide safeguarding supervision to the NELFT Havering Named Nurse, BHRUT Named Nurse and Named Midwife. The designated nurse meets with them individually every 2 – 3 months. During these sessions, complex cases were discussed and specific safeguarding supportive work also took place. For example, additional time was spent with the NELFT Named Nurse to consolidate the learning from case reviews into themes and assign the recommendations to appropriate agencies. The designated nurse also supported the Named Midwife to achieve a good outcome for a challenge she raised on a specific BHRUT maternity issue in a learning review report.

2.9 The designated nurse was invited to attend the BHRUT safeguarding assurance meetings where BHRUT safeguarding activities are reviewed and received assurances from the safeguarding team. The designated nurse provided scrutiny, advice and support to this process. Previously there were safeguarding operational meetings where operational leads were invited to attend but these meetings were subsequently cancelled.

How has your agency utilised the views of children, young people, parents and carers to improve services?

The CCG has worked with children in care council to develop LAC health passports for all children leaving care. The LAC health passports are issued to children following their health assessments and reports from the children were positive. The CCG continues to meet with

parents and young people at their forums to understand their views around safeguarding and support services and the outcome of these conversations continues to influence and shape our thinking.

How has the organisation contributed to the Havering SCB vision statement and strategic aims?

Vision Statement

Keeping children and young people safe is the Havering Safeguarding Children Board's overarching priority. All partnership agencies are committed to raising safeguarding standards and improving outcomes for all the children and young people of Havering.

The CCG commitment to this vision statement was evidenced by their continuing participation and contribution to the Havering Safeguarding Children Board meetings, working groups and through their commissioning role ensuring commissioned healthcare providers have met their safeguarding standards and are also held to account for their safeguarding arrangements to the board.

Six Strategic Aims

3.1 ***Ensure that the partnership provides an effective child protection service to all children and young people ensuring that all statutory functions are completed to the highest standards***.
Section 11 audits serves as benchmark to ensure the highest standards are met in providing an effective child protection service. Therefore, the CCG ensured that their own Section 11 audit and the Section 11 audits from the two major commissioned healthcare providers are completed, reviewed and actions taken to ensure full compliance was embedded into practice. Monitoring of this process was carried out via the SAC process.

3.2 ***Monitor the effectiveness of the multi-agency early offer of help to children and young people in Havering.***
The CCG monitors the effectiveness of the multi-agency early help through SAC reports of continued engagement work by designated safeguarding professionals with NEFLT and BHRUT.

3.3 ***Ensure that agencies work together to provide the most vulnerable children and young people with the correct help at the right time.***
An interim Designated Clinical Officer (DCO) for Havering was appointed by the CCG to support the SEND agenda. The joint children's commissioner works closely with the DCO to ensure that children and families who require services such as therapies for children, short breaks, including respite care, are being delivered. The DCO also provides a report to the SAC for monitoring purposes.

3.4 ***Ensuring an integrated multi-agency approach to respond to emerging themes and priorities identified by the Board and through national learning*****.**
The designated safeguarding professionals provide reports, briefings of emerging themes and progress of SCRs and the subsequent action plans are reported to and discussed at the SAC and safeguarding team operational meeting.

3.5 ***Assuring the quality of safeguarding and child protection to the wider community*****.**
The CCG utilises the section 11 audit and the CQRM process as a basis of seeking assurances. These in turn are communicated to our GPs, our wider staff via the staff e-newsletter and meeting the community at patient forums

3.6 ***Ensure that partners learn lessons identified through local and national learning, and***

ensure that learning is acted upon and embedded in practice across all partner organisations

The designated nurse is a member of the case review working group and a panel member of the two SCRs. Her reports to the CCG SAC meeting include progress of SCRs and subsequent action plans for CCG as well as the two major health care providers. This will ensure SCRs and action plans are monitored and any delay in implementation of action plans is identified. Actions needed to deal with the delay will be taken.

In respect of the completed SCR of the neglect case, an action for Havering SCB was to produce an escalation policy. The CCG had disseminated the policy to Havering CCG staff and GPs and ensured that the policy was also embedded within its safeguarding children

Long and short term risks and priorities

There was an ongoing risk with the initial review of health assessments for looked after children which were not completed within the statutory requirement time frame and there were concerns regarding the quality of the assessments that were carried out. The CCG has addressed this risk through having a robust recovery plan and the CCG has achieved a real improvement in this area. All outstanding health reviews are now completed and the completed health assessments are quality assured by a Paediatric Consultant. Going forward the CCG is ensuring that the contractual service level agreement for this process is robust.

5. **Actions to be taken to address the risks and the expected impact on outcomes**

The Designated Doctor and Designated Nurse for Looked After Children will ensure progress made is maintained and that the contractual service level specification is agreed, signed and delivered.

6. **Example of Effective/Emerging Practice (can be a sentence or two.)**

The Havering CCG designated nurse has provided the steer to support the implementation of Child Protection Information Sharing (CP-IS) by health services that provides unscheduled care and the three local authorities. Joint meetings with the CP-IS leads from all three local authorities and unscheduled health care providers such as BHRUT, PELC - which provides GP out of hours services and Walk-in-Centres - have shown agencies' commitment to implementing this national programme within their own agency.

London Ambulance Service (LAS)

The London Ambulance Service NHS Trust (LAS) has a duty to ensure the safeguarding of vulnerable persons remains a focal point within the organization and the Trust is committed to ensuring all persons within London are protected at all times.

This report provides evidence of the LAS commitment to effective safeguarding measures during 2015/16. A full report along with assurance documents can be found on the Trusts website.

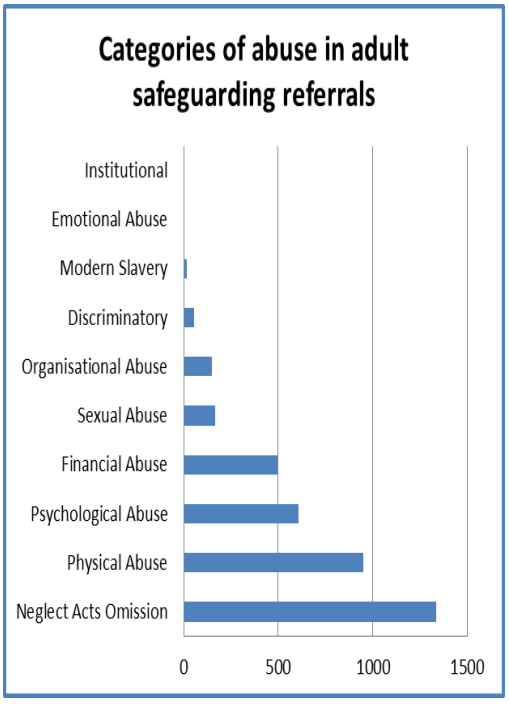
Referrals or concerns raised to local authority during 2015-16

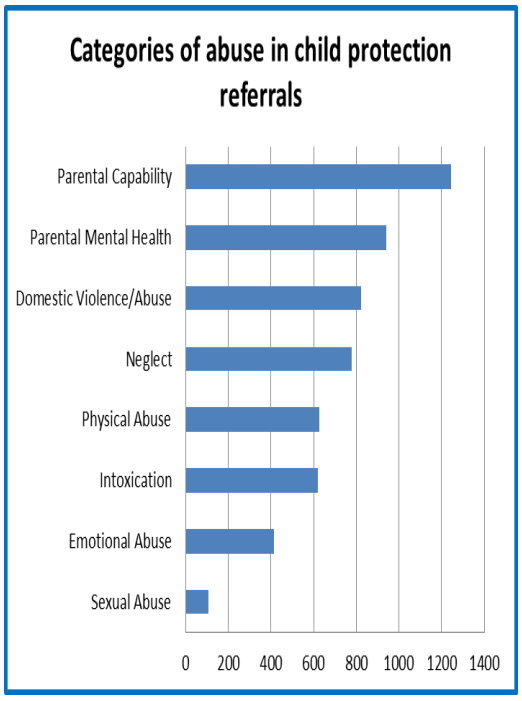
The LAS made a total to 17332 referrals to local authorities in London during the year.

4561 children referrals, 4331 Adult Safeguarding Concerns, 8440 Adult welfare Concerns

	Adults Safeguarding	Adults Welfare	Children	Total Referrals	Referrals as % of incidents
LAS	4331	8440	4561	17332	1.66%
Barking and Dagenham	107	162	189	458	1.62%
Barnet	144	259	159	562	1.34%
Bexley	120	326	146	592	2.09%
Brent	157	258	138	553	1.40%
Bromley	153	317	153	623	1.73%
Camden	109	177	72	358	1.05%
Croydon	262	458	343	1063	2.26%
Ealing	174	319	183	676	1.70%
Enfield	132	267	217	616	1.62%
Greenwich	137	274	220	631	1.93%
Hackney	128	238	113	479	1.67%
Hammersmith and Fulham	89	176	63	328	1.48%
Haringey	123	238	134	495	1.59%
Harrow	80	136	92	308	1.28%
Havering	148	205	116	469	1.42%
Hillingdon	148	260	150	558	1.32%
Hounslow	165	330	152	647	1.98%
Islington	129	240	91	460	1.53%
Kensington and Chelsea	72	155	39	266	1.42%
Kingston upon Thames	75	152	69	296	1.63%
Lambeth	185	327	188	700	1.65%
Lewisham	149	348	194	691	2.07%
Merton	108	171	111	390	1.80%
Newham	143	232	182	557	1.38%
Redbridge	121	237	125	483	1.46%
Richmond upon Thames	90	203	62	355	1.92%
Southwark	191	313	166	670	1.62%
Sutton	128	223	108	459	2.00%
Tower Hamlets	111	194	141	446	1.35%
Waltham Forest	160	309	136	605	1.96%
Wandsworth	153	238	141	532	1.67%
Westminster	98	256	58	412	0.95%

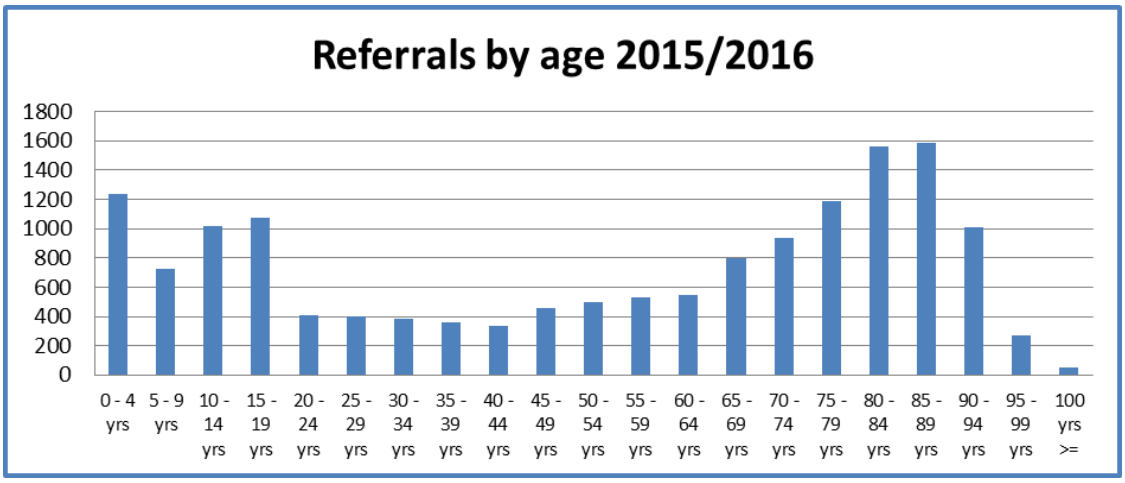
Categories of abuse





Referrals by age

Perhaps not surprisingly, the very young and the old are most likely to be the subject of referrals. For children, once out of infancy and their most vulnerable period they are most likely to be the subject of a referral once over 15. Around a third of referrals for all children, according to an in-house audit conducted in Q1 of this year are related to self-harm. The majority of these are in the 15-18 age range.



Safeguarding Training

The Trust is committed to ensuring all staff are compliant with safeguarding training requirements. The chart below shows staff directly employed by the LAS as well as voluntary responders and private providers who we contract to work on our behalf.

Training required	Total Staff	Frequency of training	2014	Target to be trained 2015/16	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total trained 2015/16	% of target 2015/16	3 year cummulative % of total staff trained
Level One																			
Induction	various	on joining		various	28	10	14	9	0	14	19	19	17	53	0	26	209		
E Learning	1389	3 yearly	672	356	69	220	67	35	18	40	60	34	22	32	33	32	662	186%	96%
Level Two																			
New Recruits	Various	on joining		various	Nil	53	88	31	39	124	13	16	47	27	74	177	689		
Core Skills Refresher	3019	annually		3019	N/A	N/A	N/A	N/A	310	596	785	936	N/A	178	N/A	N/A	2805	93%	
EOC Core Skills Refresher	443	annually		443	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0%	
EOC new staff	Various	on joining		various	34	10	9	27	4	12	17	0	14	7	12	8	154		
PTS/NET	114	annually		114	Nil	N/A	20	N/A	25	29	N/A	N/A	N/A	N/A	N/A	N/A	74	65%	
Bank staff	390	annually	58	390		N/A	N/A	N/A	6	8	43	66	0	31	N/A	N/A	154	39%	54%
111	152	annually	101	51	9	15	3	0	1	2	16	9	5	26	1	6	93	182%	128%
Community first Responders (St John)	140	3 yearly	135	50	Nil	12	13	10	13	12	12	14	15	N/A	13	12	126	252%	186%
Emergency responders	150	3 yearly		100	Nil	Nil	Nil	Nil	Nil	29	11	Nil	69	N/A	7	10	126	126%	
Level Three																			
EBS	30	3 yearly		25	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	13	14	N/A	27	108%	
111	11	3 yearly	11	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0		100%
Local leads	various	3 yearly		various	6	5	N/A	N/A	N/A	7	6	12	N/A	N/A	N/A	N/A	36		
Specific training																			
Prevent- clinical staff	3019	one off		3019	N/A	N/A	N/A	N/A	310	596	785	936	0	178	N/A	N/A	2805	93%	
Prevent- Non clinical	1389	one off		0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0%	
Trust Board	17	3 yearly		17	N/A	N/A	12	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	12	71%	
HR/ Ops managers	Various			various	29	N/A	N/A	N/A	N/A	7	N/A	N/A	N/A	N/A	N/A	N/A	36		
Private providers	450	3 yearly	226	112	26	21	13	10	19	16	14	11	6	18	21	13	188	168%	92%
Other safeguarding	various	as required			104	12	N/A	N/A	N/A	N/A	N/A	12	0	0	0	75	203		
Nil = no figures provided																	8399	total	
N/A= no course planned this month																			

Emergency Operations Control (EOC) staff have safeguarding training planned for quarter 1 2016.

Patient Transport Staff (PTS) are also receiving safeguarding training in quarter 1-2 2016.

Bank staff position is currently under review by LAS Executive Leadership Team.

Trust Board training is arranged for May for those outstanding safeguarding training.

All non-clinical staff will undertake Prevent awareness in 2016.

The LAS full safeguarding report for 2015-16 can be accessed via the Trusts website.

Alan Taylor

Head of Safeguarding

National Probation Service (NPS)

Brief summary of service as it relates to safeguarding children: S11 compliance will be drawn from the S11 audit of compliance and resultant action plan completed June 2015

The NPS has a statutory duty to safeguard children and promote their wellbeing. At the first point of contact with an offender we explore their social and family circumstances. In line with the Service Delivery Model, there are instances where information requests can be made to Children's Social Care (CSC) Departments as part of fulfilling our safeguarding statutory duty. Given our presence in the Courts, NPS is well placed to identify children that may be at risk and offenders who pose a direct risk of serious harm to them.

Review of Safeguarding Activity 2013-2014

- What has your organisation done in terms of your own agency safeguarding priorities?
- How has your agency utilised the views of children, young people, parents and carers to improve services?
    -

NPS London revised its safeguarding children policies and procedures in March 2015 and the NPS National Partnership Framework (LSCBs) was published in February 2016. Practitioner friendly processes and documents have been created with a child-centred approach. NPS's (London Division) policy and procedures also make it clear that all children have equal rights to safety and protection from harm. The final policy and procedures are being reviewed by NOMS and a National Policy is expected shortly.

NPS has a network of safeguarding children champions, locally and pan-London that are the first points of contact for advice and support for practitioners working with cases where there are safeguarding or child protection concerns. There will be bi-monthly seminars , which have commenced, for this group of staff with multi-agency involvement highlighting specific safeguarding perspectives such as FGM, CSE, Modern Slavery, Child trafficking; we will also keep abreast with new safeguarding policy developments, learning/feedback from SCRs, outcomes of case audits and service provision in MASH.

NPS will continue to work with statutory and other partners to develop effective pathways in offender engagement. We have a bespoke pathway for women offenders, we continue to embed

the think family approach and will liaise with service user councils where appropriate to ensure that we hear the voice of the child.

How has the organisation contributed to the Havering SCB vision statement and strategic aims?

Vision Statement

- Keeping children and young people safe is the Havering Safeguarding Children's Board overarching priority. All partnership agencies are committed to raising safeguarding standards and improving outcomes for all the children and young people of Havering.

Six Strategic Aims

7. Ensure that the partnership provides an effective child protection service to all children and young people ensuring that all statutory functions are completed to the highest standards.
8. Monitor the effectiveness of the multi-agency early offer of help to children and young people in Havering.
9. Ensure that agencies work together to provide the most vulnerable children and young people with the correct help at the right time.
10. Ensuring an integrated multi-agency approach to respond to emerging themes and priorities identified by the Board and through national learning.
11. Assuring the quality of safeguarding and child protection to the wider community.
12. Ensure that partners learn lessons identified through local and national learning, and ensure that learning is acted upon and embedded in practice across all partner organisations.

The NPS engages with a number of local partnership working arrangements and have agreed protocols relating to participation and information sharing. The NPS is also a key statutory partner with Local Safeguarding Children's Boards. One of our key priorities as part of that board is to comply with Section 11 (Children Act 2004) which places duties on Probation to ensure our functions and any services that we contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. This includes appropriate vetting levels of all staff and ongoing safeguarding training. We continue to remain committed to this agenda.

The NPS play an active role in contributing to the MARAC, MASH, MASE and the troubled families agenda. We remain committed to ensuring that staff are fully trained in managing domestic abuse cases and high risk domestic abuse perpetrators. A probation officer is seconded one day a week into the local MASH and a part time Probation officer is seconded into the local YOS.

The NPS does not work directly with children, but Probation staff do come into contact with children and families during the course of their work with Offenders. Evidence indicates that outcomes for children of offenders are often not as good as those of their peers. Through our work with a parent/carer to support desistance from offending we are improving the life chances for their children. Probation Officers are encouraged to undertake more home visits and to get to know the family to embed the "think family approach".

Any child safeguarding concerns are promptly followed up; Probation Officers can make valuable contributions to the effective assessment of a child's needs. NPS can represent the Statutory sector, given its regular contact with parents convicted of criminal offences.

The NPS remains committed to working with partnerships to improve outcomes for children, safer recruitment principles and the professional development of the workforce.

The HMIP inspection in 2014 reinforces areas of improvement, to undertake routine checks with CSC, incorporate actions into offenders' sentence plans and be more proactive in assessing the likely impact on children of any change in an offender's circumstances. This will be integral to NPS's pan London Business Plan.

NPS's current priorities both locally and nationally include delivering ongoing training for practitioners and managers. To imbed effective quality assurance processes, implement a new audit tool and contribute to the development of the National Performance and Improvement framework on safeguarding children.

All performance and quality work surrounding safeguarding children continues to be via our senior leadership team meetings and performance and quality sub groups.

7. Long and short term risks and priorities

- Pre-Sentence Report delivery, change in report format and need for speedier Police and Children's Services checks.
- Developing the workforce: utilising local training provision from partnerships and internal NOMS training packages.
- Leaving Probation officers on the periphery of the child protection network - we must be fully integrated in the team around the child.
- Developing practitioners confidence in making appropriate referrals and improved understanding of thresholds continues to be a challenge. In addition, effective identification and assessment of safeguarding issues when the index offence is not related directly to children is also an area needing further development. It is hoped that closer liaison with the Referral and Assessment and Early Help teams should assist with this.

8. Actions to be taken to address the risks and the expected impact on outcomes

- Continued participation in MASH and appropriate information sharing will assist in improving outcomes for all children. We also need to constantly revise and refresh our quality assurance processes to ensure that we fully capture the practitioner's experience and equip accordingly for best practice**.**
- Improving attendance : NPS / NOMS mandatory training and any appropriate multi-agency training run by the local SCB
- We need to get better at using other community resources provided by our partners such as family contact centres.
- NPS is keen to create and maintain exchange days/shadowing opportunities between Probation officers and social workers. This will raise awareness for both agencies about the roles which each respective agency does and also manage expectations. This will also assist in enhancing the integrated approach in future multi-agency working across boroughs.

9. Example of Effective/Emerging Practice

10.

NPS has made improvements to case management systems to encourage more detailed and accurate recording of safeguarding concerns. This improved data will be used locally to focus resources and assist staff to identify cases requiring additional support and a multi agency approach. It will also provide more meaningful and useful data to the NPS LSCB rep to be able to comment upon and contribute towards future strategic consultation and development.

Havering VI Form College (HSFC)

1. Summary of Service

Havering VI Form College in Hornchurch, are a provider of qualifications comprising of 56 different A levels and 14 vocational subjects. We have 2714 full time students.
In terms of Safeguarding, S11 compliance is checked against the 'Section 175 Education Act Audit Tool' and regular reviews of relevant legislation is undertaken.

Review of Safeguarding Activity 2015-2016

What has your organisation done in terms of your own agency safeguarding priorities?

- Two audits to ensure compliance – external completed April 2016, Borough audit undertaken June 2016.
- Annual Safeguarding Policy review and annual report to governors.
- 6 weekly report to Executive (Senior Leadership Team)
- Full staff & governor training in Safeguarding & 'Prevent'
- Partnership focus – representation at HSCB, BAP Pastoral Strategy group (SG leads from local schools) and the Serious Group Violence Strategy Group; links with FE providers both in and out of Borough to share best practise; Information Sharing Agreement with Met Police; working relationship with Prevent Coordinator.

2. How has your agency utilised the views of children, young people, parents and carers to improve services?

Parents:

Information is gathered via:

- Open communications policy – email/phone
- Parents invited to attend Principal & Deputy Principal's talk in September
- Verbal feedback during the interview process
- Staff survey

These forms of feedback are used to inform course Quality Improvement Plans and form a part of the College Self-Assessment Process.

Students:

- Student Survey (annual) - actions feed into the College Quality Improvement Plans and Self-Assessment process. These then inform the College Strategic Plan.

3. How has the organisation contributed to the Havering SCB vision statement and strategic aims?

Strategic Aim 1:

Representation at HSCB, annual review of Safeguarding Policy, annual report to Governors, 6 weekly report to HSFC Executive, to ensure compliance to statutory responsibilities.

Strategic Aim 3:

HSFC partnership focus (as highlighted in part 2.5 above)

Strategic Aim 5:

Partnership work with Police, partner schools & Havering FE College to ensure risk of young people becoming NEET is minimal, whilst ensuring Safeguarding/CP risks are controlled as far as practicable.

Strategic Aim 6:

BAP group

Membership of NAMMS (National Association for Managers of Student Services)

Membership of both groups helps us identify and share operational and strategic practises in response to local and national issues.

4. Long and short term risks and priorities

- 'British Values' awareness raising / training for staff & students – not yet fully embedded
- CSE awareness training to be fully embedded for both staff and students
- Staff opportunity to reflect on and contribute to, Safeguarding Policy and practise to be embedded.

5. Actions to be taken to address the risks and the expected impact on outcomes

- Staff training on 'British Values' & CSE awareness to be undertaken in June – thereby meeting HSCB strategic objective 1
- British Values and CSE awareness training for students to begin in the next academic year, via a mix of tutorials (similar to PHSE) and various communication methods.
- June meeting with Executive Team on how to fully embed staff feedback into Safeguarding practise and policy.

6. Example of Effective/Emerging Practice

- Partnership work developing with similar institutions out of Borough, to assist in meeting HSCB strategic aim 1.

- Actively seeking 'Prevent' training opportunities, to be in a position to more readily train staff and meet statutory responsibilities under the 'Prevent' Agenda, without reliance on external agencies.

- Seeking to embed Safeguarding reflective practise in the College appraisal process, enabling staff to reflect upon their practise and contribute to future development and policy.

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Havering Safeguarding Adults Board

Annual Report 2015-2016

Havering Safeguarding Adult Board Chair Forward

Welcome to the Havering Safeguarding Adult Board (HSAB) annual report 2015-16. The past year was the first that the HSAB has been operating as statutory body following the introduction of the Care Act 2014. The HSAB has focused on ensuring that it is able to comply with the requirements of the Act.

This report sets out how this has been achieved through the introduction of policy and procedures, formulation of processes to identify serious adult reviews (SAR) and systems to monitor how individual agencies will ensure that they are compliant with the Act.

Adult safeguarding activity has continued to increase over the year especially in respect of the number of contacts and referrals and conference activity.

The major increase has been in respect of the application of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLs) assessments.

This safeguarding activity is being undertaken under continued financial constraints and the on-going restructuring of some organisations. This, and the demography of Havering which has the oldest population in London, will continue to pose significant challenges to the local agencies and the HSAB.

I would like to acknowledge the continued support of the HSAB given by all agencies and the continued hard work and vigilance of all staff involved in supporting adult safeguarding. This report will set out those challenges.

The coming year will continue to see an increase in activity but the work of the board over the past year will help the HSAB identify risks and focus action to help keep adults at risk safe from abuse.

Brian Boxall
Havering Safeguarding Adult Board Independent Chair

1) Introduction

The purpose of this report is to fulfil the statutory requirement set out in Care Act 2014, which states that all Safeguarding Adults Boards (SAB) must publish an annual report on the effectiveness of safeguarding in their local area.

The Care Act 2014 came into force in April 2015 and Havering SAB became statutory. The purpose of the SAB is to help and safeguard adults with care and support needs. It does this by:

- assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance
- assuring itself that safeguarding practice is person-centred and outcome-focused
- working collaboratively to prevent abuse and neglect where possible
- ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred
- assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

This report will provide an overview of the following:

1. HSAB activity 2015-16.
2. Adult Safeguarding Activity 2015-16.
3. HSAB Governance 2015-16.

Appendices: Each agency was asked to supply a summary of their responses to safeguarding in 2015-16. These reports are attached to the annual report in the appendix

Our Vision

***'To make sure that Adults at risk from harm in Havering are safe and able to live free from neglect and abuse'*.**

These are at the centre of all we do are the **Six Adult Safeguarding Principles**, and our business plans and performance monitoring reflect these:-

EMPOWERMENT – people feeling safe and in control, encouraged to make their own decisions and giving informed consent. People feeling able to share concerns and manage risk of harm either to themselves or others

PREVENTION – it is better to take action before harm happens, so good information and advice are really important

PROPORTIONALITY – not intruding into peoples' lives more than is needed by responding in line with the level of risk that is present

PROTECTION – support and representation for those adults who are in greatest need because they are most at risk of harm

PARTNERSHIP – working together with the community to find local solutions in response to local needs and issues

ACCOUNTABILITY – being open about what we are doing and responsible for our actions - focusing on outcomes for people and communities

2) HAVERING SAB ACTIVITY 2015-16

During 2015-16, the Board focused on action that placed it in position to be compliant with the Care Act 2014. The following is a summary of the work of the Havering Board during 2015-16 and the challenge for the Board in the coming year. Some of the issues identified will be covering in more detail later in the report.

Policy and Procedures In December 2015 the Board adopted the new Pan London Safeguarding Adult Procedures. The introduction of the new procedures, which where revised to take into account the Care Act, was supported by the HSAB with a week of briefings in March 2016 open to staff all agencies.

The HSAB also produced during 2015-16 an Escalation Policy to emphasis the need to challenge at times.

Board Challenge: For the board during 2016-17 is to be assured that staff are fully aware of the procedures and that they are being applied. The procedures will be supported through the production of local safeguarding procedures.

Safeguarding Adult Reviews: The Care Act made the SAB responsible for undertaking **Safeguarding Adults Reviews (SAR)** when:

'*someone with care and support needs dies as a result of neglect or abuse and there is a concern*

that the local authority or its partners could have done more to protect them'

In order to fulfil this function effectively the HSAB agreed that the SAR sub group would combine with Havering Safeguarding Children Board SCR sub group, a group with extensive experience of reviewing and making recommendations of when to undertake full serious case reviews or learning reviews. This combined sub group supported by new membership with adult safeguarding experience will review and make recommendation in respect of potential SAR's.

To help the process, the HSAB have produced guidance for the consideration of a SAR including a referral form. As yet Havering have not undertaken a SAR.

During 16-17 the group will potentially also have responsibility for Domestic Homicide Reviews. This will ensure consistency in decision-making as each of these three statutory reviews often have elements of adult and children safeguarding. This should ensure that the appropriate review is undertaken and the lessons learnt are promulgated across the agencies and the boards including Community Safety.

Board Challenge: To ensure that appropriate referrals are made being made and SARs are being undertaken.

Strategic Action Plan: The HSAB is required to produce a Strategic Plan. HSAB has continued to progress the 2015-18 three year strategic action plan based on the 6 P's.

In order to ensure the HSAB identifies immediate major risks, a risk register has been produced. This is still in its infancy but has started to provide a focus for HSAB.

The current risks are:

Mash - *Financial constraints may impact on ways in which partners support MASH.*
Capacity issue in relation to homecare- *Choice for people with care needs depleted and liberty deprived unnecessarily. Impact on residential settings*
Capacity issue in relation to DOLS *- Volume of referrals is high.*
Mental capacity *- there is still a need to continuously brief staff in their responsibility to undertake MCA assessments.*

Self-neglect - *Risk is that self-neglect may be not be responded to due to confidence in practitioners ability to consider capacity when undertaking a person-centred approach to assessment and safeguarding.*

2016-17 will see the production of a comprehensive prevention strategy and guidance on self-neglect.

Board Challenge: To ensure that the strategic plan remains relevant and is informed by data. To be able to ensure that it results in improved outcomes.

Agency Compliance: The Board has produced a self-audit tool for completion by each individual agency during 2016-17. This will provide the HSAB with and overview of the agencies position with regard to their ability to safeguard adults.

Awareness Raising: It is the role of the Board to raise awareness of safeguarding with staff and in the community. To achieve this, the HSAB will produce a newsletter in May 2016, the first addition focuses on Self Neglect.

2015-16 saw the introduction of a Community Engagement group. The membership of this group consists of representatives of the Voluntary and Community Sector Group. It will have a rotating Chair. Its aim is to raise awareness within the Community and the voluntary sector. It will enable the SAB to be better able to engage and use the knowledge of this sector.

In October 2016, Havering SAB and LSCB will be holding a joint adult and children safeguarding week. The HSAB conference will be included and a number of other events and information days will be held.

Board Challenge: To support the new Community Group and respond to the needs they identify.

Making Safeguarding Personal (MSP): MSP is in its infancy in Havering. It is currently starting to be applied within Adult Social Care. There is a need during 2016-17 to start to ensure that all agencies adopt the MSP principle when interacting with adults at risk. To that end, a review of agencies current position will be undertaken.

Board Challenge: To continue to evidence the application of MSP across services.

3) SAFEGUARDING ACTIVITY 2015-16

Safeguarding Contacts: Multi Agency Sharing Hub (MASH)

In June 2014, Havering became the first borough in London and one of the first authorities in the country to implement a joint children and adults MASH.

The purpose of the MASH is to improve the quality of information sharing and decision-making at the point of referral. This is achieved in Havering by facilitating the sharing of intelligence across agencies. This enables the MASH to ensure safeguarding interventions are timely, proportionate and necessary. The MASH has a number of partners co-located such as Police, Public Protection, Housing, Probation, Adult Mental Health, Early Help Advisor and independent Domestic Violence Advocacy supported virtually by Youth Offending Team, Education, Drugs and Alcohol service.

Contacts are assessed and graded and then signposted to the appropriate structure to progress as required. The integration of the Adult MASH did not commence until June 2014 so comparison in terms of activity with the full year 2015-16 is not possible.

MASH 2015-16	
All Contacts	4004
Police Contacts (MERLINS) account for 46% with residential care staff accounting for 15% of contacts.	
Safeguarding Adults Concerns	1100 (27.5%)
MASHed	194 (17.6%)
Not MASHed	733 (66.6 %)
Number of Repeat contacts	1176 (40.3%)
Welfare Adult Concerns	2904 (72.5%)
MASHed	55 (1.9)
Not MASHed	2449 (84.3%)

The majority of referrals continue to be assessed as non-safeguarding cases.

Whilst the MASH has been effective it was identified that it was a victim of its own success. It was receiving a high level of contacts that were MASH'ed and progressed to assessments with a high proportion of assessments being concluded with no further action required.

In order to address this, a review of business processes (LEAN review) was undertaken between January and March 2016. The finding of this review will be implemented during 2016-17.

One of the areas identified as a risk to the MASH is the ability for agencies to continue to support the MASH. Due to funding constraints and organisational restructures some are questioning the ability to continue to provide staff to the process.

Board Challenge: To progress learning identified in the MASH review and to continue to monitor and challenge agencies commitment to the MASH.

Adult Safeguarding Concerns.

The below chart sets out the separation between adult safeguarding concerns and welfare concerns. The source majority of safeguarding concerns was social care (CASSA and Independent). Health staff also raised a significant % of safeguarding concerns whilst those raised by police are minimal. However, police are the source of 54% of all welfare concerns this is probably due to the fact that the MERLIN is used for all referrals regardless of the level of concern.

Safeguarding Adult Concerns 15/16		
Concerns	2102	Repeat enquires 15%
Social Care Staff	703 (41%)	
Health Staff	519 (27.9%)	
Police	31 (4.6%)	
Welfare Adult Concerns 15/16		
Concerns	3183	
Social Care Staff	699 (22%)	
Health Staff	481 (15.1%)	
Police Merlin	1736 (54%)	

Board Challenge: For the board to be assured that the police referrals are relevant and are subject to quality control within police prior to submission.

Abuse Types

The Care Act has added four new categories of abuse, Domestic Abuse, Sexual Exploitation, Modern Slavery and Self Neglect. These have been recorded in the 2015-16 abuse type figures

Abuse Type	
Physical	258 (38.6%)
Sexual	18 (2.7%)
Emotional	57 (57%)
Financial	125 (18.7%)
Neglect	224 (33.5%)
Discriminatory	1
Institutional	6
Domestic Abuse	1
Sexual Exploitation	0
Modern Slavery	0
Self Neglect	16 (2.4%)

Physical abuse and neglect still account for 70% of the recorded abuse categories'. Whilst there have been a few cases recorded as self neglect there have been minimal recorded against the new categories.

Abuse Locations	
Own Home	42.6%
Care Home –Residential	26%
Care Home- Nursing	15.8%
Hospital	4.3%
Service within the community	0.4%
Supported Living	6.5%

The home still remains still remains the biggest location of abuse followed by residential care homes. This is clearly reflected in the data in respect of the relationship between the abused and the abuser. 70% related to relatives and family carer and care supporter in the private sector.

Relationships	
Social Care Support- Public Sector	2.2%
Social Care Support - Private Sector	48.7%

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Relationships	
Social Care Support- Public Sector	2.2%
Social Care Support -Private Sector	48.7%
Relatives/Family carer	20.9
Health	4.5%

The majority of referrals are related to incidences of neglect and omission especially within Care Home settings. Referrals relating to financial and physical abuse were more prevalent within own home settings.

Relatives/Family carer	20.9
Health	4.5%

Strategy Activity	14/15	15/16
Strategy Discussions	546	644
Completed within Timescale (5 working Days)	469 (85%)	497 (77%)
Investigations Ended	405	368
Ended within Timescale (20 working days)	260 (64.2%)	210 (57.1%)
Conferences	277	358
Within Timescale (20 working days after end of investigation)	236 (85.2%)	263 (73.5%)
No of Completed Safeguarding Enquiries		603
Completed open for more than 2 months		65 (29.2%)

Board Challenge

- To be assured that categories are being correctly recorded.
- To raise awareness to agency staff and the community of the new categories.
- To ensure that there is in place a self-neglect guidance/strategy.

Safeguarding Referrals Outcomes

There has been a significant increase in safeguarding activity specifically in the number of strategy discussions and resulting conferences. This has had a slight impact in achieving

required timescales but the complexity of cases will also have an impact.

The outcome in the majority of cases has led to either the reduction or removal of the risk.

Action and Result	
Increased Monitoring	124
Adult Removed	14
Moved to Increased care	25
Management of Finances	7
No Action Taken	151
Action ended at strategy meeting	254
Restriction /management of alleged abuser.	13

Board Challenge:

- With the emphasis on providing support to vulnerable adults in order to enable them to remain within their own home environment, the HSAB need to continually ensure that this environment remains safe. This will be undertaken through audits and increase information available to the public.

- The challenge is to ensure that action taken is a long-term solution, so the monitoring of repeat referrals will help identify failure to find long term solutions**.**

Care Establishments

There are currently 39 Residential and Nursing Homes; 30 Domiciliary Care Agencies and 6 Day Opportunities, 26 Learning Disability (LD) Homes, 9 LD Day Opportunities, 3 Extra Care provisions and 18 LD Supported Living establishments, which are monitored by the Quality Team.

During 2015-16 the Local Authority Quality Team suspended the local use of 9 establishments for various periods of time whilst the initial identified concerns were remedied or in 3 cases the supplier left the market.

This provides assurance that complaints against establishments are being dealt with appropriately.

Mental Capacity Act Deprivation of Liberty Safeguards (MCA DOLS)

The application of MCA and DOLS has remained a major focus of the SAB. Highlighted in last year's annual report was the Supreme Court Judgment in March 2014 has continued to significantly impact on the number of applications during 2015/16.

MCA DOLS Authorisations	
2014/15	383
2015/16	560

The end of year position (for 2015/2016) was approximately 560 referrals. Up to March 2014 there were 25-30 referrals. This increased in 2014/2015 to 345. There are a couple of areas that adult services are bringing in additional capacity. This will assist adult services with assessments, the organisation progress and assurance. Training has been done with social workers and NELFT to increase the number of BIA assessors. There are currently 25 internal BIA assessors across NELFT and social care.

BIA assessment can take between 5-8 hours to complete which includes significant planning and co-ordination.

The local authority Cabinet has agreed growth for 2016/2017 to enable the service to bring in more BIA assessor on a permanent basis.

Every DoLs that has been authorised needs to be reviewed. This takes the same amount of time as the original assessment.

Adult Social Care service is mindful of individuals that do not reside in residential/ nursing homes or hospitals. Court of protection has recently introduced a fast track process to deal with people who are not in those setting.

Board Challenge:

The board will continue to monitor the use of MCA. DOLs and challenge were necessary.

4) HSAB GOVERNANCE & STRUCTURE

Governance

The HSAB is chaired by an Independent Chair; the appointment was made by a panel which was chaired by the Chief Executive. The Independent Chair holds meetings with the Lead Member for Adult Safeguarding, the Chief Executive and the Director of Adults. The purpose of each meeting is to hold the Independent Chair to account for the effectiveness of the HSAB and to provide space to ensure open and honest discourse between the Director of Adult Services and the Independent Chair regarding the service activity as it relates to adult's safeguarding within Havering.

The three statutory partners are represented at the HSAB at an appropriate level and actively participate within the business of the Board. The SAB also consists of members of non-statutory agencies.

There has been difficulty in securing/maintaining regular attendance from NHS England. The impact of this has meant strategic insight into NHS England priorities and direction of travel from Board discussion. The structure of Havering's SAB was reviewed during 2015 in order to strengthen governance processes to support the Board to manage business priorities more effectively as the Board's responsibilities increased.

Structure

Executive Board

The Executive Board is chaired by the Independent chair; it has a small membership consisting of the strategic leads from all statutory partners and holds ultimate responsibility for the effectiveness of the multi-agency safeguarding offer to children and young people in Havering.

The Executive Board formally agrees:

- Business priorities of the board and the business plan
- The annual report
- Final overview reports and recommendations from SARs
- Action plans to respond to SCR/LR recommendations
- Actions to respond to Board risks and the responsible working group/partner organisation to progress the actions.

Operational Board

The Operational Board is chaired by the Independent Chair and has senior staff with links to practice within the membership. All members actively participate within the discussions and this is evidenced within minutes of meetings. The Operational Board's agenda includes both children and adult priorities to ensure that cross cutting priorities are considered by both strategic boards.

The Operational Board is in place to provide overview and scrutiny of the progress of HSCB/ SAB Business plan priorities and to provide assurance to the SA/SC Executive Boards in relation to the progress of business plan objectives. Concerns that are identified by the Operational board and HSCB working groups in relation to the effectiveness of the safeguarding offer are added to the HSCB /SAB risk register, monitored by the Operational and reported to the Executive Boards.

Progress of the HSAB action plan is monitored by the Operational Board. The Operational Board drafts the Executive Board agenda to ensure that it is appropriately focused on relevant areas of business.

Operational Board minutes are circulated to Executive Board to allow for scrutiny and challenge of business activities.

Working group activity is overseen by the Operational group

- Quality and Effectiveness Working Group

  The Q&E group is chaired by a member of NELFT's SMT and all organisations except CAIT are represented. All members participate fully within meetings, identifying areas of risk and areas that require further scrutiny. These are progressed by the group and also raised at the Operational/Executive level

- Case Review Working Group

  The Case Review Working group is chaired by a member of NELFT's SMT and all partner organisations are represented at the meetings.

- Community Group working group

HSAB risk register

The HSAB risk register holds the areas identified by the Board as requiring oversight in order to progress actions quickly to reduce risks. The risk register is owned by the Executive and activity progressed through the working groups and operational board. The risk register is RAG rated to include impact of activities agreed to mitigate risk and is a standing agenda item at every HSAB group meeting and is used by the Independent chair to inform discussions held with the lead member and meetings with senior strategic leads from the partnership.

Annual report

The HSAB publishes an annual report. The report is presented to the Havering H&WBB and Overview and Scrutiny by the Independent Chair. The report is sent electronically to MOPAC, Chief Executive and London Councils and held on the HSAB website.

Multi-agency training programme

During this period Havering SAB conducted a training needs analysis to identify what current single agency training is being offered through the partnership in a bid to collaborate resources and reduce costs. The training sub group identified that although there were a number of similar courses on offer within each agency, the delivery of a number of their training courses was targeted at specific niche groups therefore making them available to a general safeguarding audience would not be suitable.

However, the group identified that basic introductory courses could be offered multi-agency and are currently exploring the possibility of creating an e-learning programme.

The Care Act 2014 statutory guidance was formally agreed in March 2016 and adopted within Havering. As a result the SAB held week long multi-agency briefing sessions to introduce the new guidance to those working and supporting adults. Self-neglect was formally recognised as a category of abuse within the Care Act for the first time. As a result the Board offered two full training courses on self-neglect and hoarding which was attended by a variety of multi-agency professionals working in adult safeguarding, health and provider settings.

SAB Sub Groups

The HSAB is supported by three sub groups:

Quality, Effectiveness and Audit Sub Group

During 2015 Havering SAB reviewed it's structure and the work of the subgroups. The Quality, Effectiveness and Audit group had its inaugural meeting in July 2015. It has met on four occasions 9/7/2015, 11/9/2025 19/11/2015 and 25/01/2016.

The group is multi-agency being made up of staff from the London Borough of Havering, NELFT and BHRUT. Other organisations receive copies of minutes etc. but it is the intention of the group to expand its membership. The group would welcome attendance from other organisations and the chair will be inviting members of other services to participate in the meetings.

The groups role and purpose is to

- To monitor and evaluate the effectiveness of activities undertaken by Havering Safeguarding Adults Board (HSAB) organisations, individually and collectively, to safeguard and promote the welfare of adults in Havering and advise them on ways to improve their practice further.
- To promote high standards of safeguarding work.
- To foster a culture of continuous improvement.

During the winter of 2015/16 the Havering SAB members completed multi-agency self-assessment. The Safeguarding Adults at Risk Audit Tool had been developed by the London Chairs of Safeguarding Adults Boards network and NHS England London. It reflects statutory guidance and best practice[i].The aim of this audit tool is to provide all organisations in the Borough with a consistent framework to assess monitor and/or improve their Safeguarding Adults arrangements.

The audit tool is a two-part process:

- Completion of a self-assessment audit
- A challenge and support event.

Community Engagement Group

A representative of YMCA Thames Gateway chairs this group. It membership comprises of representatives from the Voluntary and Community Sector and has 11 organisations involved.

It has met on a couple of occasions and has produced an action plan for 2016-17. This has three intended outcomes:

- Public know where to go when they have a safeguarding concern
- Empowerment to challenge.
- Communication - raise awareness of the importance of acting early in cases of self-neglect to reduce the risk of unnecessary escalating need.

Serious Case Review Group

As previously set out this group is responsible for both Adult and Children Reviews. Over the past year it has not identified any adult cases that have required a full SAR.

HSAB Financial Contributions

HSAB is funded under arrangements set out in the Care Act. The contribution made by each member organisation is agreed locally. The member organisations' shared responsibilities for the discharge of the HSAB's functions include determining how the resources are provided to support it. Funding agreed for the past year was as follows.

Name of Agency	Contribution 14/15
Havering Council	£43,800
Police	£5,000
CCG	£10.284
BHRUT/NELFT	£1740
NPS	£360
The London Community Rehabilitation Company LTD	£360
Total	**£51,270**

Funding for the board remains a challenge that will need to addressed in the coming years if the Board is going to be able to fulfil their statutory duties.

Staffing and support

Board staffing has remained stable over the year. A business manager, training and development officer and an administrator are in place to assist the board in achieving agreed priorities. The Board is chaired by an independent person and the Lead of business and performances **LBH** acts as the vice chair.

APPENDIX

Single agency successes and areas for further improvement

This section will set out the overview by the three statutory agencies Local Authority Social Care, CCG and Police of the work achieved 2015-16 and identified risks and challenges the year 2016 to 2016. The Probation Service and NELFT have also submitted a review of their activity that is included.

Adult Services

FACT SHEET This document summarises the Top 10 Strengths and the Top 5 challenges facing Adult Services.

Key Strengths:

FACT 1: Integration

Adult Services already has existing and very successful partnerships within the Community Learning Disabilities Team and the Mental Health Service jointly run with NELFT. In addition the Joint Assessment and Discharge Team, run with BHRUT and Barking and Dagenham, has made a real impact on preventing delayed, unsafe discharges.

The Council and NELFT are currently on track with the *Integrated Localities Project* project to co-locate the adult social care community teams with their NELFT community health colleagues due to be completed by late spring 2016. We are confident that the new service is already improving care and support across Havering and we have developed a performance management framework for the integrated teams that measures client/patient satisfaction, staff satisfaction, activity and process measurements as well as the statutory metrics. When the co-location phase has been completed, the project will focus on reconfiguration of the adult social care workforce to make maximum available advantage of the opportunities for joint and integrated working with the community health teams to deliver the best possible outcomes for carers, patients and service users in Havering.

There are a number of services across health and social care that constitute the *Intermediate Care Pathway*; these have all been reviewed in light of developing a more integrated approach to delivering care. A range of options have been considered in terms of the commissioning of a more integrated intermediate care pathway with the recommended long term strategic option to commission the Intermediate Care pathway as a single, multi-disciplinary health and social care team across Barking and Dagenham, Havering and Redbridge.

The *Community Treatment Teams* and *Intensive Rehabilitation Service* have continued to make excellent progress. In November 2015 following the evaluation of a pilot the CTT/IRS service was mainstreamed. The service demonstrated very high patient satisfaction with over 9 out of 10 patients, 93% of patients supported at home with no need for hospital admission and an overall increase from 2,000 to 12,000 patients seen over the year. This followed extensive public consultation with widespread support to maintain the services.

The *Transforming Care Partnership* (for people with learning disabilities and autism who are in or at risk of being admitted to Assessment & Treatment Units) is a new programme that sees us working with partners from health and social care across the Barking, Havering and Redbridge footprint, and is ambitious in its scale and delivery timetable. We need to embed its principles into our front line services and commissioning activities. The TCP's ambition is to support people with complex learning disabilities who are in long stay inpatient settings, coming back to Havering, to their families, communities and support networks. Nationally it is recognised that there is still far too many people with learning disabilities in inpatient settings (such as the former Winterborne

View unit that received national attention in 2011 with the residents of the unit subject to appalling and widespread abuse).

Fact 2: Improved Commissioning

Underpinning what we do, we are committed to the development of a robust joint commissioning strategy with other Council departments and partner organisations in particular with Havering Clinical Commissioning Group. We are increasingly working with residents and people with experience of services to co-design more collaborative model of commissioning, harnessing the power of local people for radically different results that benefit everyone. We need to ensure that the resident voice is used to genuinely drive changes in how and what we commission.

To meet the challenge of increased demand for care and support and reduced resources, we have developed a different approach to how we commission. Rather than always purchasing directly we are now working to shape and influence the market to ensure there is a range of high quality, affordable services available to residents. To achieve this we have developed new interactive provider forums where issues are raised and solutions are developed in partnership. We have launched 'Care Network', an online hub providing opportunities to share information with providers and gain feedback. We have recently launched Havering's co-produced market position statement laying out the direction of travel and future needs of Adult Social Care in Havering. Commissioning are shifting resources towards services that reduce or prevent problems from occurring. This is a key theme for the redesign of Havering's voluntary and community sector services.

Fact 3: Assistive technology (AT)

There is currently a review of AT services within ASC as the Service had seen a rapid increase in the number of referrals leading to significant budget pressures. Whilst we celebrate the success of our Assistive Technology service, Adult Social Care is committed to ensuring that people, who receive the service, are actually using it as it has been designed to be used to ensure that we are able to stay within the budget available. We are therefore reviewing our policy (covering eligibility) and want to make sure people who need AT continue to have access to it. A number of people have had AT without adult social care involvement, so our review is covering only those people where adult social care is involved in supporting them to remain at home as independently as possible.

Fact 4: Work with health

There is a strong history of successful collaborative working across health and social care in Barking and Dagenham, Havering and Redbridge, with an emerging track record of true partnership working leading to real improvements for our local population. This is driven by the BHR Integrated Care Coalition (ICC) which was established in May 2012 to bring together the lead organisations in our health and social care economy to support the commissioning of integrated care. The ICC states their purpose as "Improving outcomes for local people through best value health and social care in partnership with the community". The Coalition has led development of a significant number of transformational programmes which have contributed to one of the most dramatic improvements in the country as the benefits of our partnership working and strengthening of community and primary care services have been realised. Some of these programmes include: The Joint Assessment and Discharge Team, Community Treatment Team, Intensive Rehab Service and Community Health and Social Care Services Integration. This builds on a strong platform of personalising social care services across the three Local Authorities.

However, the benefits of partnership working in its current form will not address the numerous population challenges that BHR is facing now, and the implications of this in the future. Our close relationship and experience has given the BHR partners confidence to bid to be a pilot-site for London to consider Devolution through an Accountable Care Organisation (ACO). We are developing a business case to explore whether an ACO could help us to bring about the improvements we need, faster and more effectively, and are doing this as part of a wider piece looking at our vision and priorities for health and social care for the next five years. This work will be completed in the summer of 2016 and the decision to go ahead with the ACO proposal will have to be taken by each partner organisation's governing body – for the council this will be Cabinet and Full Council. In addition, since the last Better Care Fund submission, the ICC has driven the agenda for change still further; with successful bids to become Prime Minister Challenge Fund and Vanguard Urgent and Emergency Care pilot sites.

Fact 5: Work with other parts of the council

Adult Social Care is currently working with Learning and Achievement in developing the new 'Preparation for Adulthood' service, which will look at how we can improve the way our children and young people transition into adulthood, supporting them with attaining the right life skills to enjoy rich and fulfilling lives as adults.

ASC Commissioning Team have also worked with partners in Housing to design and build a new housing scheme consisting of seven one bedroom self-contained properties (houses and flats) and one staff flat. These properties were built with the express purpose of providing housing for clients with learning disabilities. This project has increased local specialised provision; operates as a 'move on' service in order to promote independence, and meets the housing needs of vulnerable adults and to ensure that services deliver in line with the new statutory framework. The project was a key co-production opportunity and underpinned the purpose of ASC Commissioning.

Fact 6: Improved Safeguarding

In the aftermath of the Mid Staffordshire and Winterbourne View scandals, the Care Act 2014 has created an opportunity to bring in more robust safeguarding duties. The Care Act put Safeguarding on a legal footing and requires local authorities to make enquiries, or ask others to make enquiries:

- When they think an adult with care and support needs may be at risk of abuse or neglect.
- To find out what, if any, action may be needed.
- This applies whether or not the authority is actually providing any care and support services to that adult.
- Housing and other partners can undertake enquiries when requested.

The Care Act is a major change in practice - a move away from the process-led, tick box culture to a person-centred social work approach which achieves the outcomes that people want. Practice must focus on the person, which accounts for the possibility that individuals can change their mind on what outcomes they want through the course of the intervention.

Adults Service has recently appointed a new Service Manager to lead the Safeguarding Team through these changes and to implement new working practices.

Fact 7: Improved work with carers

Our shared vision for carers in Havering is that carers will be universally recognised and valued as being fundamental to strong families and stable communities, and respected as expert partners in care. We will support carers to maintain their own health and wellbeing and to achieve a balance between their caring responsibilities and a life outside caring, while enabling the person they support to be a full and equal citizen. With this in mind, Adults Services have co-produced with carers a Joint Havering Carers Strategy 2016-2019. The official launch of the Strategy will be during Carers Week 2016 (June).

There has been great progress to date including:

- Introduction of the Jointly produced Havering Carers Information Booklet. The booklet provides carers with an overview of a range of services and support in Havering, including how to access a carers assessment and local voluntary and community sector support and contact details.
- In June 2015, we introduced the Havering Carers information e-bulletin, a quarterly electronic publication, which receives input from Council services, the Havering CCG and community and voluntary partners.
- We have now re-launched the Havering Carers Register including to produce new sign up forms and we are circulating them across Havering. We expect to see an increase in the number of carers signing up to the Havering Carers Register in 2016 to 2017. Over 750 carers are currently signed up to the Havering Carers Register.
- Redesigned the Carers Forum. A new Havering Carers Forum flyer has been produced to provide people with the dates of the meetings well in advance. In February 2016, 85% of carers said that they found the Carers Forum very helpful/helpful to them. Voluntary and Community Sector service representatives are regularly participating.
- Carers Personal Budgets were introduced in April 2015 and a Resource Allocation System for calculating an indicative budget for carers was introduced in June 2015. To date, over 50 eligible carers have opted to take up a Carers Personal Budget.

Key Challenges:

Challenge 1: **Demographic changes**

Demand for services will rise in the future, and at a greater rate than in previous years. This is, in part, due to Havering's ageing population and the changing demographic profile of the Borough. Demand for front-line services is increasing at an unprecedented rate. The impact of demographic changes has led to increased cost pressures, with a particular increase in demand for homecare and supported living. A cross-cutting Strategy has been developed for Havering and the biggest change will involve identifying, prioritising, tackling and mitigating the main root causes of demand. There is a commitment to being truly innovative and will prioritise early help, intervention and prevention (EHI&P). This will lessen the burden on more expensive statutory services such as social care.

Of the pilots in Tranche One, ASC are leading on a Social Isolation Pilot. Social isolation has so far been identified as the single biggest root cause of demand for services. The first such pilot is looking to develop a locality based approach to addressing social isolation that can be adopted by both health and social care as a referral mechanism into wider community resources, and includes how we can make best use of technology to keep people connected. On the latter we successfully bid to become a 'Visbuzz' pilot site, with simple voice and video enabled devices to be trialled with people are or at risk of becoming socially isolated, to enable them to stay connected with family, friends and professionals.

Challenge 2: Market capacity

The change in demography has led to real challenges in the local home care market providers with a number of issues leading to capacity issues. Demand is increasing in both hours per customer and a market that is struggling, with external drivers due to increased regulations and the new national minimum wage. The number of clients has steadily increased, coupled with the increasing size (and complexity) of care packages, this has meant the actual cost of packages has increased significantly. Adult Services have been working with providers and need to challenge ourselves and them in establishing a different kind of relationship, including co-producing with them the model for the future. On average, 11,000 hours of homecare are delivered each week to Havering funded residents, delivered by 26 homecare providers. Homecare providers are struggling to meet the demand for homecare due to problems with recruiting and retaining staff in Havering, and this is a national problem. This is backed up by Skills for Care data which shows that Havering has a staff turnover rate of 35.9% in the care sector, as at January 2015 which is significantly higher than the turnover rate for London which was 21.7%.

In addition, there are 39 care homes in Havering that support older people with a total capacity of 1615 beds. On average the Council funded placements fill 34% of these beds. The remaining beds are filled by people who fund their own care, placements from other Councils and vacancies (14%). Therefore, in Havering, the Council is not the main purchaser of care home beds.

Challenge 3: Stretched and challenged health economy

BHR Queen's and King George Hospitals continue to be on "special measures" following the CQC (Care Quality Commission) inspection outcome in 2013, with areas of concern identified around clinical safety in A&E (including performance) and across inpatient services. Whilst CQC has seen evidence of improvement in the hospitals, BHRUT remains on special measures, and we continue to support them with their improvement plan. BHR system has a total estimated funding gap of over £400m and our current plans will not fully address this. We have a marked distance from capitation at organisation level and further Public Health Grant reductions need to be managed long with the demand and demographic pressures emerging in parts of the social care market (home care). Activity from the hospital increased to unprecedented levels throughout 2015/16 with resulting budget and performance pressures for adult social care, and this looks set to continue in 2016/17. Our Acute hospital trust provider (BHRUT) has:

- High non-elective admissions rate (41% emergency admissions as a percent of total admissions vs 35% England, 33% London)
- High occupancy levels (94.7% vs England average 86.9%)
- Planned care performance and efficiency challenges

All three BHR CCGs have higher than average inpatient spend for over 75s.

Challenge 4: Workforce

Adult Social Care is in the midst of the biggest change since the 1990 NHS & Community Care Act. The Care Act 2014, the first phase of which was introduced from 1 April 2015 has led to substantial change and challenge. Sadly, this has also led to a regional and national crisis in the recruitment and retention of qualified social workers. This crisis has seen the growth of social work agencies offering higher salaries, resulting in an increased turnover of staff in the adult social care workforce and creating some instability. Given this, there has never been a more critical time to review Havering's approach to the recruitment, retention, development and support of its social care workforce. We want Havering Adult Social Care to be an employer of choice for social care staff. We need to ensure our workforce feels confident, is supported to have the right skills, have resilience, and feel motivated and committed to the work they do for Havering residents.

Working with the Principal Social Worker, across the service we need to continue to embed changes to how we practice, focusing on peoples outcomes, rather than process. A Workforce Development Strategy 2014-17 has been developed to increase training and development opportunities for staff and to begin more focus recruitment efforts.

Challenge 5: Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS), (as set out in the Mental Capacity Act 2005) gives adult social care the statutory duty to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Where someone is being restricted due to, for example, health and safety issues if the person was not supervised, adult social care must undertake a 'best interest assessment' of that person to satisfy ourselves that the deprivation is necessary and is being actioned in a safe and correct way. We must ensure that this is only done when it is in the best interests of the person and there is no other way to look after them.

A Supreme Court ruling in 2014 in the cases of Cheshire West v. P&Q, effectively lowered the threshold for what constitutes deprivation of liberty in care settings. In doing so, it significantly increased the number of people requiring assessment for protection under the DoLS scheme. The ruling has driven a significant increase in the number of referrals for DoLS and has placed a major strain on best interest assessors (BIAs). To combat this Adult Services have trained up a significant number of additional BIAs and are managing the increase within the Safeguarding Service and wider teams. In 2013/14 there were only 33 referrals; following the ruling in 2014/15 there were 370 and to date in 2015/16 there have been 568.

Barking, Havering Redbridge CCG's

BHRCCG's is a commissioner of local health services. As part of this function it has responsibilities to ensure that local commissioned services fulfil contractual requirements in the areas of quality & safeguarding.

Review of Safeguarding Activity 2015-2016

- **What has your organisation done in terms of your own agency safeguarding priorities?**
  Ensuring safeguarding adults is embedded with the development and addition of Safeguarding Standards within contracts. Proactive approach to safeguarding by conducting quality and assurance monitoring visits to commissioned services.
  Development of a Nursing Home Strategy in order to gather various elements of soft intelligence to translate into measured levels of risk. Allowing us to plan the appropriate levels of response and monitoring within an early warning system.

- **How has your agency utilised the views of adults and carers to improve services**?
  Seeking of feedback from people at risk of abuse via locality patient forum groups.

  How has the organisation contributed to the Havering SAB *Vision statement:*
  ***To make sure that Adults at risk from harm in Havering are safe and able to live free from neglect and abuse*.**

  Leading on the Transforming Care Programme (TCP), reviewing community resources to support effective transition from out-patient to community services and securing reductions in the levels of community to provided services for people with Learning Disabilities.
  Appropriate challenge of providers through reporting and analysis of safeguarding concerns and Route Cause Analysis (RCA) in ensuring proportionate responses in terms of quality improvement and outcomes for users of services.

  Clear organisational safeguarding structures and governance arrangements.
  Designated Nurse – Adult Safeguarding appointed to strengthen BHR CCG's commitment to adult safeguarding agendas including MCA/DoLS and PREVENT.

How has the organisation supported practitioners to understand and embed the six principles of safeguarding (Care Act 2014 updated 201*5)*

EMPOWERMENT

Key Achievements/Successes

Ensuring safeguarding adults is embedded with the development and addition of Safeguarding Standards within contracts. Proactive approach to safeguarding by conducting quality and assurance monitoring visits to commissioned services.

Seeking of feedback from people at risk of abuse via locality patient forum groups.

Development of a Nursing Home Strategy in order to gather various elements of soft intelligence to translate into measured levels of risk. Allowing us to plan the appropriate levels of response and monitoring within an early warning system.

PREVENTION

Key Achievements/Successes

Leading on the Transforming Care Programme (TCP), reviewing community resources to support effective transition from out-patient to community services and securing reductions in the levels of community to provided services for people with Learning Disabilities.

Regular concise reports presented to the Governing Body on high risk safeguarding and quality concerns within the local health economy.

The Benchmarking and analysis of internal processes following introduction of The Care Act.

Extensive participation in local quality and surveillance forums with appropriate follow-up of concerns.

PROPORTIONALITY

Key Achievements/Successes

Appropriate challenge of providers through reporting and analysis of safeguarding concerns and Route Cause Analysis (RCA) in ensuring proportionate responses in terms of quality improvement and outcomes for users of services.

Developing processes for the early identification of emerging risks through an effective partnership approach to safeguarding concerns.

A regular and proactive approach to Safeguarding Adult Review (SAR) meetings.

Lead agency for the Performance & Assurance sub-group.

PROTECTION

Key Achievements/Successes

Clear organisational safeguarding structures and governance arrangements.

Designated Nurse – Adult Safeguarding appointed to strengthen BHR CCG's commitment to adult safeguarding agendas including MCA/DoLS and PREVENT. Effective review of provider policies and procedures relating to adult safeguarding, MCA/DoLS to provide assurance of effective, legal and robust responses to concerns.

Assessed as having areas of good/outstanding practice following a safeguarding "Deep Dive". CQC using work seen as an identifier of good practice for other commissioning services.

PARTNERSHIP

Key Achievements/Successes

Active engagement and proactive attendance and the local SAB.

Development of a Transforming Care Pathway Board that has input through user voices, taking a system-wide approach to effective transition.

Effective integrated work-streams between internal child-protection and adult safeguarding functions.

ACCOUNTABILITY

Key Achievements/Successes

Effective internal “safer recruitment” practices.

Strengthening accountability of providers to ensure their own “safer recruitment” processes.

Appropriate challenge of adherence with regulation of commissioned services through CQRM, quality and surveillance visits.

Your long and short term risks and priorities

- Empowerment of those individuals having care provided through individualised budgets or personal assistants in relation to keeping themselves safe and understanding their own vulnerabilities.
- Development and communication of a single, whole health economy approach to adult safeguarding; including acute, community, private and third sector agencies.
- Effective collection and analysis of SAB-wide safeguarding adult’s data dashboard containing valuable knowledge to assure improvements are made where required and areas of good practice identified.

Example of Effective/Emerging Practice (can be a sentence or two.)
Joint work with Designated Nurses for Safeguarding Children in cases where child protection concerns are identified with children moving towards transformation into adult services.

Metropolitan Police Havering

Brief summary of service as it relates to Safeguarding Adults

The MPS responds to calls for assistance from a variety of forums, spanning the emergency requiring an immediate response to the slower less time critical requests for assistance.

Havering officers provide a 24/7, 365 days a year service to the people of London. We have Emergency Response Teams augmented by Safer Neighbourhood Teams and the more specialist services provided by the Community Safety Unit (CSU).

The CSU’s remit is the more protracted, complex and serious crime allegations. Supported through Multi Agency Partners.

Havering has London’s first fully integrated MASH, staffed by 1 Police Sergeant, 2 PCs and 4 support staff (all part-time equating to 2.3 members of staff).

Havering Police provide the initial RAG rating and disseminate cases to partners for action, addressing fast time actions and mitigating risk.

The MASH deal with about 400 Merlin enquiries and 75 Adults Coming to Notice referrals each week.

2. Review of Safeguarding Activity 2015-2016

What has your organisation done in terms of your own agency safeguarding priorities?

Havering Police are an active participant on the Adult Safeguarding Board.

Havering has adopted operational safeguarding toolkits which reflect the Care Act requirements as approved by the commissioners policy forum in Autumn 2015. Havering Mash conduct risk

assessment and research of potential adult safeguarding incidents that are identified through front line business.

How has your agency utilised the views of adults and carers to improve services?

Staff within Havering borough are utilising the LSCB training on various safeguarding topics.

The MPS has corporate structures with rank specific areas of responsibility for the recording and management of incidents.

Police have a formal process for the investigation of complaints providing unsatisfied service users with a conduit for airing complaints. Havering Police are also key partners in statutory and non-statutory serious case reviews. Key decisions and identified failings can be disseminated within the organisation both locally and pan London.

3. How has the organisation contributed to the Havering SAB *Vision statement:*

The MPS have introduced operational safeguarding toolkits.

Frontline staff have received mandatory training on the vulnerable assessment framework.

Additional training is being rolled out for all staff who work under the MPS umbrella.

Havering staff attend LSAB strategic and operational meetings to ensure the statutory requirements are met in support of the vision.

4. How has the organisation supported practitioners to understand and embed the six principles of safeguarding (Care Act 2014 updated 2015*)*

- Empowerment: adults are encouraged to make their own decisions and are provided with support and information
- Prevention: Strategies developed to prevent abuse and neglect
- Proportionate: Least intrusive response is made to balance with level of risk
- Protection: Adults offered ways to protect themselves, and a co-ordinated response to adult safeguarding given
- Partnership: Local solutions reached through partner collaboration
- Accountability: Accountability and transparency in delivering a safeguarding response

The MPS gather, risk assess and refer relevant information. Havering Police do not have any services of support and rely on our partners to follow up on referral provided.

Front line officers have all received mandatory training on the Vulnerability Assessment Framework. This enables officers attending every call to assess the vulnerability of victims, witnesses and suspects. Details of vulnerabilities identified are recorded on Cris and Merlin records.

All Merlins are subsequently reviewed in line with the MPS Mash protocols and where appropriate levels of risk are identified information is shared with Havering Adult Social Services.

5. Your long and short term risks and priorities

The short term risk is the backlog of referrals awaiting research within the Police Mash. The organisational risk both short and long term is the vulnerability of a victim, witness or suspect not being identified by the initial responding officers/supervisors, leading to serious neglect or death of an adult where MPS information has not been shared through the Mash protocols.

6. Actions to be taken to address the risks and the expected impact on outcomes

Havering Police identified a significant backlog in referrals both child and adult of up to 300. This is currently sitting at 11 adults awaiting research. This has been managed through an additional police officer post being put into Mash.

Officers have also attended briefings on serious case reviews (Family Z) Details of which have been disseminated within the organisation.

7. Example of Effective/Emerging Practice (can be a sentence or two.)

Havering Mash identified that the quality of referrals was becoming generic and lacked information requiring remedial action within the Mash. A training package was devised and delivered to all Havering staff which has seen an improvement in the quality of referrals. This has contributed to the reduction in outstanding referrals through the reduction of remedial activities of the MASH staff.

The introduction of a daily referral review at the MASH has ensured shared understanding of the reason for referrals and also expectation management here by the time taken and amount that can be achieved with a referral.

North East London Foundation Trust (NELFT)

Officer completing the report: Helen Davie Specialist Safeguarding Adults Advisor and Helen Bowman Clinical Lead Safeguarding Adults.

1. Brief summary of service as it relates to safeguarding adults

Safeguarding Adults responsibilities as set out in the Care Act 2014 are to safeguard an individual over the age of 18 whom:

- Has needs for care and support;
- Is experiencing, or is at risk of, abuse or neglect ;
- As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

This relates to NELFT because, as an NHS organisation, we come into contact with children and adults with care and support needs both directly through providing a service to them and indirectly, through providing a service to a member of their family.

The Chief Nurse & Executive Director of Integrated Care Essex is the executive lead and board member for safeguarding. The Chief Nurse has Board level responsibility for safeguarding adults and children, LAC and Prevent, which is the health service component of Contest; the British governments counter terrorism strategy.

NELFT has a well-resourced Safeguarding Team to support and guide frontline staff and their managers. This is actualised via a 'Duty' system with dedicated Safeguarding Adult's professionals staffing a helpline, email account and walk-in advice and guidance service for all NELFT staff. Additionally, they review safeguarding adults internal electronic incident reporting (Datix) where there is a potential safeguarding concern regarding either a Child or Child and Adult.

The team also delivers Mandatory Training regarding Safeguarding Adults, Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS) and Counter Terrorism (Prevent/Channel). By doing so learning and themes gained from cases brought through the Duty Desk can be immediately translated into the training of frontline staff and good practice highlighted across the whole organisation.

NELFT Safeguarding Children's Team has a co-located Duty Desk for staff to discuss safeguarding concerns relating to those under the age of 18. The co-location of Adult and Children's Safeguarding Team in July 2015 now allows for a "Think Family" approach and allows enhanced screening of cross of information where there may be intergenerational abuse.

2. Review of Safeguarding Activity 2015-2016

Impact from legislation and policy changes had resulted in an increase in activity in relation to MCA/DoLS, PREVENT and harmful practices i.e. PREVENT has become a mandatory training requirement. Therefore the introduction of a 1.0 WTE Safeguarding Adults Clinical Lead Team Manager and 1.0 WTE Safeguarding Adults Clinical Lead MCA, DoLS and PREVENT was part of the consultation.

3. How has your agency utilised the views of adults and carers to improve services?

There is a patient centred approach to care across NELFT services demonstrated in individualised care planning and empowering approaches to management. Service user empowerment and involvement is demonstrated throughout the Safeguarding Adults, MCA and Domestic Violence, Equality and Diversity training delivered throughout the organisation.

Compliance around service user involvement in all aspects of care is monitored against the CQC Fundamental Standards outcomes and any exceptions are reported monthly. The practice Improvement team support services and deliver localised training around patient centred care.

Service user experience questionnaires extend to specific measures of patient centred care the results of which go back to teams who use them to inform improvements. All patients who access mental health and community services are sent a questionnaire about their experience of care and treatment and results are reported back into teams to improve practice.

Any proposed changes in service delivery receive input from service user forums and service users participate in trust wide recruitment days. Direct service user feedback is provided at Trust Board level and incorporated in conferences across NELFT.

4. How has the organisation contributed to the Havering SAB *Vision statement:*

To make sure that Adults at risk from harm in Havering are safe and able to live free from neglect and abuse.

NELFT ensure that all staff working within the organisation have access to the appropriate advice and guidance to enable them to raise Safeguarding concerns and to keep the patient and service user at the centre of all decision making. In addition, there is an acknowledgement that support for carers and relatives is essential. Work has been undertaken to ensure that through training and awareness raising, there is increased referrals to Advocacy services including Independent mental capacity advocates (IMCAS) and Independent Domestic Violence Advocates (IDVAS).

The activity regarding making referrals is monitored by the safeguarding adult's duty desk and saw an increase of enquiries to 140 for Havering in the last quarter of 2015. Overall a total of in excess of 600 safeguarding alerts were made by NELFT across all boroughs in 2015.

5. **How has the organisation supported practitioners to understand and embed the six principles of safeguarding (Care Act 2014 updated 2015*)***

The six principles of safeguarding are specifically referred to during all levels of safeguarding training delivered by the NELFT Safeguarding Adults Team.

- **Empowerment: adults are encouraged to make their own decisions and are provided with support and information.**

Within NELFT we are committed to involving patients and service users in all decisions regarding their care and treatment through the gaining of consent. As an Organisation, NELFT want to engage with patients/service users about the outcomes they want at the beginning and middle of supporting and working with them and then be able to demonstrate at the end, the extent to which those outcomes have been realised.

A Quarterly Consent audit is now undertaken by the Safeguarding Adults Team which is in line with the principles of 'Making Safeguarding Personal'. It audits against the standard that consent will be sought to raise safeguarding alert to the Local Authority in 100% of instances. There is the recognised exception: when a person is deemed to lack capacity and a best interest's decision is required, when patient/service user is acting under duress/ undue influence and when it is in the public interest or legal restrictions where a crime has or will be committed. The most recent audit findings have demonstrated that there has been significant improvement overall with Havering reaching the required standard of 100% with all referrals. Raising awareness around Domestic Abuse, historical abuse and harmful practices amongst frontline staff also supports patient and service users to feel empowered around decision making required in order to keep themselves safe.

- **Prevention: Strategies developed to prevent abuse and neglect**

In order to continue to ensure all staff within NELFT understand their roles and responsibilities in relation to safeguarding patients and service users from abuse, considerable work has been undertaken to ensure Safeguarding adults training compliance for staff working is maintained above 85%. Overall training compliance for NELFT staff working in the borough of Havering at the end of 2015, was an average of 93% across Recognition and Referral, Enhanced and Strategic delivered in accordance with staff groups.

Safeguarding training has been extended to cover Domestic abuse and Harmful practices.

Following the Counter Terrorism and Security Bill (2015) Prevent training also became mandatory for all NELFT staff in July 2015. Safeguarding adults and children's team became integrated following a service consultation in August 2015. They now both operate co-located Duty Desks, where frontline staff can directly access advice and guidance in relation to safeguarding concerns. This further embeds the "Think Family" approach and will often prevent safeguarding concerns escalating.

The specialist safeguarding advisors have initiated a high visibility campaign shadowing staff in community and inpatient settings. Staff are supported and encouraged to recognise where potential abuse may be taking place within a service user's experience and as part of the high visibility campaign service users are informally met with and invited to voice any concerns or fears they may have, particularly in relation to the care they are receiving.

- **Proportionate: Least intrusive response is made to balance with level of risk.**

NELFT staff work alongside patient, service users and their families to ensure that any interventions are proportionate to the level of risk. This is done effectively through a multidisciplinary approach and through seeking specialist advice where appropriate. A

success in relation to proportionality is the increase in appropriate application of the Deprivation of Liberty Safeguards (DoLS). There has been a significant increase in the number of authorised applications in community inpatient settings which indicates the impact of training, visibility of Specialist safeguarding and the role of the dedicated DoLS administrator which has supported the process significantly in the last year. A challenge remains in terms of sustained embedding of Mental Capacity Act and DoLS application. A success of the NELFT Safeguarding Adults Duty Desk and the high visibility of Safeguarding Clinical Advisors both in the community and in-patient settings has encouraged more effective case management and effective communication between service users, those closest to them and the services involved in their care. A challenge identified this year continues to be additional ways of capturing service user feedback specifically in relation to the safeguarding process and desired outcomes from the perspective of the service user.

- **Protection: Adults offered ways to protect themselves, and a co-ordinated response to adult safeguarding given.**

NELFT ensures that staff working within the organisation have access to the appropriate advice and guidance to enable them to raise Safeguarding concerns and to keep the patient and service user at the centre of all decision making. In addition there is an acknowledgement that support to carers and relatives is also essential. Work has been undertaken to ensure that through training and awareness raising there is increased referrals to Advocacy services including Independent mental capacity advocates (IMCAS) and Independent Domestic Violence Advocates (IDVAS).

Significant work has been progressed by the Lead for Domestic Abuse and Harmful practices in relation to the production of specific guidance for staff around completion of appropriate risk assessment tools to identify Domestic Abuse(DASH-RIC) indicating the need to refer to the Multi Agency Risk Assessment Conference (MARAC). MARAC conferences across NELFT reported an increase of between 10-15% reporting of high risk cases and over 20% increased reporting of medium to low risk cases. On-going analysis suggests that the increase is partly aligned to increased awareness. Representation by NELFT practitioners at MARAC remains at 100%.

- **Partnership: Local solutions reached through partner collaboration**

NELFT continues to embrace and engage in partnership working in order to ensure the effective safeguarding of not only patient and service users but the wider community. Members of the Safeguarding team and operational staff are regular attenders of SAB subgroups which extends to chairing of the Case Review, Quality and Audit and Transition subgroups. Full contribution to the annual development days is always maintained.

NELFT hosted a self-neglect conference in the early part of 2015 which looked at learning from a previous Serious Adult Review and looked at ways to strengthen how partner agencies can work together to effectively to provide the most appropriate support and safeguarding when self-neglect occurs. Staff are trained in the principles of effective information sharing with partner agencies to facilitate the safeguarding of adults with care and support needs. Successful partnership work has taken place this year between the Prevent Lead and the Prevent engagement officers which has extended to training delivered to the safeguarding Team to increase the knowledge of staff.

- **Accountability: Accountability and transparency in delivering a safeguarding response**

NELFT continues to revise policies and procedures in line with changes in legislation, local and national guidance to ensure all staff are aware of their roles and responsibilities in relation to safeguarding. The Safeguarding Adults policy has been reviewed in line with the Care Act (2014) and Prevent, Domestic Abuse and DoLS procedures have been

implemented. NELFT participates in annual self-assessments in relation to Safeguarding to identify areas where improvement is required and set out priorities. In addition in the last year there has been more effective partnership working between the Serious Incident, Safeguarding and Complaints team and HR to ensure that any concerns relating to delivery of care are appropriately investigated and that learning is shared to prevent a similar incident occurring in the future. Where harm has occurred NELFT adheres to duty of candour being open and honest and involving service users and their relatives. Lessons learned strategy has been developed to look at the variety of ways learning can take place.

6. Your long and short term risks and priorities

An identified challenge is the further embedding of the Mental Capacity Act and Deprivation of Liberty Safeguards and this is planned priority for the coming year. The challenge remains around transferring knowledge around the Mental Capacity Act (2005) into application and the support of patients and service users. NELFT Safeguarding Adults Specialist Clinical Advisors have continued to support the In-patient units across NELFT and have been providing bespoke training to staff on those units around the application of the Mental Capacity Act and Deprivation of Liberty Safeguards. Additional training has also been provided to Mental Health In-Patient Units, particularly in relation to the interface between the Mental Health Act and the Mental Capacity Act. Looking to the future, NELFT are looking into alternative ways of delivering Mental Capacity Act training.

NELFT aims to maintain 85% compliance for Prevent E-learning and face to face WRAP training, and to embed the Channel referral procedure into routine business in regards to the safeguarding of children, young people and adults.

A challenge identified this year continues to be additional ways of capturing service user feedback specifically in relation to the safeguarding process and desired outcomes from the perspective of the service user.

Actions to be taken to address the risks and the expected impact on outcomes

MCA and DoLS training became a mandatory requirement for qualified staff Band 5 and above in July 2016. An E-learning package has been launched and staff have the option to complete training, although there is still the provision for staff to attend face to face training if required.

Following the Counter Terrorism and Security Bill (2015), Prevent training has also become mandatory for all NELFT staff from July 2015 delivered by E-learning package and face to face to priority staff groups.

7. Example of Effective/Emerging Practice (can be a sentence or two.)

After a full consultation in August 2015, the safeguarding adults and children's team became integrated and now both operate a daily duty desk where frontline staff can directly access advice and guidance in relation to safeguarding concerns. This has further embedded the think family approach and early access to advice and interventions can prevent safeguarding concerns escalating.

The specialist safeguarding advisors have initiated a high visibility campaign shadowing staff in community and inpatient settings. Staff are supported and encouraged to recognise where potential abuse may be taking place within a service user's experience and as part of the high visibility campaign service users are informally met with and invited to voice any concerns or views they may have, particularly in relation to the care they are receiving.

National Probation Service

Brief summary of service as it relates to safeguarding adults

The role of the National Probation Service (NPS) is to protect the public, support victims and reduce reoffending. It does this by:

- assessing risk and advising the courts to enable the effective sentencing and rehabilitation of all offenders;
- working in partnership with Community Rehabilitation Companies (CRCs) and other service providers; and
- directly managing those offenders in the community, and before their release from custody, who pose the highest risk of harm and who have committed the most serious crimes.

In carrying out its functions, the NPS is committed to protecting an adult's right to live in safety, free from abuse and neglect.

Review of Safeguarding Activity 2015-2016

What has your organisation done in terms of your own agency safeguarding priorities?
National training for the National Probation Service on Safeguarding Adults, e-learning and classroom is being rolled out.

There is a network of Safeguarding Adult SPOCs/ leads within each cluster across the division. There are quarterly meetings for this group to discuss best practice and developments.

A reflective practice approach is encouraged through NPS London and is committed to ensuring the SEEDS (Skills for Effective, Engagement, Development and Supervision) is used across the Division. This featured in the Business Plan for 15/16.

There is a nominated lead for Safeguarding Adults in the NPS London.

Responsibilities of the NPS for Safeguarding Adults are made clear in national policy and guidance documents.

A National Policy and Guidance document has been published.

How has your agency utilised the views of adults and carers to improve services?
NPS issues an Offender Survey twice yearly to ask offender's feedback on their views of the organisation. The feedback from these surveys inform operational delivery plans and local commissioning arrangements.

A policy has been developed to ensure exit interviews are taking place so that feedback and evaluation can be used to improve the services and support provided to offenders, victims and their families.

How has the organisation contributed to the Havering SAB *Vision statement:*
The NPS is committed to:

- Making sure there is senior management recognition of the importance of safeguarding adults. To help achieve this, there is a designated senior manager who represents NPS at SAB, CSP and LSCB. The senior manager ensures that there is a

clear line of accountability within the borough for safeguarding adult work and that safeguarding is embedded within relevant local practices and processes.

- Promoting the duty to co-operate as a relevant partner under section 6 of the Care Act 2014, at both the strategic and operational level, in the exercise of functions relating to offenders in the community who have care and support needs or who are carers.

How has the organisation supported practitioners to understand and embed the six principles of safeguarding (Care Act 2014 updated 201*5)*
Empowerment: adults are encouraged to make their own decisions and are provided with support and information.

NPS issues an Offender Survey twice yearly to ask offender's feedback on their views of the organisation. The feedback from these surveys inform operational delivery plans and local commissioning arrangements.

A policy has been developed to ensure exit interviews are taking place so that feedback and evaluation can be used to improve the services and support provided to offenders, victims and their families.

Improvements are being made to the NPS case management system to more accurately record adult safeguarding concerns, so that services can be more appropriately targeted and focused based upon need and priority.

National training has been developed and an e-learning module is available for all staff. There is a one day face to face training for staff who work directly with offenders which was rolled out in February 2016. The training makes links to Prevent, safeguarding children, domestic violence and equality and diversity issues.

Prevention: Strategies developed to prevent abuse and neglect
NPS work directly with offenders and thus the organisational focus is upon protection of the public and reducing the risk of further offending and a reduction in harm posed.

In the past year there has been evidence of increased number of safeguarding referrals. This is linked to the delivery of mandatory safeguarding training for all staff, as well as identified local Safeguarding Adult 'champions' who attend relevant multi agency meetings and support front line colleagues to identify and escalate safeguarding concerns. 'Making Safeguarding Personal' has been incorporated into training events.

NPS has National guidance, policy and training for Domestic Violence. The Serious Organised Crime work stream is being developed within London and Nationally (which incorporates response to modern slavery).

Local engagement in MAPPA, MARAC and offender management (including enforcement of licences/Orders) highlights the organisational priority to prevent abuse and neglect from taking place.

Proportionate: Least intrusive response is made to balance with level of risk
NPS hold statutory responsibility to work with offenders. Delivery of interventions and protective measures are considered on a case by case basis to ensure proportionality, that the needs of the individual are met and the protection of current and potential future victims is ensured.

To ensure and monitor proportionality across the London NPS division, a Senior Manager holds central oversight and strategic lead for Safeguarding Adults. This enables learning from DHRs, SCRs, SARs, SFOs, MAPPA Serious Case Reviews to be collated centrally and shared across the London division.

Performance and data reports are regularly produced to identify resource needs and interventions that need to be commissioned locally to ensure adequate safeguarding measures can be considered and implemented as required.

Multi-agency forums such as MAPPA, MARAC and MASH are central for NPS to ensure proportionality and appropriate utilisation of resources across the cluster.

The NPS has written guidance and procedures for handling complaints and allegations against staff and this is accessible to staff. This includes whistle blowing.

Protection: Adults offered ways to protect themselves, and a co-ordinated response to adult safeguarding given
Safeguarding Adults is included in the existing NPS London Business Plan.

There is a network of Senior Probation Officer and practitioner safeguarding adult single points of contact (SPOCs) within each cluster/ business area.

There are a number of policy documents and processes, and some in development which reflect the organisations commitment to safeguarding adults. These include: a NPS National Partnerships Framework for Safeguarding Adults Board, June 2015. Probation Instruction 11/2015 Adult Social Care and PI 2/14 – Safeguarding of children and vulnerable adults.

Safeguarding Adults – A quick guide has been issued to all staff which reminds them of their responsibilities regarding safeguarding adults.

London NPS is currently part of a national pilot which introduces increased powers for the Head of Cluster to make licence variations and amendments as deemed appropriate. This allows for immediate intervention and protective measures in circumstances where an individual may be identified to pose, or be vulnerable to, a risk of imminent harm to others.

Partnership: Local solutions reached through partner collaboration
The document, 'NPS National Partnerships Framework for Safeguarding Adults Board' (June 2015), sets out the expectation that where possible a local senior manager attends the Safeguarding Adult Board. As such the Head of Cluster is identified representative at CSP, LSCB and SAB within BDH which ensures appropriate level of organisational representation and a consistent approach to facilitate joint learning and appropriate liason. This also ensures appropriate engagement and contribution towards Safeguarding Adult Reviews as required. The document also specifies that probation staff should attend Board sub groups as required and this is now fully established within the local boroughs.

The findings from Serious Further Offences, MAPPA Serious Case Reviews and other internal audits are shared where appropriate with external partners.

Local information sharing agreements are in place and there is a good understanding of local information sharing protocols.

Accountability: Accountability and transparency in delivering a safeguarding response
Probation is one of the responsible authorities for Multi-Agency Public Protection Arrangements (MAPPA) and works with the police, prisons and duty to co-operate agencies in protecting adults vulnerable to abuse who are potential victims of MAPPA nominals or who are subject to MAPPA directly themselves.

Your long and short term risks and priorities
Within 3 months: To ensure the principles of making safeguarding personal are embedded in staff practice – Development of staff supervision to ensure that safeguarding adults is a constant agenda item for discussion.

Within 3 months: Incorporate feedback and outcomes from offender surveys into the Cluster Delivery plan to ensure that adult safeguarding consideration are imbedded and fully considered in cluster development activity during 2016-17.

Within 6 months: There is a need to review local information sharing practice to ensure that decisions regarding the management of an offender fully incorporate a multi agency approach. This will assist to prioritise preventative measures that can be considered and implemented to ensure the ongoing safeguarding of the public and individuals we have a statutory responsibility to supervise within custody and the community.

Within 6 months: Performance recording of referrals – Improvements to the NPS case management system will allow for accurate recording of adult safeguarding concerns. This will ensure that performance and data can be more robustly reviewed to ensure that referrals are being undertaken in all appropriate cases.

Example of Effective/Emerging Practice

Development of NPS case management system to improve how safeguarding adult concerns are identified and recorded. This will improve accuracy of performance reports and assist to identify

HEALTH & WELLBEING BOARD

Subject Heading:	Havering's Local Account 2015/16
Board Lead:	Barbara Nicholls, Head of Adult Social Care and Commissioning
Report Author and contact details:	Caroline May, Head of Business Management 01708 433 671 Caroline.May@havering.gov.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

Local accounts should be published each year by local authorities who have responsibility for adult social care services. These accounts are designed to provide residents and service users with information on their council's adult social care performance, activity and objectives. This Havering Local Account summarises adult social care and support achievements in 2015-16 and ambitions for the future.

Local accounts form an important part of the Towards Excellence in Adult Social Care (TAASC) which is a national programme of sector improvement led by the Association of Adult Social Services Directors and the London Government Association. Local Accounts provide a key mechanism for demonstrating accountability for performance and outcomes. Local accounts can also be used as a tool for planning improvements, as a result of sharing information on performance with people who use services and engaging with them to get feedback on their experience.

The London Borough of Havering Adult Social Care Services Local Account 2015/16 is the third local account that will be published and it explains:

- What is Adult Social Care
- Who we provide services to and what they cost
- Case studies of the outcomes achieved for those receiving services
- What our priorities for 2016/17 will be

It will be published on our website to report publicly on performance and provides accountability to local people and partners.

RECOMMENDATIONS

That the Health and Wellbeing Board note the Local Account 2015/16 prior to publication.

REPORT DETAIL

The key messages of the Local Account 2015/16 include:

The Services we Provide:
Havering Council has a responsibility to care for and protect the borough's most vulnerable residents. The Council also helps all local people to help themselves, live independent lives and stay involved in their local community.

In 2014/15, we supported 7,500 service users with 5,500 over the age of 65. This included over 2,600 people over the age of 85.

This increased to more than 7,770 in 2015/16 – a 2.7% increase from last year - with almost 6,117 of them over the age of 65. This included 3,080 over the age of 85.

The Financial Challenge
Havering Council faces significant financial challenges due to funding reductions and increasing demand for services. Demand is increasing in terms of numbers of people who need care and support, and also in terms of complexity.

We are actively developing savings plans to address budget shortfalls, in line with overall Council budget plans and considering how we will continue to provide Adult Social Care services. This may mean that we have to provide services in different and innovative ways in order to address the funding reductions that we are seeing. 2015/16 savings were £5.2m against a budget of £52m (representing 10% of the service budget).

National and Local Context
Demand for adult social care services is increasing. In the UK people are living longer lives and this is resulting in a rise in the number of older people in the population. According to the Department of Health, 80% of older people will need care in the later years of their lives. Havering's population has increased by 3.1%

between 2011-13, with an increase of 5.3% in residents aged over 65 years. Havering's population is set to swell to 282,999 by 2031 – an increase of 18%.

The number of over 65s in Havering is set to increase to 57,100 by 2031 and the number of over 85s is set to increase to 9,300. The ageing population is also living longer and the Council must address the needs of each individual as they arise.

The Care Act 2014
The Care Act 2014 is the most wide-ranging reform to adult social care in nearly 70 years that, for the first time, places adult care and support law into a single clear statute. The Care Act imposes a duty on local authorities to promote individual wellbeing when carrying out any of their care and support functions in respect of a person. This duty is sometimes referred to as the "wellbeing principle" because it is a guiding principle that puts wellbeing at the heart of care and support system.

Much work has taken place to ensure that Havering is compliant with those aspects of the Care Act which came into force on 1 April 2015. This is a large and complex undertaking that has been delivered through a programme management approach.

Joining up Health & Social Care
Havering is working with regional agencies including the Greater London Authority to secure devolution at a local level. Devolution is the statutory delegation of powers from central government to govern at a local level.

Integrated Social Care Teams
In 2015 co-located teams were established in place in Cranham and Harold Hill, with two more locations in Romford and Rainham/Elm Park to co-locate in 2016. The locations house social work and health (North East London Foundation Trust - NELFT) teams.

Service Objectives
The Local Account states our objectives which are as follows:

1. Care Act Implementation and Personalisation – modernising our service from end to end, including our provider market.
2. Integration – working with health and other partners to deliver seamless services centred on people who need them.
3. Commissioning - developing and signing up to a coherent strategic framework setting out our priorities for Havering with its partners.
4. Quality and Safeguarding – strengthening safeguarding arrangements and ensuring high quality services and that services are safe.
5. Workforce development – having a motivated and skilled workforce, both internally and externally.
6. Finance and Performance – balanced budgets, deliver savings and improve/sustain performance.

Safeguarding
During 2015/ 16 the board focused on Care Act 2014 compliance. In December 2015 the Board adopted the revised Pan London Safeguarding Adult Procedures. The

introduction of the new procedures, which were revised to take into account the Care Act, was supported by the Havering Safeguarding Adults Board with a week of briefings in March 2016 open to staff from all agencies.

Mental Capacity Act Deprivation of Liberty Safeguards (MCA DOLS)
The application of MCA and DOLS has remained a major focus. Highlighted in last years local account was the Supreme Court Judgment in March 2014, which has continued to significantly impact on the number of applications during 2015/16. There were 560 referrals with numbers expected to increase significantly by 2016/17.

Information and Advice
Information is fundamental to enabling people, carers and families to take control of, and make well-informed choices about, their care and support and how they fund it. In Havering, following a consultation it was felt an organisation based in the local community would be best placed to provide residents with information and guidance about care and support. The preferred option was to make use of existing community resources with the service operating from community hubs, which are places or buildings where people already go that are easy to access, rather than from one building in one location as was the previous service model. The Care Act 2014 places a duty on Local Authorities to: *'…establish and maintain a service for providing people in its area with information and advice relating to care and support for adults and support for carers'.*

Complaints and Compliments
There has been a very slight increase in the number of complaints received within Adult Social Care. However what has been noted is that there is a continuing trend of increased complaints regarding disputing charges. As a result of this, a working group was set up to look at ensuring that correct and consistent information was provided regarding paying for care. This group produced a financial checklist and a financial charging case note. Use of this and the impact will be monitored through 2016/17.

There have been a variety of compliments received some of which are reflected in the Local Account.

Priorities
The Local Account outlines the priority areas in Havering and the plans for the future. These priority areas include:

- **Focus on prevention and early intervention** through working more effectively across the Council to reduce the need for intervention and services in the first place, and support residents to be self care as much as possible.

- **Be more ambitious** integrating services with our health partners to provide seamless care and support to residents. We need to provide more services that are joined up with health, provided by the NHS, and social care, provided by the council.

- **Provide more choice** and increase the take-up of personal budgets and direct payments. This is key to helping people manage their own care. We will also help shape Havering's care market to ensure real choice and control for everyone whether through a local authority managed budget, a direct payment, individual service fund or for those who self fund their own care.

- **Be more strategic in how we commission and contract services** not just across the council but with our health partners and with residents shaping the decisions we make.

- **Embrace our new responsibilities under the Care Act** fully modernising our services including how we assess people's needs, put together a support plan, provide choice and control, improve well-being and maximise independence. In Havering, care and support is changing for the better as a result.

- **Continue to strengthen our safeguarding arrangements** to make sure we are doing as much as we can to protect people from abuse – preventing it happening in the first place and in dealing with issues quickly.

- **Ensure our workforce has the right tools** to do the job and feels confident in meeting the challenges ahead. Our new Principal Social Worker will help us focus on outcomes for people rather than our processes, our senior management restructure will help us integrate services with our health partners, and our Assistant Chief Executive will ensure the needs of adults are always the priority.

- **We need to ensure we effectively manage the council's largest budget** in light of significant demographic pressures and increased demands.

The challenges ahead

With even more Havering residents dependent on care and support services provided by Havering Council and its partners, the biggest challenge remains meeting the needs of a growing number of service users - particularly those aged over 65 - with the resources and funding available.

In 2014/15, we supported 7,500 service users with 5,500 over the age of 65. This included over 2,600 people over the age of 85. This increased to more than 7,770 in 2015/16 – a 2.7% increase from last year - with almost 6,117 of them over the age of 65. This included 3,080 over the age of 85.

A range of services have been provided to support people to stay as independent and healthy as possible. We have seen an increase in those we support who receive long-term adult social care support, and those with mental health issues.

Whilst the need for services is continually increasing and will continue to rise, the financial challenges and the need to be create in delivering services become more difficult. Havering has a growing population with a profile that is ageing, with needs that are more complex. With Havering facing more cuts in funding in the next four

years, the challenges in continuing to provide quality services to our residents within available resource will continue to manifest.

IMPLICATIONS AND RISKS

The Local Account must be produced and published annually to meet Government requirements.

Financial implications and risks:

The financial situation, as outlined in the 2015 local account, remains challenging with large savings targets and growing demand. We continue to work closely with partners and agencies to manage resources wisely and target these to support those who are most vulnerable in our society.

There are no direct implications arising from this report which is for information only.

Falil Onikoyi, Strategic Finance Business Partner

Legal implications and risks:

Whilst there is no strict requirement for the Local Account to be produced and published this is recommended by the Local Government Association and there is minimal risk in so doing**.**

Stephen Doye, Legal Manager (litigation)

Human Resources implications and risks:

There are no direct implications arising from this report which is for information only.

Cheryl Graham, Strategic HR Business Partner

Equalities implications and risks:

The local account sets out how the Council has delivered and will continue to deliver services to communities in Havering and as such will protect the most vulnerable members within these communities.

Savinder Bhamra, Corporate Policy & Diversity Advisor

BACKGROUND PAPERS

- The Havering Local Account 2015

London Borough of Havering

Adult Social Care Services Local Account 2015/16

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Contents

London Borough of Havering

Adult Social Care Local Account 2015/16

Introduction & Foreword

Welcome to the third Local Account for adult social care services in Havering. The Local Account is an important part of the Government's plan to let people know about their local care and support services for adults and how well they are performing. It also gives us the opportunity to make more information available to residents on our successes, challenges and priorities.

Foreword: adult social care in Havering

With London's oldest population, adult social care services in Havering are instrumental in helping individuals and their families live independent and fulfilling lives in all parts of the borough.

This is reflected in the amount that Havering spends on adult social care. With the largest budget in the Council of £52.9 million - around 36 per cent of the Council's total net budget - we help over 7,500 people each year use services ranging from reablement to residential care.

However, demand for our services are increasing at a time when people are living longer, our population is swelling and funding for services is reducing.

In an age of austerity, making the best use of our resources, working in partnership with a range of care providers, providing choice, shaping the local care market and improving the experience of service users is essential.

We are doing this by integrating our services with health partners, providing early help, intervention and preventative measures to stop care and support needs from developing and helping our residents live as independently as possible in the comfort of their own homes.

The Council has strong partnership arrangements in place with the local NHS, the community and voluntary sector and, with our Integrated Care Coalition, the neighbouring boroughs of Barking and Dagenham and Redbridge.

In this local account, we aim to make it easy to see how we are progressing. Although we recognise that we are on the way to delivering better outcomes for our service users we know we can - and will - do much more to improve the lives of all Havering adults.

Cllr Wendy Brice Thompson, Cabinet Member for Adult Services and Health

Barbara Nicholls, Director Adult Social Care

What is Adult Social Care?

Adult Social Care (ASC) is about providing personal and practical support to help people live their lives, supporting them to maintain independence, dignity and control, with individual wellbeing at the heart of every decision.

ASC services are provided after a care assessment, and are subject to a national eligibility criteria. Services might include assistance with mobility, help with daily chores, short-term assistance after a period of illness, or adaptations to someone's home. The intention is always to help people remain independent in their own homes wherever possible, although support may be provided in a community setting or in a care home. We also look to provide personalised care wherever possible; an individual might receive a direct payment or personal budget to enable them to purchase tailored care to meet their needs. An important part of social care is safeguarding vulnerable people.

Adult Social Care services (ASC) in Havering helps and supports residents with the highest social care needs. Our service users may have a range of needs and include:

- older people; and
- people with physical disabilities, learning disabilities, mental health needs, and people with memory and cognition needs.

We also offer support for the unpaid carers of those receiving our services.

The services we provide and what they cost

Havering Council has a responsibility to care for and protect the borough's most vulnerable residents. The Council also helps all local people to help themselves, live independent lives and stay involved in their local community.

From equipment & adaptions to direct payments, assistive technology to leisure activities, Havering provides a range of support to help people do as much as they can for themselves and stay healthy.

For those who need it most, Havering Council and its partners provide services that aim to help them lead better, and more comfortable, lives.

In 2014/15, we supported **7,500** service users with 5,500 over the age of 65. This included over 2,600 people over the age of 85.

This increased to more than **7,770** in 2015/16 – a 2.7% increase from last year - with almost 6,117 of them over the age of 65. This included 3,080 over the age of 85.

Table 1: What adult social services did from April 2015 to March 2016

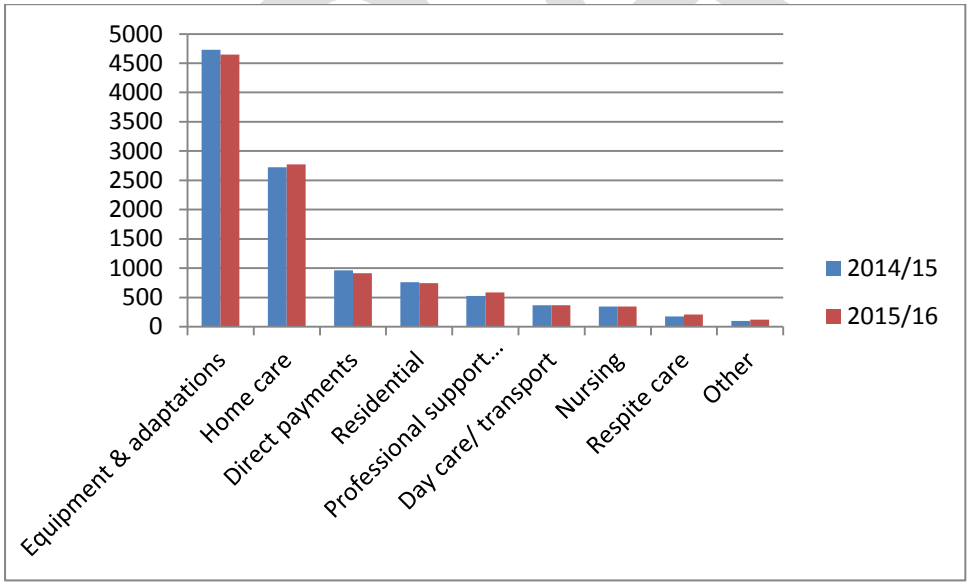
2014/15	2015/16	
3776	3887	People receiving long-term adult social care support
811	867	Carers received an assessment of their needs
1570	1500	Older people supported in the community
465	481	Older people living in residential accommodation
656	668	People with mental health issues supported by services
151	155	Working age people with learning disabilities living in residential or nursing accommodation
2055	2358	People who received a direct payment or personal budget
1787	3027	Support plans reviewed with service users
860	848	Referrals for adult safeguarding

A further breakdown is detailed below. It should be noted that some people may receive more than one service during the year, and this table shows the number of instances that each service was provided during 2015/16.

Table 2

	2014/15	2015/16
Equipment & adaptations	4732	4,646
Home care	2724	2,775
Direct payments	961	916
Residential	759	746
Professional support (services provided as part of a care plan)	527	586
Day care/ transport	368	370
Nursing	347	346
Respite care	176	210
Other	102	124
	10,696	10,719

The graph below represents table 2 visually:



Although numbers increased significant savings were still delivered, as outlined in the financial challenge section.

The financial challenge

Havering Council faces significant financial challenges due to funding reductions and increasing demand for services. Demand is increasing in terms of numbers of people who need care and support, and also in terms of complexity. For example, we are seeing people with different types of dementia coming to us for support. We are supporting a growing population in Havering with a profile that is ageing. We must continue to meet our responsibilities which are laid out in stature in the Care Act 2014, the Mental Health Act 2007; as a society we carry a moral responsibility to support our most vulnerable individuals but this is also enshrined in law. Overall the Council needs to reduce its total budget by around a third by 2018.

Havering is facing huge funding cuts to our revenue support grant, which has traditionally been the main funding source for local authorities. The table below illustrates how our grant will diminish:

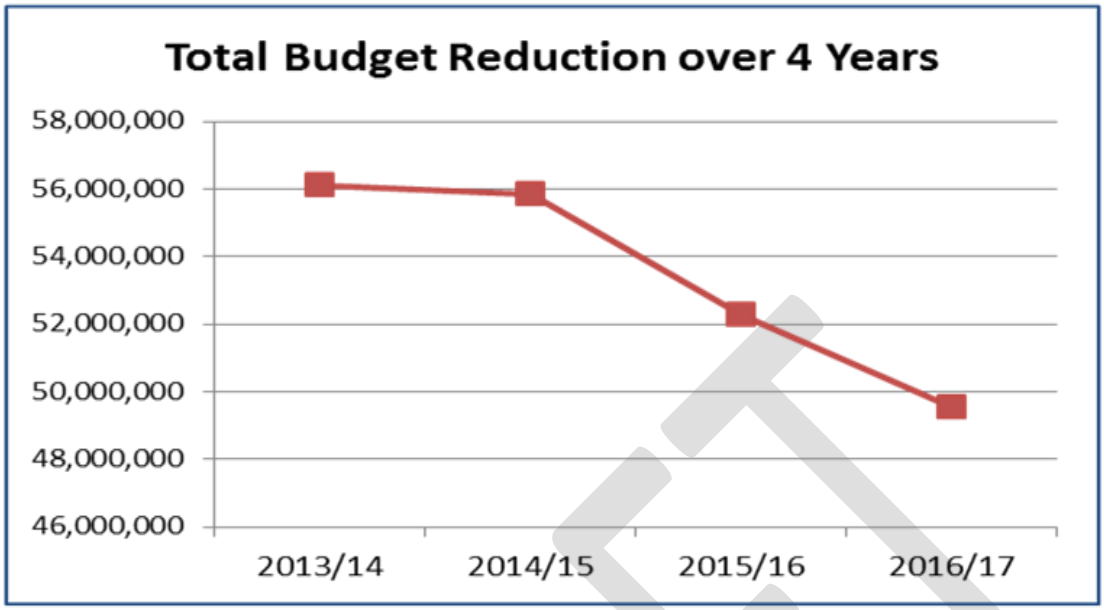
Table 3: Funding cuts

	2015-16	2016-17	2017-18	2018-19	2019-20
Core Funding	**(m's)**	**(m's)**	**(m's)**	**(m's)**	**(m's)**
Revenue Support Grant	30.443	20.890	12.284	6.847	1.376

Government has recognised at a national level demand and budgetary pressures facing adult services, as such local authorities have the option to levy an additional council tax precept of 2% for Adult Social Care. Havering has applied the additional precept, but this is not enough to bridge the funding gap we see opening up in terms of Adult Social Care services.

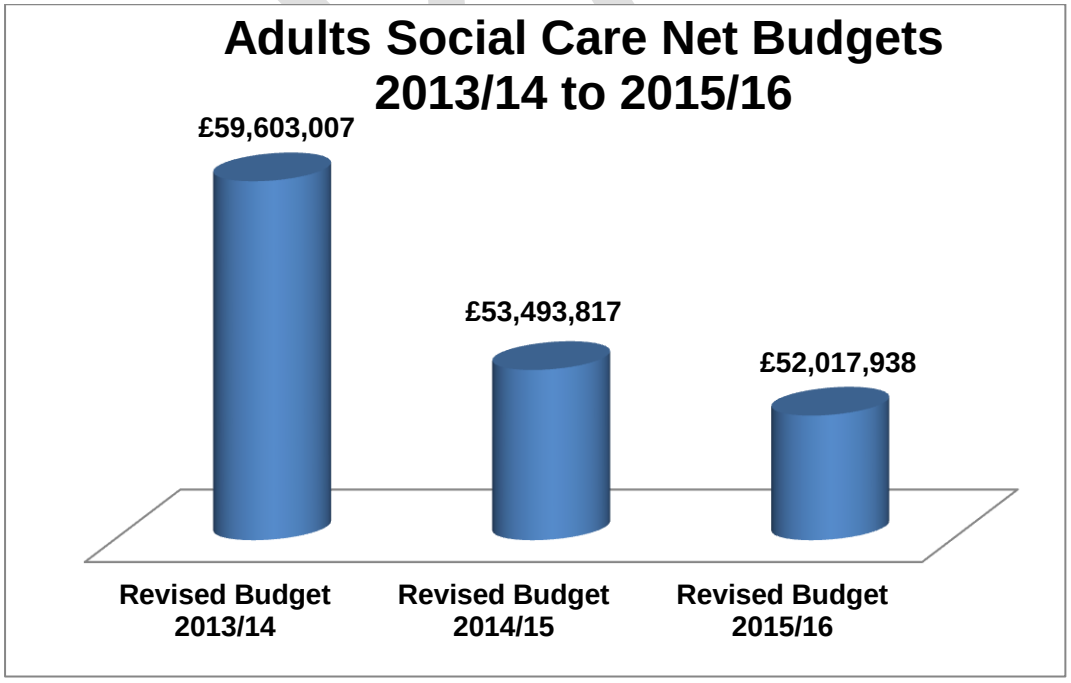
Equally, as Table 3 shows, the main Revenue Support Grant received by the Council is reducing significantly by 2019/20, and the Government is looking at how funding for essential services provided by councils will work in the future. This includes changes to the way local business rates are managed, and for adult social care, working more closely with our local NHS partners (including GP's, community health services and acute hospital services), including jointly funding services where it makes sense to do so. We have started this work already, and whilst recognising there are tough challenges ahead, we know that it is important that we continue to deliver services that help our most vulnerable residents achieve outcomes that are important to them.

The following graph illustrates the scale of the budget reduction that we expect to be facing:

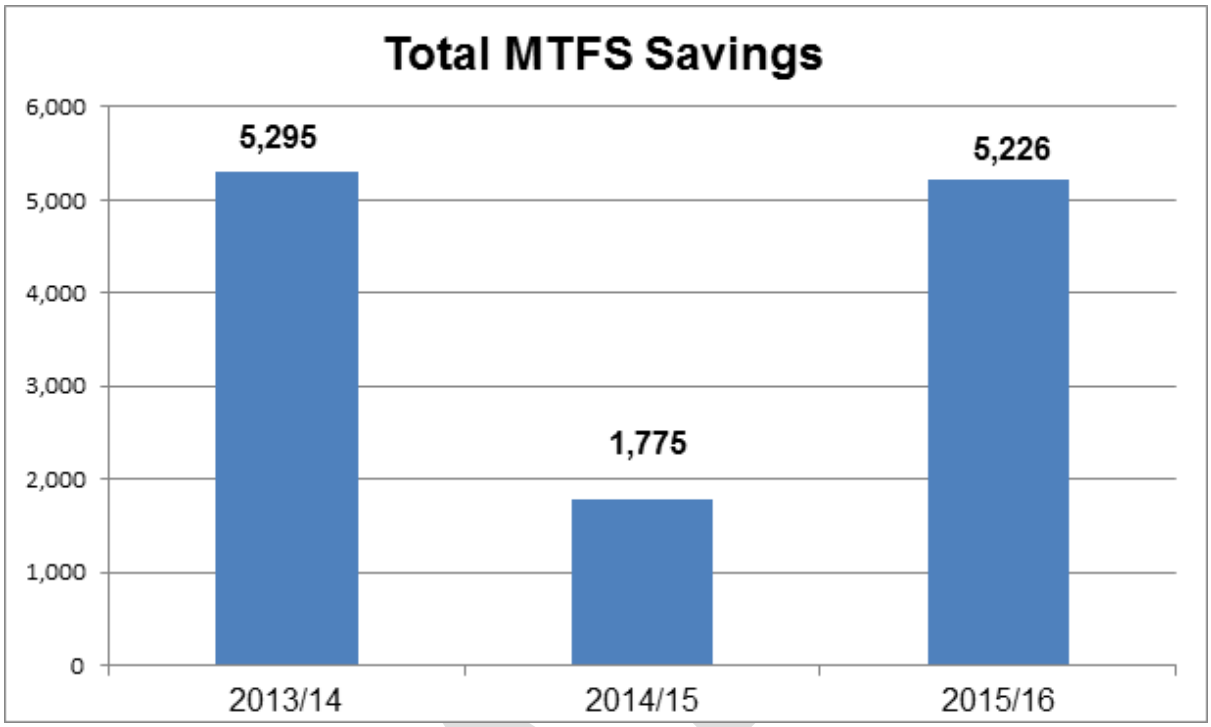


We are actively developing savings plans to address budget shortfalls, in line with overall Council budget plans and considering how we will continue to provide Adult Social Care services. This may mean that we have to provide services in different and innovative ways in order to address the funding reductions that we are seeing.

The graph below shows the ASC budgets year on year:



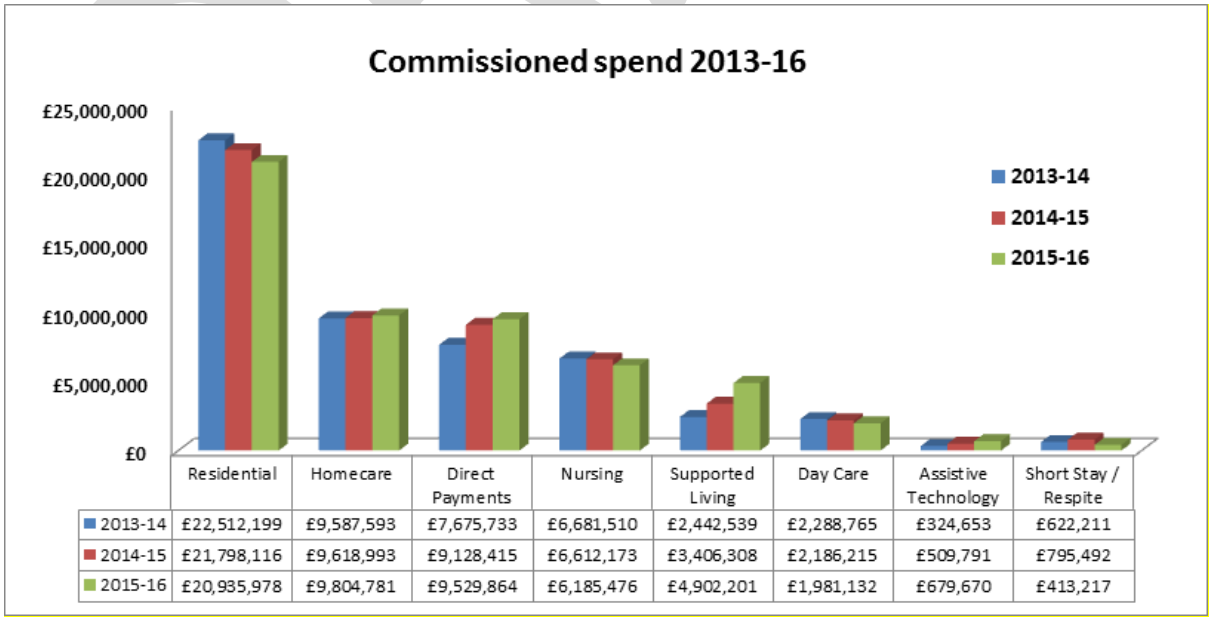
The savings we delivered were:



Note – MTFS stands for medium term financial strategy.

Growth was applied to areas of pressure during 2015/16, notably DOLS which is explained within the safeguarding section. The council tax precept was also applied within Adult Social Care Budgets. The net difference in budget between 2014/15 and 2015/16 was a decrease of £1,475,869.

This graph shows year on year spend by activity area:



	Residential	Homecare	Direct Payments	Nursing	Supported Living	Day Care	Assistive Technology	Short Stay / Respite
2013-14	£22,512,199	£9,587,593	£7,675,733	£6,681,510	£2,442,539	£2,288,765	£324,653	£622,211
2014-15	£21,798,116	£9,618,993	£9,128,415	£6,612,173	£3,406,308	£2,186,215	£509,791	£795,492
2015-16	£20,935,978	£9,804,781	£9,529,864	£6,185,476	£4,902,201	£1,981,132	£679,670	£413,217

Table above shows what we commissioned to spend over the past three years for the different types of service.

Havering in numbers

To illustrate the position in Havering and to give some context, here are some numbers related to the local population

In 2016/17 there were 249,085 residents living in Havering. Some 259,927 people are registered with a Havering GP.

51.97% of Havering's population are female, 48.03 per cent are male.

There are 191,827 people aged over 18 years. Of this, 43,345 (17.4%) people are over the age of 65, and 5,824 (2.3%) people are aged over 85.

With over 43 square miles, Havering is London's third largest Borough. Half of the Borough is greenbelt or parkland.

Havering is ranked 166 out of 326 local authorities for deprivation and 26 out of 32 London boroughs.

Havering's population is set to swell to 282,999 by 2031 – an increase of 18%.

The number of over 65s in Havering is set to increase to 57,100 by 2031 and the number of over 85s is set to increase to 9,300.

The life expectancy for men is 80.2 years and 83.9 years for women.

The National and Local Context

Ageing population

Demand for adult social care services is increasing. In the UK people are living longer lives and this is resulting in a rise in the number of older people in the population. According to the Department of Health (DoH), 80% of older people will need care in the later years of their lives. Havering's population has increased by 3.1% between 2011-13, with an increase of 5.3% in residents aged over 65 years. The ageing population is also living longer and the Council must address the needs of each individual as they arise.

Implementing the Care Act 2014

The Care Act 2014 is the most wide-ranging reform to adult social care in nearly 70 years that, for the first time, places adult care and support law into a single clear statute. The Care Act imposes a *duty* on local authorities to promote *individual wellbeing* when carrying out *any* of their care and support functions in respect of a person. This duty is sometimes referred to as the *"wellbeing principle"* because it is a guiding principle that puts wellbeing at the heart of care and support system.

Much work has taken place to ensure that Havering is compliant with those aspects of the Care Act which came into force on 1 April 2015. This is a large and complex undertaking that has been delivered through a programme management approach.

Sections 19 and 48 to 57 of the Care Act 2014 place a new temporary duty on local authorities to meet an adult's care and support needs and a carer's support needs when a registered care provider or agency becomes unable to carry on a regulated activity because of business failure. In response, amongst other changes, we have focused on developing joint commissioning arrangements with health and have produced a **Provider Failure Procedure**. The procedure explains what this duty means and Havering Council's approach to ensure that adults and carers are not left without the care or support needed if their care provider becomes unable to carry on providing it because of business failure.

Joining up Health & Social Care

Havering is working with regional agencies including the Greater London Authority to secure devolution at a local level. Devolution is the statutory delegation of powers from central government to govern at a local level.

In Havering we intend to use devolution authority to transform health and wellbeing. We recognise:

- the importance of preventing someone's needs from escalating by signposting to guidance, help and support early on;
- the importance of providing services close to home, where possible;
- the scale and complexity of the present health and care system
- the need to tailor solutions for different people
- The importance of infrastructure, including estates.

We have committed to explore, working with health partners and other local authorities to consider:

- removing barriers to make best use of health and social care infrastructure;
- pooled budgets;
- developing local services
- planning our workforce

As a part of this work, we are developing plans for working across Barking & Dagenham, Havering and Redbridge, to deliver a personalised and sustainable health and care service. This will help us address the budget pressure that we are facing across the wider geographical area, as well as in Havering.

Across local health and social care partners, the next few years will bring a combination of financial challenge and rising demand which is without precedent. Managing this situation will require more than the incremental cutting of elements of service. We need to accelerate work that is currently underway to strengthen prevention and to strengthen care in the community.

The Better Care Fund

The Better Care Fund (BCF) is a national programme which creates a local single pooled budget to enable closer working between the NHS and local government. It is designed to improve outcomes for people; drive closer integration between health and social care; and increase investment in preventative services in primary care, community health and social care.

The Havering Better Care Fund (BCF) is developing a health and social care system in which all adults are supported to live healthy, long and fulfilling lives. Havering Clinical Commissioning Group (CCG) and the London Borough of Havering want everyone to have more control over the health and social care they receive, for it to be centred on their needs, supporting their independence and provided locally wherever possible.

Integrated Social Care Teams

People benefit from care that is person-centred and co-ordinated within healthcare settings, across mental and physical health and across health and social care. For care to be integrated, organisations and care professionals need to bring together all of the different elements of care that a person needs. In summary, it is better to work together across health and social care, as well as with other partners such as GPs. s

A person's care may be provided by several different health and social care professionals, across different providers. As a result people can experience health and social care services that are fragmented, difficult to access and not based around their (or their carers') needs. Approaches that seek to address fragmentation

of care are common across many health systems, and the need to do so is increasing as more people live longer and with complex co-morbidities.

Integrated care may be judged successful if it contributes to better care experiences; improved care outcomes; and the delivery of more cost effective services.

Our BCF 2015/16 plan stated: The strategic objective will deliver by 2019: ‘A locality based integrated health and social care workforce comprising multi- disciplinary workforce across six GP cluster-based localities. Remaining sensitive to practice list profiles, the service will incorporate adult social care eligibility criteria in its risk profiling. It will include voluntary sector provision of local information and advice and integrate mental health professionals. This will ensure a smooth pathway between locality and specialist provision and to provide support to GPs and their patients in a similar way to physical health specialists. ‘Individuals will have a named care professional who will be responsible for ensuring their care is appropriately coordinated for their needs.’

Co-located teams are now in place in Cranham and Harold Hill, with two more locations in Romford and Rainham/Elm Park co-located by October in 2016. The locations house social work and health (North East London Foundation Trust - NELFT) teams.

, Next steps are that the service delivery model will be reviewed to agree how we can then progress towards full integration with NELFT partners. The key aim will be to have a joint approach to assessments and care planning and integrated packages of care.

In the future we intend to locate health and social care teams around GP clusters or localities in Havering. We are also working in partnership with the NHS to provide the technology to share social care records.

Health and Wellbeing Strategy 2015-2018

Between January and May 2015, we consulted on Havering's new Health and Wellbeing Strategy, to cover the period 2015 to 2018. Havering's Health and Wellbeing Strategy 2015-18 sets out eight priorities for tackling some of the borough's most challenging health issues, which are:

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

- Priority 1: Provide effective support for people with long term conditions and their carers so that they can live independently for longer
- Priority 2: Improve identification and support for people with dementia and learning disabilities and their carers
- Priority 3: Reduce obesity
- Priority 4: Reduce premature deaths from cancer and cardiovascular disease

Theme B: Providing better integrated support for people most at risk:

- Priority 5: Better integrated care for the "frail elderly" population
- Priority 6: Improve integrated care for children, young people and families most at risk
- Priority 7: Reduce avoidable hospital and long term care home admissions

Theme C: Improving quality of service and patient experience:

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

In total almost **200** residents, patients/service users, and carers were consulted. The responses to the 2015 public consultation provide further insights into the views, priorities and proposals of residents, local voluntary community organisation and partners.

The purpose of the strategy is to enable:

- all Health and Wellbeing Board (HWB) partners to be clear about our agreed priorities for the next three years
- all members of the HWB to embed these priorities within their own organisations and ensure that these are reflected in their commissioning and delivery plans
- key agencies to develop joined-up commissioning and delivery plans to address these priorities
- the HWB to hold member organisations to account for their actions towards achieving the priorities within the strategy
- members of the HWB to work with and influence partner organisations outside the HWB to contribute to the priorities agreed within this strategy; includes engaging residents in co-producing solutions

We have developed a delivery plan to implement the Health and Wellbeing Strategy. The Delivery Plan details the programmes and projects that will deliver the interventions identified in the Health and Wellbeing Strategy.

Our Objectives

Havering's Future

- We want Havering to be clean and to look after our environment for future generations.
- We want you to be safe – whether you're a pensioner walking through a town after dark, or a young child growing up without the security of a loving home.
- And we want you to be proud to live in Havering – where we respect each other, value our traditions and work together to improve our quality of life.

The Children, Adults and Housing directorate had seven priorities for 2015/16 that cut across its services, as follows:

1. Target our limited Resources on those who need the most support.

2. Work in partnership with Health and other key partners to deliver improved services and improved value for money through integration, including preparing and equipping our workforce for change and ensuring that our teams understand and appreciate one another's pressures and priorities.

3. Where needed we will intervene early to prevent further escalation of needs – by identifying emerging issues and intervening early.

4. People and communities will look after themselves and each other where possible.

5. We will effective signposting to the appropriate service.

6. We will seek to manage demand by prioritising the most cost effective provision.

7. We will seek to revitalise the voluntary sector to be best placed to deliver services in the most cost effective ways.

Following on from this, the service objectives were:

1. Care Act Implementation and Personalisation – modernising our service from end to end, including our provider market.

2. Integration – working with health and other partners to deliver seamless services centred on people who need them.

3. Commissioning - developing and signing up to a coherent strategic framework setting out our priorities for Havering with its partners.

4. Quality and Safeguarding – strengthening safeguarding arrangements and ensuring high quality services that are safe.

5. Workforce development – having a motivated and skilled workforce, both internally and externally.

6. Finance and Performance – balanced budgets, deliver savings and improve/sustain performance.

Older people

In Havering some 45,859 people are aged over 65. At over 18 per cent of the Borough's total population this is the largest proportion of older people in London. This age group tends to have the highest health and social care needs.

Most older people in Havering live healthy, independent and active lives without support from the Council and a large number receive care and support from family and friends – around 27,000 according to the 2011 census.

In 2015/16

- 272 older people were admitted to nursing or care homes, with an average age of 85yrs highlighting our on-going commitment to support committed to helping residents stay in their own home for longer,
- Almost 85% of older people using our reablement service were able to remain living in their own home after leaving hospital.
- We helped over 500 carers of older people with services like respite or a temporary care home stay for the person they care for.

Case study 1 – integrated services helping for Mr A and Mrs A

Mrs A aged 83 and Mr A aged 89 are an elderly couple living together. Mr A is the main carer for his wife who has dementia. The couple also received support daily from their daughter who lives in the borough, although she has health conditions and became unable to manage. A package of care was introduced to enable their daughter to visit less frequently. Mr A experienced several falls in a short space of time. A referral to physiotherapy was made and a walking stick was provided.

Mrs A was reviewed by a Memory Clinic and a Community Psychiatric Nurse was allocated. Mrs A received a support package provided by a health team, while Mr A's care remained with a community social worker. There was co-ordination across agencies to ensure all decisions were aligned – enabling clear definition of roles and responsibilities between health and social care, so that partnership working was enabled.

The impact on the daughter and her family has been reduced, and there have been no instances of crisis or further hospitalisation since.

Social Isolation Project

In response to the increasing issue of social isolation and loneliness in our community, we set up a Social Isolation Project. This Project is aligned with the Health and Wellbeing Strategy, and is themed to support older adults in the community. This approach focuses on addressing social isolation by supporting a

person to access services and support, for example existing community groups. This sis to increase their social networks

The project has provided evidence of a number of barriers which impact on the older adult achieving a positive change to their routine to engage in the wider community. It has also developed a broad understanding of wider community resources. This is informing service developments and commissioning plans.

- The Project has provided home visits to socially isolated older adults across the borough. Referrals are accepted from Health and Social Care Staff, the voluntary sector or individuals themselves.
- The Project provides a link for older adults into their local community and promotes network building and community connections.
- The Project has accepted 275 referrals and has actively worked with 138 older adults, providing varied levels of input to support the older adults to achieve their goals relating to social inclusion.
- Networking with a range of stakeholders has been essential to identifying positive solutions to enable older adults to overcome their barriers to engaging in the community.
- The project concludes in November 2016, and will provide recommendations on the ways forward to support our social isolated older adult community.

Supported Living
Supported living means that an individual is supported to live in the way that they wish. This is a housing model that offers support to live independently in the community.

In Havering we are looking to increase supported living services, where appropriate, to allow greater access to the community and increased choice and control.

Case study 2 : helping to start afresh with supported living

Mr Ks journey is an example of a success story of a transition from Long stay Hospital to the community made possible by the development of specialist supported living accommodation for learning disability clients.

Mr K is a 28 year old man with a moderate learning disability and epilepsy who spent his childhood in foster care and then lived in a variety of residential placements before he was 18 years old when he was placed in hospital following incidents of challenging behaviours and destruction to property. Mr. K was clear that he wished to return to the Havering area to maintain family links. With support from his social worker team, working with clinicians and Housing colleagues, this was made possible by offering him supported living accommodation commissioned specifically for learning disabled clients in purpose built flats.

As a result Mr K appears happier and healthier and is growing in confidence. The support team assist him to maintain his tenancy and manage his flat, thereby promoting his independence and dignity. He has recently said that he is ready to look for voluntary work, something his support workers are helping him with.

Supporting Havering's Carers

A carer is someone who looks after a relative or friend who because of age, physical or other disability cannot manage at home without help. This can range from personal care including toileting, washing and feeding to help with the shopping, housework or simply keeping them company.

During 2015/16 almost 2,000 carers were either assessed or received information and advice.

- Nearly 752 carers were signed up to the Havering Carers' Register, connecting them to a number of services and a wealth of information.

- 500 carers got a break from caring when the person they care for received respite care.

In 2015, we introduced the jointly produced Havering Carers Information Booklet. The booklet provides carers with an overview of a range of services and support in Havering, including how to access a carer's assessment and local voluntary and community sector support and contact details.

In June 2015, we launched the Havering Carers information e-bulletin, a quarterly electronic publication, which receives input from Council services, the Havering Clinical Commissioning Group and community and voluntary partners. There was also the re-launch of the Havering Carers Register and new sign up forms were produced and circulated across Havering. Over 750 carers are currently signed up to the Havering Carers Register.

The Havering Carers Forum was evaluated by carers and subsequently redesigned and a new Havering Carers Forum flyer was produced to provide people with the dates of the meetings well in advance. In February 2016, 85% of carers said that they found the Carers Forum very helpful to them. Voluntary and Community Sector service representatives were also regularly called upon to participate. Carers Personal Budgets were introduced in April 2015 and a Resource Allocation System for calculating an indicative budget for carers was introduced in June 2015. To date, over 50 eligible carers have opted to take up a Carers Personal Budget.

Next steps for 2016/17:

- We expect to see an increase in the number of carers signing up to the Havering Carers Register in 2016 to 2017.
- Officially launch the Joint Havering Council/Havering CCG Carers Strategy and Action Plan.
- Increase the number of carers signing up to the Havering Carers Register to receive carer's newsletters and invitations to carer's events etc.
- Deliver more dementia awareness training.

Some feedback we have received from carers who have had dementia awareness training is below:

"The dementia training has really made a difference to the way I will think and feel about dementia going forward. My dad is living with it at the moment and after today I think he will be able to 'live well' because of the extra support and understanding I will be able to provide him".

"I would advise retailers that awareness does not cost them anything – it is more about understanding. Dementia affects people in different ways, which means there are so many things that businesses may not have even considered. For example, many shops have black mats at their entrances. To some people with dementia, these can actually appear to be holes. We are not necessarily advising retailers to get rid of their black mats – just to get some dementia awareness training so that staff can spot someone who may be concerned or worried by it".

Dementia Friendly Community (with award)

Around 3,500 people aged over 65 live with Dementia in Havering and the Havering Dementia Action Alliance was developed with our partners to help those affected by the disease.

Nationally to date, over 1,730,260 organisations or teams have received dementia friendly training, 350 have completed it online and 1,965 clinicians who have been trained in dementia symptoms.

The Havering Dementia Action Alliance, which has more than 81 member organisations, 23 of those are GP practices and has won the Best Dementia Friendly Community Initiative in the Dementia Friendly Awards, and the Community Organisation Award for Disability in The National Diversity Awards.

Providing choice

Havering Council wants service users to have choice and control over the way care and support is provided.

Self directed support (SDS) covers personal budgets including Individual Service Funds, Council managed accounts and direct payments. Anyone who is assessed as needing care services has the right to request a direct payment instead of having services provided by the Council.

There are some limited circumstances when direct payments are not awarded but the majority of people already receiving, or assessed as needing services have a right to direct payments.

We intend to:

- Increase the proportion of service users who receive some form of self-directed support.
- Introduce a Havering Direct Payments Pre-paid account and card to make managing direct payment a lot easier.
- Reviewing the voluntary sector and continue to commission services that help people remain independent

Case study 3: A personal budget for Mrs D

A personal budget was set up for Mrs D. Her daughter recently told a Direct Payments Co-ordinator how receiving a personal budget for her mother has made a difference. She can now arrange extra care for her mother when she needs it, as direct payments work well because of the flexibility.

There is no need to have a fixed day and time for care to be provided, like there used to be in the past. Because of the flexibility a personal budget has been convenient in meeting Mrs D's needs.

Improving communication with social care providers

Havering strives to work closely with its stakeholders. Effective communication from both providers and the local authority is essential in achieving this aim and building better relationships.

Weekly email updates to social care and health providers

Havering Council produced a weekly email update to its social care and health providers. The bulletins' overarching aim was to inform providers of National best practice, innovations in how health and social care is provided globally and to notify services of new training opportunities, events, local projects and tenders.

Following the response to these weekly email updates, the Council is in the process of developing this into a scheduled e-bulletin that it is inclusive of health, children's and adult's social care information. With this, the local authority intends to expand on its e-bulletin content to incorporate information and advice, local and national news reports, best practice resources and provider-appropriate funding opportunities.

Calendar of provider forums dedicated to provision areas
The local authority schedules quarterly forums for its network of care providers. There are provider forums related to 'Homecare', 'Residential and Nursing', 'Voluntary and Community Sector' and 'Learning Disabilities and Autism' provisions. The forums range from frequencies of six weekly to quarterly and are developed in partnership with providers, with providers completing evaluation forms on the quality of agenda items, frequency of forums and the approach of Council officers. The forums enable an outlet for providers to make suggestions for future discussion areas and issues that they face. The Council intends to develop its provider forums further with its providers to help build better relationships and support the commissioning of services.

Online Care Network portal for social care and health providers
Havering launched its online Care Network for the Borough's social care providers last year. The network enables care providers of all sizes – from large care homes to small voluntary organisations – to discover what support is available, browse and book local training and events and, where appropriate, share service details and apply for tenders. The site allows providers to have a page dedicated to their organisation and the services they provide. There are opportunities for discussion through the network with online forums and private chat facilities.

There are plans to further develop and redesign some aspects of the Care Network in the next year in co-production with social care providers, in order to suit changes in need and demand, and to further improve and simplify communication. Providers can access the Care Network and request an account by visiting www.carenetworkhavering.org.

Developing the council's information and advice website in conjunction with providers
Havering Council has been improving its information and advice website in collaboration with social care providers in order to promote access to information, ensure consistency in out-going messages about social care and support and act as a resource for providers of services to keep informed of social care processes. Providers can access the information and advice website by visiting www.haveringcarepoint.org.

Developing information on the Havering Council website for social care providers
Havering Council provides a range of support to social care providers in Havering. It was recognised by providers that information about this support was not reflected on the Havering Council website. The Council responded to providers' needs and developed a webpage on the Havering Council website which contained information

for the adult social care workforce, in terms of training and support available, details of provider forums, Havering's vision and market position and how providers can apply for tenders in Havering. The webpage can be accessed on www3.havering.gov.uk/Pages/Services/adult-social-care-workforce.

Preventing or delaying the need for health and social care

The Council and its partners provide a number of services to help people recover faster from illness, prevent unnecessary admission to hospital or premature admission to residential care, enable timely discharge from hospital and help people live independently.

Reablement provides an intensive short term (six week) service to help people back into their own home and on the road to independent living once they leave hospital.

In 2015/16 we provided reablement to 1,191 people at home and 128 people received reablement at our residential facility at Royal Jubilee Court in Romford.

Only 5.9 per cent of services users who received reablement returned within 91 days for further ongoing care or support.

Case study 4: Reablement helped Mrs Clark get back on her feet and return home

Mrs C is a 78 year old lady who was living on her own in her one bedroom bungalow, until she had a fall outdoors when doing her shopping.

Prior to the fall Mrs C was very active and went out nearly every day to run errands. She believed that this was very important to stay fit and to keep herself occupied. Mrs C found being in hospital very difficult as she was confined to her bed. She was keen to be discharged home as soon as possible.

A recommendation for reablement support for up to 6 weeks was agreed. This would comprise of 3 support calls a day focusing on enhancing Mrs C's confidence and independent living skills. Mrs C was also provided with some equipment to aid her independence at home.

Two days after discharge, the Social Worker contacted Mrs C to follow up on how she was settling back at home. Mrs C continued to receive Reablement support initially 3 times a day but she had reduced it to 2 times daily in her 2nd week of being at home. The 4th week post discharge, Mrs C had made really good progress and was confident in managing her daily tasks, so no longer required support. The Reablement support was terminated and Mrs C continued to manage her day to day tasks independently.

Whilst adult social care works to support people with care needs to live their lives as independently as possible and enjoy the best quality of life as they can, we recognise that we have a part to play in supporting the wider council priority of reducing the need for our services in the first place. By supporting residents and communities to understand their own assets and abilities we aim to move to a different relationship with our residents. By assets we mean things that enable people to support themselves and be independent, for example we work with family and friends to build a supportive environment for individuals. When people feel confident to be able to do more to manage their lives in the way they want to, they become more independent, and don't need our services in the same way. This is all about helping people at the right time, and in the right way for them.

Safeguarding

An adult at risk is someone who finds it difficult to protect themselves from harm or abuse due to age, illness, disability or other impairment. Harm can be physical, psychological, sexual or financial and can be caused by another person, a carer or an institution.

Our Vision

'To make sure that Adults at risk from harm in Havering are safe and able to live free from neglect and abuse'.

At the center of all we do are Six Adult Safeguarding Principles, and our business plans and performance monitoring reflects these principles:

EMPOWERMENT – people feeling safe and in control, encouraged to make their own decision and giving informed consent. People feeling able to share concerns and manage risk of harm either to themselves or others

PREVENTION –it is better to take action before harm happens, so good information and advice are really important

PROPORTIONALITY – not intruding into peoples' lives more than is needed by responding in line with the level of risk that is present

PROTECTION – support and representation for those adults who are in greatest need because they are most at risk of harm

PARTNERSHIP – working together with the community to find local solutions in response to local needs and issues

ACCOUNTABILITY – being open about what we are doing and responsible for our actions - focusing on outcomes for people and communities

Havering Safeguarding Adults Board (HSAB)

The HSAB is the lead partnership with responsibility for ensuring that all adults at risk in the borough are able to lead safe, fulfilling lives and are not subject to abuse or neglect by others. The Board develops strategies to reduce risk and prevent harm adults and also co-ordinates and monitors how effectively partner organisations are working together as well as implementing their own safeguarding responsibilities.

The key objectives of the HSAB, as set out in the Care Act 2014 are:

- To help and protect adults in the London Borough of Havering who have need for care and support, are experiencing, or are at risk of abuse or neglect, and

as result of those needs are unable to protect themselves against the abuse or neglect or risk of it, and

- To co-ordinate and ensure the effectiveness of what each of its members does.

The HSAB must publish an Annual Report each year setting out how well it has achieved its objectives. During 2015/ 16 the board focused on Care Act 2014 compliance. In December 2015 the Board adopted the revised Pan London Safeguarding Adult Procedures. The introduction of the new procedures, which where revised to take into account the Care Act, was supported by the HSAB with a week of briefings in March 2016 open to staff from all agencies.

The HSAB also produced during 2015/16 an Escalation Policy to emphasise the need to challenge as appropriate to support staff from different organisations in feeling confident to raise issues, and test decision making in a constructive and safe way.

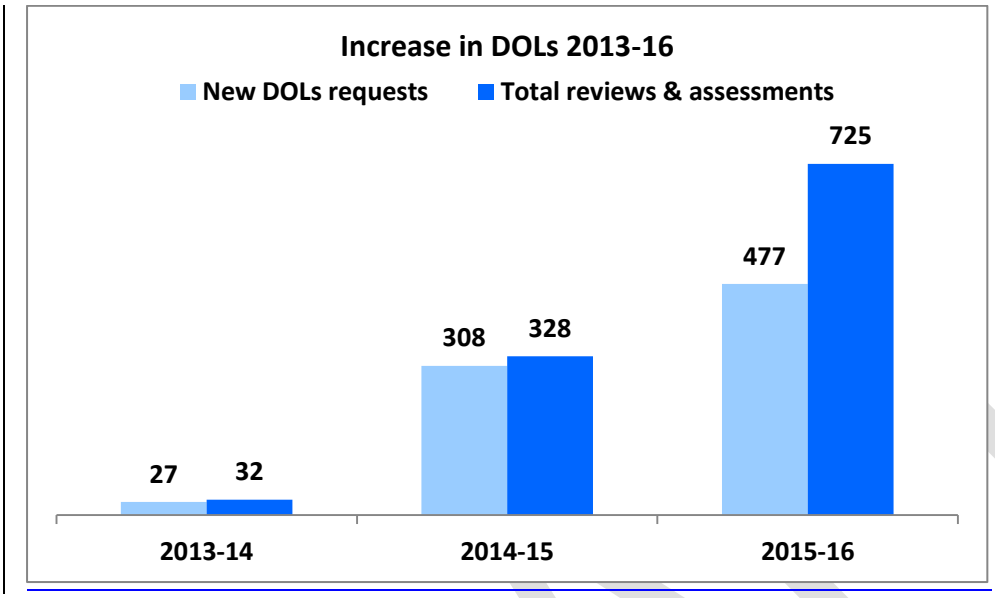
Making Safeguarding Personal (MSP)

MSP is about ensuring safeguarding is as centred on the individual whom the concern is about as is possible. MSP is starting to be applied within Adult Social Care, where we are focussing on outcomes people are looking for through actively participating in the safeguarding process. A measure of success is whether people are supported to meet their expectations and outcomes from our safeguarding interventions... There is a need during 2016/17 to ensure that all agencies adopt the MSP principle when interacting with adults at risk. To that end a review of all agencies current position will be undertaken.

We have embedded MSP within our new safeguarding toolkit. We have developed a questionnaire to get feedback from the adult at risk or their advocate, to see that MSP was evident in the process they went through and to evaluate the difference our intervention has made. We also undertaking a number of audits to ensure that there is a consistent approach throughout our service.

Mental Capacity Act Deprivation of Liberty Safeguards (MCA DOLS)
The Deprivation of Liberty Safeguards aims to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom or support living arrangement only deprives someone of their liberty in a safe way that is in their best interest... The application of MCA and DOLS has remained a major focus. Highlighted in last year's local account was the Supreme Court Judgment in March 2014, which has continued to significantly impact on the number of applications during 2015/16 as shown below:

	New DOLs requests	Total reviews & assessments
2013-14	27	32
2014-15	308	328
2015-16	477	725



To help us manage this increased demand on our service, we have the following priorities;

- To ensure that we have sufficient Best Interest Assessors to meet the forecasted demands.
- Raise awareness around the Deprivation of Liberty Safeguards and provide relevant training.
- Support providers to recognise when a person is being deprived of their liberty and refer in for an authorisation as soon as possible.
- Ensure that where a person is an unlawful deprived of their liberty immediate alternative options/solutions are explored.

Multi Agency Sharing Hub (MASH)

In June 2014, Havering became the first borough in London and one of the first authorities in the country to implement a joint children and adults MASH.
The purpose of the MASH is to improve the quality of information sharing and decision-making at the point of referral. This is achieved in Havering by facilitating the sharing of intelligence across agencies this enables the MASH to ensure safeguarding interventions are timely, proportionate and necessary. The MASH has a number of partners co-located such as Police, Public Protection, Housing, Probation, Adult Mental Health, Early Help Advisor and independent Domestic Violence Advocacy supported virtually by Youth Offending Team, Education, Drugs and Alcohol service.

Multi-agency training programme
There has been a training needs analysis to identify what training is being offered through the HSAB partnership and to plan future training needs.
There have been multi-agency briefing sessions to introduce the new Care Act guidance to those working with and supporting adults. Self-neglect was formally recognised as a category of abuse within the Care Act for the first time. As a result the Board offered two full training courses on self-neglect and hoarding which was attended by a variety of multi-agency professionals working in adult safeguarding, health and provider settings.

Case study 5: Safeguarding residents
Background to the case
The Safeguarding Adult Team received a referral. The police were called to the address by Mrs X because she had been assaulted that morning by her husband, who had left prior to the arrival of the police. Mrs X stated she has suffered an abusive relationship from her husband for the last few years. Police reportedly spoke to her 7 year old daughter who also confirmed the case of domestic abuse.
Action by SAT.
Following the safeguarding referral, several attempts were made to contact Mrs X by the phone without success. However, as the case appeared very urgent, it was triaged and referred to children's service due to the presence of child in a household where there was domestic violence.
In addition, a referral was made where professionals discussed the domestic violence concerns and measures were put in place to safeguard Mrs X and her daughter. The referral also triggered an IDVA referral (Independent Domestic Violence Advisor).
Outcome
Due to joint working between all professionals the husband eventually handed himself in at Romford Police Station and was arrested and placed in police custody, thus ensuring the safety of Mrs X and her child and to allow appropriate support to be put in place.
Mrs X has contacted us to express her support and has complimented all for all the support she has received as she now feels safer.

Information and Advice

'Information and advice is fundamental to enabling people, carers and families to take control of, and make well-informed choices about, their care and support and how they fund it. Not only does information and advice help to promote people's wellbeing by increasing their ability to exercise choice and control, it is also a vital component of preventing or delaying people's need for care and support.' (Care Act Guidance para 3.1)

The Care Act 2014 places a duty on Local Authorities to: '…establish and maintain a service for providing people in its area with information and advice relating to care and support for adults and support for carers'.

In Havering, following a consultation it was felt an organisation based in the local community would be best placed to provide residents with information and guidance

about care and support. The preferred option was to make use of existing community resources with the service operating from community hubs, which are places or buildings where people already go that are easy to access, rather than from one building in one location as was the previous service model.

During 2015/16:

- **New Care Point Information and Guidance Service was launched in September 2015** The service, provided by Family Mosaic, offers free independent information and guidance to Havering residents who want to find out more about care and support, health and wellbeing and advice for carers.
- **A total redesign of our information and advice website (Carepoint) was carried out.**

Since the launch the Care Point service has developed and extended its reach by increasing the number of community hubs used across the borough to provide residents with information. Care Point can be accessed in places such as, Romford Shopping Centre, Queen's Hospital, Children's Centres, Libraries, Job Centres and various GP Surgeries. A full list of locations where Care Point can be accessed are displayed on the Care Point website www.haveringcarepoint.org.

Over the last year Care Point has been working in partnership with a variety of stakeholders to build relationships, generate referrals and facilitate joint working. The stakeholders include

- GPs
- Healthwatch Havering;
- Adult Social Care;
- Children's Service;
- The Richmond Fellowship;
- Sycamore Trust;
- Salvation Army;
- Havering Disabled Association;
- Havering Mind;
- Citizens Advice Bureau;
- Age UK; and
- Carers Groups.

Since the launch the number of residents accessing Care Point has been increasing steadily each month. During the period 01/09/15 to 31/08/16, the service provided information and guidance to 3,277 Havering residents. The service has provided direct assistance to over 500 residents in relation to welfare benefits and blue badge applications over the last year.

Next Steps

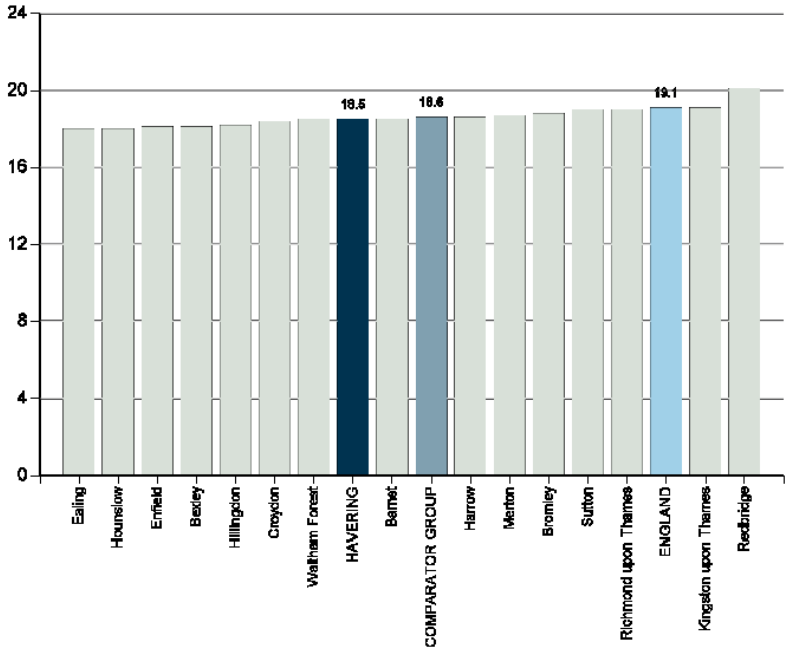
- Develop new ways of reaching people in the local community and varying the use of community hubs based on the demand.
- Target information and advice at particular parts of the community that are hard to reach or would benefit most from receiving the service.
- Continue to build relationships with local stakeholders to generate referrals and share information.
- Establish a local information and advice (I&A) steering group comprising of local I&A stakeholders, to ensure up-to-date information is maintained and reduce duplication.
- Support changes and improvements to the Care Point website based on feedback from the community

Feedback from our residents

ASS wants to ensure that residents have a say in how we plan and deliver services, how we can improve them, as well as take part in key decisions concerning changes to services. We use customer surveys, meetings, regular forums, complaints and compliments to make sure we know what is important to local residents to improve services and review progress.

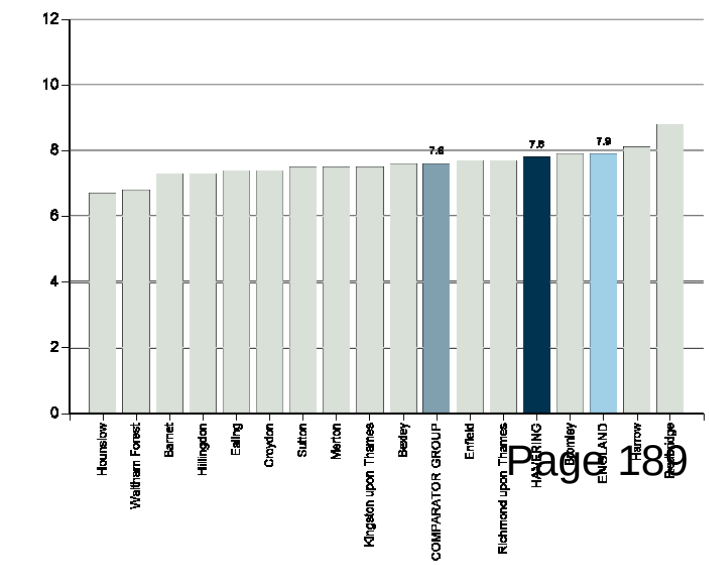
Two of the more formal ways of doing this are the ASC survey and the Carers survey. As these surveys are done by all councils in England who provide adult social care, they also help us to compare how we are doing. Nationally, the ASC survey is done once a year and the carer's survey once every 2 years.

Adult Social Care Survey



Social care related quality of life score this indicator gives an overarching view of the quality of life of users of social care. It is a composite measure based on responses to eight questions in the ASCS.

Carers Survey



Carer-reported quality of life score this measure gives an overarching view of the quality of life of carers. It is a composite measure based on responses to six questions in the Carer survey

Complaints and compliments

There has been a very slight increase in the number of complaints received within Adult Social Care. However what has been noted is that there is a continuing trend of increased complaints from people who use services and/or their families disputing charges resulting from our financial assessment of their ability to contribute to the cost of their care... As a result of this, a working group was set up to look at ensuring that correct and consistent information was provided regarding paying for care. This group produced a financial checklist and a financial charging case note. Use of this and the impact will be monitored through 2016/17.

Numbers of **complaints** over the last three years are as follows:

2015/16	2014/15	2013/14
93	92	108

There has been an increase in complaints around 'level of service,' which could reflect the increasing demand on resources that Adult Social Care are having to work within. With the implementation of the Care Act the indication is that more service users are challenging the level of service provided. The implementation of part two of the Care Act involving the finance aspects and the Appeals Panel process has been deferred until 2020 and it is not clear what the impact will be.

Closer working with providers has helped reduce the number of complaints involving providers, where we have seen a decline over the last two years. This is encouraging.

The number of new clients coming into the service during 2015/16 was 3,707 and this will be monitored in future years against the number of complaints received.

Below are some examples of the **compliments** received across the different areas:

Everything done in a professional manner and more assistance given than expected – ACT North

Thank you for all your time, patience and all your help in respect of my Aunt' – ACT South

A mother placed on End of Life care – *she was kept safe, warm and clean and was treated kindly and with respect. Even when she was at her most difficult, the patience of the nursing/support staff was outstanding*. – Cranham Nursing Home

Your carers were invariably courteous, helpful and tolerant and their good spirits, cheerfulness and good humour helped to get us through some very difficult and trying times – Community Care Line

It felt like you were listening to him and supporting him to make discharge easier on his aunt and this, he feels has led to a well-controlled discharge. – JAD

Thank you for all your support and care over the last 15 years. Thank you for listening to all our problems and seeing us through some very tough times. – Learning Disabilities

The carers have so far been lovely and she feels well supported and enjoys their company. – Medic2

Following a relative who died intestate a family member writes in - *I very much wanted the opportunity to give you feedback regarding the amazing way she has helped my family… You are extremely fortunate to have her managing this work, she really is a rare person in the busy world we live in* – Client Finance

Thanks to each and everyone of you, have made it possible for me to have the time and the great support to get my confidence back to return home. – Royal Jubilee Court/Reablement

For more information see the 2015/16 Annual Report (insert link)

Our Priorities for 2016/17

With ever more Havering residents dependent on care and support services provided by Havering Council and its partners, the biggest challenge remains meeting the needs of a growing number of service users - particularly those aged over 65 - with the resources and funding available.

With each generation in Havering living longer than the last it is important to ensure that people can enjoy these extra years in good health. Meeting the challenges ahead we will:

- **Focus on prevention and early intervention** through working more effectively across the Council to reduce the need for intervention and services in the first place, and support residents to be self-care as much as possible.

- **Be more ambitious** integrating services with our health partners to provide seamless care and support to residents. We need to provide more services that are joined up with health, provided by the NHS, and social care, provided by the council.

- **Provide more choice** and increase the take-up of personal budgets and direct payments. This is key to helping people manage their own care. We will also help shape Havering's care market to ensure real choice and control for everyone whether through a local authority managed budget, a direct payment, individual service fund or for those who self fund their own care.

- **Be more strategic in how we commission and contract services** not just across the council but with our health partners and with residents shaping the decisions we make.

- **Embrace our new responsibilities under the Care Act** fully modernising our services including how we assess people's needs, put together a support plan, provide choice and control, improve well-being and maximise independence. In Havering, care and support is changing for the better as a result.

- **Continue to strengthen our safeguarding arrangements** to make sure we are doing as much as we can to protect people from abuse – preventing it happening in the first place and in dealing with issues quickly.

- **Ensure our workforce has the right tools** to do the job and feels confident in meeting the challenges ahead. Our new Principal Social Worker will help us focus on outcomes for people rather than our processes, our senior management restructure will help us integrate services with our health partners, and our Assistant Chief Executive will ensure the needs of adults are always the priority.

- **We need to ensure we effectively manage the council's largest budget** in light of significant demographic pressures and increased demands.

Tell us what you think

We hope you have found this local account of Havering adult social care useful.

The requirement to publish our Local Account comes from the Towards Excellence in Adult Social Care (TEASC) Programme and from the national Association of Directors of Adult Social Care. The TEASC programme helps councils perform to the highest standard in adult social care.

Let us know your thoughts. Please email your views to adultsocialcare@havering.gov.uk and help us improve future accounts and publications.

Keep Informed

To keep up-to-date with the latest developments in adult social care in Havering, visit www.havering.gov.uk and subscribe to our email updates including Health and Well-being, Carers, Care Connect and Active Living.

Social care providers can sign-up to www.carenetworkhavering.org to connect with a range of information and training.

For further information on adult social care visit www.haveringcarepoint.org.uk

The Care Act 2014 can be found here:
http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

The Care and Support Statutory Guidance can be found here:
https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

The Mental Health Act 1983 can be found here:
http://www.legislation.gov.uk/ukpga/1983/20/contents

Glossary of Terms

Care and support assessment:
Under the Care Act 2014, Local Authorities must carry out an assessment of anyone who appears to require care and support, regardless of their likely eligibility for state-funded care. This is called a care and support assessment and it will focus on the person's needs and how they impact on their wellbeing, and the outcomes they want to achieve.

Devolution:
The transfer or delegation of power to a lower level, especially by central government to local or regional administration.

Direct payments:
Direct payments are payments made to individuals or carers who request them to meet some or all of their assessed and eligible care and support needs. They are one way of receiving a personal budget and are intended to give users greater choice in their care. The payment must be sufficient to enable the service user to purchase services to meet their eligible needs, and must be spent on services that meet eligible needs.

Greater London Authority (GLA):
The (GLA) is a top-tier administrative body or local authority for Greater London. It consists of a directly elected executive Mayor of London and an elected 25-member London Assembly with scrutiny powers. It was created in 2000 to fulfil the needs of London as a whole and to work with the boroughs in areas such as transport, planning, economic development, the environment, police, fire and emergency services, culture and health.

Making Safeguarding Personal
Making Safeguarding Personal is a shift in culture and practice in response to what we now know about what makes safeguarding more or less effective from the perspective of the person being safeguarded.

National eligibility criteria:
The national eligibility criteria can be found in the Care Act 2014 and set a minimum threshold for adult care and support and carer support. All local authorities must at a minimum meet needs at this level.

Personal budgets:
Personal budgets are an allocation of funding given to users after an assessment which should be sufficient to meet their assessed needs. Users can either take their personal budget as a direct payment, or – while still choosing how their care needs are met and by whom – leave councils with the responsibility to commission the services. Or they can take have some combination of the two.

Pooled budgets:
Pooled budgets combine funds from different organisations to purchase integrated support to achieve shared outcomes.

Reablement services:
Reablement services are for people with disabilities and those who are frail or recovering from an illness or injury. The aim is to help people regain the ability to perform their usual activities, like cooking meals, washing and getting about, so they can do things for themselves again, stay independent and live in their own home.

Revenue support grant:
Revenue Support Grant is a central government grant given to local authorities which can be used to finance revenue expenditure on any service. The amount of Revenue Support Grant to be provided to authorities is established through the local government finance settlement.

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Referral To Treatment Update BHRUT and BHR CCGs
Board Lead:	Alan Steward, Chief Operating Officer, Havering CCG
Report Author and contact details:	Sarah Tedford (BHRUT) and Louise Mitchell (BHR CCGs)

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

Our local Hospitals' Trust (BHRUT) and clinical commissioning groups (BHR CCGs) are working together to tackle unacceptably long waits for treatment for some patients across our area.

RECOMMENDATIONS

The Health and Wellbeing Board is recommended to: Review the joint presentation by BHRUT and the BHR CCGs and comment on progress so far and plans to further reduce waiting times for patients.

REPORT DETAIL

This presentation – delivered jointly by the Trust and the CCGs - updates Board members on the latest position around cutting the backlog of patients waiting for treatment, having been referred by their GPs. The presentation also updates on the status of Legal Directions issued against Havering CCG by NHS England in respect of this issue.

BACKGROUND PAPERS

Referral to treatment- PowerPoint

REFERRAL TO TREATMENT

NOVEMBER 16

Sarah Tedford
Chief Operating Officer
BHRUT

Louise Mitchell
Chief Operating Officer
BHR CCGs

TAKING PRIDE IN OUR CARE

Barking, Havering and Redbridge University Hospitals NHS Trust

CONTEXT

- Significant issues were identified with how the Trust had historically reported RTT
- Reporting suspended in 2014 - processes improved and data validated
- Unacceptable waits for some patients
- CCGs responsible for contract management and assurance
- Havering lead CCG for the BHRUT contract – Directions issued by NHSE in June 2016.

IMPROVING CARE

System-wide approach to improvements, working together to treat patients who had been waiting too long.

Range of measures including:

- Validation
- Outsourcing
- Theatre productivity
- Enhanced resource
- Demand and capacity work
- GP Referral demand management.

CLINICAL HARM PROGRAMME

Review of information on patients waiting more than 52 weeks to identify risk of harm and ensure they are appropriately and efficiently managed

Phase 1

- Focused on patients on admitted pathway
- More than 900 reviews carried out
- No moderate or severe harm identified.

Phase 2

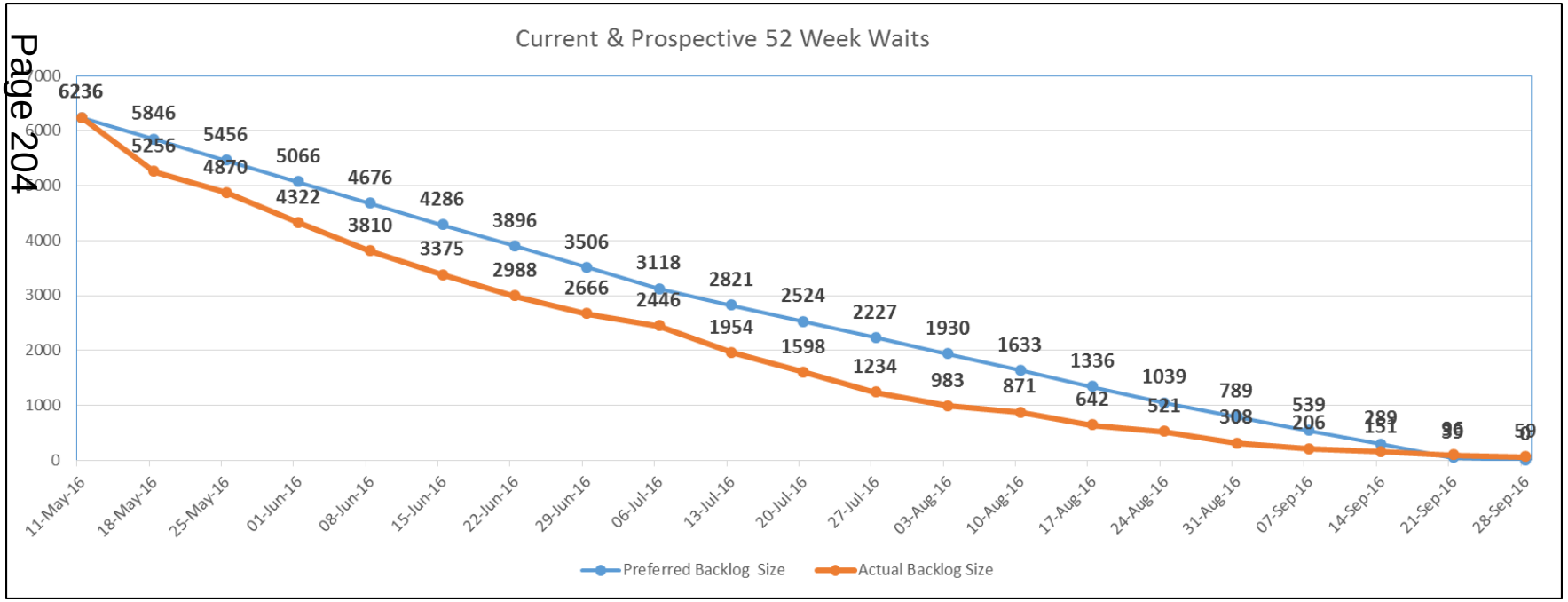
- Focused on patients on non-admitted pathway
- More than 3,500 reviews carried out
- No moderate or severe harm identified

DEMAND MANAGEMENT

- RTT prioritised by all three BHR CCGs
- Delivery responsibility - avert 30k GP outpatient referrals in year
- Range of alternative independent sector and community providers identified and contracted
- New clinical pathways designed jointly with BHRUT clinicians
- 10,000+ patients redirected by GPs at end Oct 2016.

PATIENTS WAITING FOR 52 WEEKS

- Working with our system partners to improve access to elective care for patients
- All long waiting patients have now been seen or have their appointment



PATIENTS WAITING MORE THAN 52 WEEKS

- We had three patients who breached the standard we have set on having no patients waiting longer than 52 weeks for treatment by the end of September. All of these patients have treatment plans and dates for next events in place.

- At the end of September we also had 42 patients who had been waiting longer than 52 weeks because they either chose to wait longer, did not attend or respond to our efforts to treat them sooner, or they have clinically complex needs which are extending their pathway of care. All of these patients have treatment plans and a date for their next appointment.

- We will not tolerate a situation where patients are having to wait longer than 52 weeks for treatment, and will continue to reduce waiting times to prevent this issue from arising again.

RESPONSE TO LEGAL DIRECTIONS ISSUED TO HAVERING CCG BY NHS ENGLAND

- System wide recovery Plan submitted to NHSE end September 2016 in response to the legal Directions issued in June 2016

- Plan sets out the detailed recovery trajectory to achieve the national RTT standard of 92% completed within 18 weeks

- NHSE Board currently reviewing our response to Legal Directions we await response.

RETURN TO REPORTING

- External assurance of progress
- Governance and Assurance Framework developed with a clear reporting line
- Robust, system-wide recovery plan submitted to NHS England
- Plan to resume reporting of RTT performance in December, publishing October's figures.

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	HRA Development
Board Lead:	Neil Stubbings Interim Director of Housing
Report Author and contact details:	As above

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 the Board with an update on the housing development proposals approved by Council and associated regeneration implications and aspirations.

RECOMMENDATIONS

That the board notes the report regarding new house building in Havering.

REPORT DETAIL

The report attached details the latest report agreed at cabinet on the 12th October. It contains the latest information regarding the councils house building programme, funded through the Housing Revenue Account (HRA) to provide affordable housing for local residents.

This paper is being presented to Health and Wellbeing Board for information and gives the Board an opportunity to raise any questions or points of clarification they may have regarding this programme.

BACKGROUND PAPERS

12th October 2016 Cabinet report: Housing Accommodation Plan: Review of HRA New Build proposals.

Havering
LONDON BOROUGH

CABINET
12 OCTOBER 2016

Subject Heading:	**Housing Accommodation Plan: Review of HRA New Build proposals.**
Cabinet Member	**Councillor Damian White** **Councillor Roger Ramsey**
SLT Lead:	**Neil Stubbings**, Interim Director of Housing. **Andrew Blake-Herbert**, Chief Executive Officer.
Report Author and contact details:	Neil Stubbings, Interim Director of Housing 01708 433747 neil.stubbings@havering.gov.uk
Policy context:	HRA Policy and budgets
Financial summary:	To receive an update on the HRA new build programme with associated financial impacts on the HRA Business Plan.
Is this a Key Decision?	**Yes**
Is this a Strategic Decision?	**Yes**
When should this matter be reviewed?	February 2017
Reviewing OSC	Towns and Communities

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

Havering will be clean and its environment will be cared for	[X]
People will be safe, in their homes and in the community	[X]
Residents will be proud to live in Havering	[X]

SUMMARY

At the 15 June Cabinet meeting, it was agreed that officers would start consultation with local residents and initiate procurement of a preferred partner for the delivery of 12 key regeneration sites for the provision of affordable housing, including older persons' housing. This report provides an update on the progress since that decision.

RECOMMENDATIONS

That Cabinet:

1. **Note** the outcome of the consultations carried out.
2. **Note** the progress made regarding the procurement of preferred partners.
3. **Agree** the prioritisation of estates as identified in Section 5 below.
4. **Agree** that the Director of Housing has authority to arrange for the service of demolition notices at the appropriate time in relation to all affected properties on the estates and schemes in this programme.

REPORT DETAIL

1. BACKGROUND

1.1 The following information was included within the June Cabinet report and is repeated here by way of useful background:

1.2 As the main level of income to the HRA BP comes from rents, it is imperative that the number of rental properties is maximised. The current HRA BP expects to lose 80 properties per year through RTB. This reduces rental income by around £330k per year, assuming a full year loss of income per property.

1.3 As increased demand for properties continues and the number of families presenting as homeless rise, there is a trend for more families to be housed for longer in the hostels and also more use of B&B. This is a General Fund cost. More properties available in the HRA mean more properties available for permanent housing and therefore reduced spend on B&B in the GF.

1.4 The HRA BP resources can be used to fund new build and can be augmented by right-to-buy receipts as the Council has struck an agreement with the GLA to use 100% of the usable element of right-to-buy receipts on the building of new social housing within three years of their generation. Failure to use right-to-buy receipts in this way would see the Council having to pay the receipts over to the GLA with additional interest. Some council housing new build schemes have also attracted grant from the GLA.

1.5 The existing level of new build already approved by Cabinet of 535 units at a cost of £96M is included with the HRA BP.

1.6 The new HRA BP identifies a further £73m that is available for new build over a period of 10 years. This report therefore identifies a total of £169m (£96m + £73m) available within the HRA BP over the next 10 years that is available for investment in new units of affordable housing to help replenish losses of units through the right

to buy and the expected high value sales regime. This report seeks approval to continue with the land and estates review already in progress and to authorise officers to use the available resources to maximise the number of units of new build provided by the HRA.

1.7 The focus of new build units will be to provide general needs rented properties, low cost home ownership and supported housing for Havering residents. This will be achieved by looking to build on unused or derelict land in the HRA, such as garage sites as well as looking to maximise the number of units on existing estates where there are opportunities for estate regeneration or in-fill developments. The additional resource will also be used to focus on out dated units, such as bedsit sheltered units and those estates where there is a negative or low value to the HRA.

1.8 There are also opportunities associated with being one of only eight London boroughs with two Housing Zones. Officers have reviewed HRA housing associated with the Rainham and Romford Housing Zones and are seeking opportunities to maximise the number of units on estates such as Napier and New Plymouth and the Waterloo Estate.

1.9 The key sites included within the Regeneration project are:

Estate/Scheme	**Ward**
Waterloo Estate	Romford Town
Maygreen (inc Park Lane Sheltered Scheme)	Hylands
Oldchurch	Brooklands
Napier and New Plymouth	South Hornchurch
Delta TMO (Elvet Ave)	Squirrels Heath
Farnham Hilldene and Chippenham Road	Gooshays
Royal Jubilee Court Sheltered Scheme	Pettits
Solar, Serena, Sunrise Sheltered Scheme	St Andrews
Brunswick Court Sheltered Scheme	Cranham
Dell Court Sheltered Scheme	St Andrews
Delderfield Sheltered Scheme	Pettits
Queen Street Sheltered Scheme (as part of the Waterloo Estate Regeneration)	Romford Town

1.10 In order to provide much needed affordable housing for local residents, the Council has an ambition to deliver at least 2000 units of affordable housing through this programme. 1000 of those will replace those already in situ, but 1000 will be new units adding to the stock of the HRA. In combination with the 535 units that had already been approved by the September Cabinet report, this means that current target for delivery of units is 2500 total with 1500 being new units of affordable housing.

1.11 The precise numbers and split of the new units between rented and low cost home ownership will be dependent on the final financial viability assessments carried out as part of the procurement exercise of the preferred partner. However, the minimum number of new rented units has been set at a target level to re-provide the number of units on the 12 estates that may have been sold under the Right to Buy scheme. That number currently stands at a minimum of 112.

1.12 These current proposals will continue to be informed as consultation continues and schemes are subject to further work regarding technical requirements and financial viability.

2.0 Update on consultation outcomes.

2.1 The consultation process for each site consisted of:

- An initial meeting where the proposals and rationale were explained followed by a question and answer session. Ward councillors were invited to this meeting.
- A newsletter was sent out generally within two weeks of that session to all residents providing details of the proposals along with FAQs and answers.
- After the initial meeting, staff offered and arranged one to one sessions with residents:
    - To ensure the proposals and implications were understood and answer any further questions,
    - To carry out a review of needs and also establish individuals preferences should a decant be necessary in the future.
    - To provide support and reassurance for residents.
    - To seek individual opinions on the proposals for the estates and schemes.
    - In the sheltered schemes, each resident was advised that any family member or friend could attend the meeting for support.
- Following the meetings and one to one sessions, all feedback and comments were considered against the original proposals and any changes to the proposals identified,
- In relation to the sheltered schemes, discussions were held with colleagues from Adult Social Care to ensure that all proposals meet their future plans for service delivery along with integration with Health Services, including the plans being developed around the Accountable Care Organisation (ACO).
- A second meeting was held at each estate/scheme, approximately one month after the first meeting, to identify the feedback received, the comments regarding each scheme and also to advise how that information had influenced the final proposals to be presented to Cabinet.
- A second newsletter was sent out to each scheme around two weeks after that meeting, detailing the feedback given.

2.2 Housing Regeneration Programme basic principles in the message used for the consultation were:

- Havering has lost more than 4,000 Council properties through Right to Buy.
- Large number of people in hostels and bed and breakfast which is not best provision for the people concerned, especially families, and is expensive for the Council.
- The programme aims to build at least 2,500 properties for local people.
- Will be modern units meeting high standards of energy efficiency, good quality etc.
- Land expected to remain in Council ownership except any freehold properties built for outright sale.
- This is an ambitious programme to provide as many affordable housing units as possible for local people.
- Where tenants wish to move back to a site, and there is suitable accommodation to meet their needs, they will be able to do so.(a right to return).

- Residents will receive home-loss and disturbance payments as appropriate.
- Help will be provided through the decanting and move process.
- Full consultation throughout the process.

2.3 The detailed outcomes of the consultations carried out so far are provided within Appendix 1to the *Housing Accommodation Plan: Review of Older Persons' Housing Needs* report. However, the key headline figures are:

- The informal consultation process will see a total of 60 group meetings in sheltered housing schemes and 21 group meetings on estates attended by 783 people, as well as more than 700 offers of individual meetings with tenants and leaseholders between July and October
- A total of 32 individual newsletters have been issued during July and August, each specific to a scheme
- New web page set up called: www.havering.gov.uk/ShelteredHousingDevelopments which includes examples of older persons' villages.
- New web page set up called: www.havering.gov.uk/HousingRegeneration giving details of the main estate proposals.
- Each site also has its own dedicated web page.
- Sheltered Times 10 – distributed 22.08.16 – contains three page feature on the regeneration programme
- At The Heart Autumn 2016 edition – due to be distributed 12.09.16 – contains six page feature on the regeneration programme
- Briefings being held for (a) Housing Services staff and (b) selected staff from Economic Development and Regulatory Services on 05.09.16
- Corporate Communications has used social media to promote the consultation meetings
- Press coverage in Romford Recorder and Havering Yellow Advertiser has been positive
- Some comments on Streetlife web site have been neutral and points answered by Corporate Communications
- Stand taken at Havering Show to explain the regeneration programme saw 87 per cent of people completing survey in support of the Housing Regeneration Programme
- Intensive support and reassurance provided to any resident and their families worried about the renewal program and potential decant process.
- Specific information provided for leaseholders.

2.3 Generally, there has been positive support for the council's regeneration plans for the estates and the sheltered schemes. Of course, some people are particularly concerned about the impact of moves on older persons from sheltered units and these are being handled very carefully and sensitively.

2.4 The decanting requirements for each scheme are also being carefully considered and will continue to evolve as further consultation occurs with affected residents.

3.0 Update on procurement of preferred partners.

3.1 Since the June Cabinet decision, a review has been completed of the procurement methods and delivery model options for the regeneration of the key estates and schemes. This has been informed by key senior staff from Havering and OneSource and an external specialist firm called Bevan Brittan. Those discussions have identified that the best procurement method for this project is to enter into a "Competitive Dialogue" process. The advantages and key stages of such an approach are:

- Ability to shortlist and limit the number of bidders to participate in the tender through a prequalification process evaluating their financial standing, technical ability and experience.
- The minimum number of candidates to be invited to participate in the competitive dialogue stage is three bidders.
- Competitive Dialogue is an iterative process, and can have multiple elimination stages to reduce the number of bidders/bids before calling for final tenders.
- Where there is an elimination stage, this involves a tender submission and an evaluation against pre-disclosed criteria and weightings.
- The competitive dialogue procedure permits the Council to negotiate with the bidders during the tender phases.
- Once the dialogue stage is concluded, the Council will call for final tenders from the two bidder finalists. Those tenders should "contain all the elements required and necessary for the performance of the project".
- Once the final tenders have been evaluated, there is a further opportunity to confirm commitments and finalise terms with the leading bidder (also called the preferred bidder) before the Council reaches a final award decision.

3.2 With regard to the delivery model, there tends to be two methods for delivering large projects of this nature. They are the recognised "Contractual Approach" where a development partner is appointed. A variation of this approach is the "Corporate Approach" where the authority would become a shareholder in a new Joint Venture company with the Developer Partner.

Contractual Approach

They key principles of a standard contractual approach with the appointment of a development partner are:

- Tried and trusted approach
- Development Agreement with phasing of sites
- Developer takes all developer risk
- Developer obtains planning and satisfies other conditions
- Development Agreement sets out Council requirements
- Possible future receipts through overage

Corporate Approach (Joint Venture Company)

The key principles of this approach are:

- Shareholders Agreement for the new Joint Venture Company in which the council and the development partner are shareholders.
- Council contributes sites
- Development Partner contributes cash and resources

- Land Agreement for each site pursuant to Business Cases
- JV takes all developer risk and as the council is a shareholder it shares the risk and reward as a developer.
- JV obtains planning and satisfies other conditions
- Possible future receipts through dividends in its role are developer/investor, as opposed to future receipts through overage under the contractual approach (as set out above) where the Council's role is as the landowner.

The two approaches when compared mean that the following questions can be considered and balanced;

- Degree of developer interest
- Balancing risks and returns
- Tried and tested approach
- Suitability for single and multiple sites
- How quickly can a developer partner be signed up
- Ease of retaining a long term interest in managing the Estates
- Nature of long term revenue interest (dividend versus overage)

Following careful consideration it has been agreed that the option that provides the best fit with the requirements for Havering is the Corporate or JV Approach.

Consequently, the chosen procurement /delivery approach for this project that will now be pursued is the corporate approach and the establishment of a joint venture company procured via a competitive dialogue.

The table below identifies the new key milestones for that procurement:

	Key Milestones	From	To
1	Appointment of external Multidisciplinary Consultant Team (MDC Team)	Sep-16	Oct-16
2	Appointment of external Legal Advisors	Sep-16	Oct-16
3	MDC Team Work Programme: (i.e. Scheme Validation, Due Diligence and Competitive Dialogue Procurement Preparation)	Nov-16	Dec-16
4	Commence procurement of a JV Development Partner through Competitive Dialogue	Dec-16	Jan-17
5	Complete a 8/9 month Competitive Dialogue process for a JV Development Partner	Jan-17	Sep-17
6	Secure Council approvals (inc ED & Cabinet approval) to appoint preferred JV Development Partner	Oct-17	Nov-17
7	Formal appointment of preferred JV Development Partner	Nov-17	Nov-17

4.0 Update on the serving of demolition notices

The Cabinet decision in June, gave authority for officers to serve the necessary demolition notices that are an essential part of any regeneration scheme. It is a significant legal step that signifies the intentions of the Local Authority with respect to the land. It also enables various activities such as decanting of existing tenants, site assembly activity leading to potential CPO action and it enables the council to stop future right to buy activity.

As we move forward with proposals to regenerate a number of estates and locations within the Borough it is important that the Council action some key elements in synergy with on-going resident consultation and the progression of a Local Letting Plan.

Officers have consulted with residents on each of the 12 identified regeneration locations. Part of this consultation was to communicate our commitment to facilitate the early relocation of those tenants that wished to move before the start of a more formal process and in advance of procuring a development partner.
We have offered our tenants this option to move now should they so wish.

In addition to this we have also spoken with many leaseholders within these locations and extended the offer to acquire their properties by negotiation.

As we progress with these actions and to further advance the impetus of managing each regeneration location the use and issuing of demolition notices is required.
The notices are required to inform residents of our continued commitment for regeneration and to legally prevent the facilitation of any further and future Right to Buy on these locations. These notices are not intended to cause distress but we are aware that some residents may be concerned to receive one.

The issuing of these notices need to be managed and co-ordinated carefully. Suitably trained individuals will issue each notice personally to every household and property within each of the regeneration locations.

Evidence that each notice has been served appropriately will be controlled, collated and managed. Should a resident wish to contact us and discuss the notice, a named person within the Council will respond.

Before the issuing of these notices it is vital that Council / Ward Members are briefed fully as to when this is to take place and why.

5.0 Prioritisation of estates and schemes

There are 12 estates/schemes identified within this overall programme. There is a need to prioritise these as part of the dialogue process with those tendering in the preferred partner process as it would not be practicable to start work on all sites simultaneously. It is therefore proposed that the following sites will be prioritised:

- Waterloo Estate,
- Queens Street Sheltered Scheme,
- Napier & New Plymouth,
- Maygreen Estate,
- Park Lane Sheltered Scheme,
- Oldchurch Gardens,
- Farnham, Hilldene and Chippenham Road
- Solar, Serena and Sunrise Sheltered Scheme.

REASONS AND OPTIONS

Reasons for the Decision:

These actions are necessary in order to achieve the agreed recommendations from the June Cabinet paper. The outcomes from these actions will lead to an increase in the number of affordable homes available for local residents and thus help to mitigate the increased pressure on housing in Havering. Increased housing supply therefore increases the options for local people to access safe, affordable housing, reduces homelessness and potential pressures on the General Fund. In addition, the creation of new homes within the HRA enables increased rent, to offset losses from properties lost through the right to buy and enables RTB receipts to be used for the benefit of Havering rather than handed back to Government.

Other Options Considered:

The options relating to the preferred methods of procurement and delivery model are detailed within the report.

IMPLICATIONS AND RISKS

Financial implications and risks:

This report provides an update on the HRA new build programme and outlines what the financial impact is within the HRA Business Plan.

Legal implications and risks:

The HRA new build Programme and the recommendations detailed in this report are actions that the Council can undertake and are authorised by Section 1 of the Localism Act 2011, which gives the Council a general power of competence.

The report confirms that the Council has adopted the Competitive Dialogue process to procure the developer. Under Public Contract Regulations 2015, regulation 26 (4) the Council is entitled to choose the Competitive Dialogue procedure if specific circumstances apply, including in situations where the Council cannot award a contract without prior negotiation because of specific circumstances relating to the nature, the complexity or the legal and financial make-up or because of risks attaching to them or where design or innovative solutions are required.

The use of the Competitive Dialogue ("CD") procedure is allowable under the Public Contracts Regulations 2015 ("PCR 2015"). PCR 2015, regulation 30 sets out the procedure required for a CD, which is broadly similar to regulation 18 of the Public Contracts Regulations 2006. A CD process can only be used when other types of

procedures under the Regulations are not suitable for the procurement or commissioning exercise. CD aims to increase best value for the local authorities by encouraging innovation and maintaining competitive pressure on bidders throughout the process.

The disposal of any land associated with the Regeneration Programme must be for best consideration reasonably obtainable and in accordance with the Housing Act 1985, section 32, 34 and the General Housing Consent 2012.

The necessary planning applications should be complaint with prevailing local and national planning policies together with material considerations in order to be granted consent

The HRA new build programme entails the demolition of various properties. To ensure that the programme is implemented taking into account best value principles, tenants' ability to exercise may need to be taken into account. The Council can serve an "initial demolition notice", specifying the demolition date, which should prevent a RTB claim arising. The Housing Act 1985, sections 138A, B, C and Schedules 5 & 5A of the Act prescribes the requirements and compensation provisions.

The buy back of leaseholder interests is permitted under the Local Government Act 1972, section 120. The section enables the Council to acquire by agreement any land for the purposes of any of the Council's functions or the benefit, improvement or development of its area.

In approving this report and in subsequent decision making relating to this project the Public Sector Equality Duty created by the Equality Act 2010 (PSED) should be considered at each stage and a full Equalities Imapact Assessment carried out. In carrying out its functions the council and officers must have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

Having due regard involves:

- Removing or minimising disadvantages suffered by people due to their protected Characteristics. Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

The protected characteristics are: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The Equality Duty must be complied with before and at the time that a particular policy is under consideration or decision is taken - that is, in the development of policy options, and in making a final decision. A public body cannot satisfy the Equality Duty by justifying a decision after it has been taken.

Human Resources implications and risks:

None specific to this report.

Equalities implications and risks:

These are contained within the Legal implications and risks detailed above.

BACKGROUND PAPERS

There are none.

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HEALTH & WELLBEING BOARD

Subject Heading:	Local Digital Roadmap
Board Lead:	Conor Burke, Accountable Officer, Barking & Dagenham, Havering and Redbridge CCGs
Report Author and contact details:	Rob Meaker, Director of Innovation, BHR CCGs, rob.meaker@nhs.net

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

Following the publication of the Five Year Forward View and Personalised Health and Care 2020, local health and care economies have a requirement to develop and publish their Local Digital Roadmap (LDR). The three-step process began in September 2015 with the organisation of local commissioners, providers and social care partners into LDR footprints. The second step was for NHS providers within LDR footprints to complete a Digital Maturity Self-assessment. Following initial submission of the LDR to NHSE in June 2016, the LDRs have undergone a review and are expected to be submitted for national publication by the end of October 2016.

The LDR is expected to include a five year vision for digitally enabled transformation, a capability deployment schedule, delivery plan and information sharing approach. Progress in delivering the commitments and aspirations in LDRs will become embedded in commissioner and provider

assurance, assessment and inspection regimes going forward. The strategy will be refreshed annually and bids, or business cases, from BHR as a system will be placed against these capabilities, making the roadmap the gateway to funding for the next five years.

RECOMMENDATIONS

The Board is asked to note the progress of the development of the digital roadmap

REPORT DETAIL

1.0 Purpose of the Report

1.1 The report seeks to update the Health and Wellbeing Board on the progress of the Local Digital Roadmap development.

2.0 Introduction

2.1 Following the publication of the Five Year Forward View and Personalised Health and Care 2020, local health and care economies have a requirement to develop and publish their Local Digital Roadmap (LDR) which sets out the technological capabilities that will be implemented over the next five years. 10 of these capabilities will be the minimum standard (known as Universal Capabilities, Appendix 1), as mandated by NHS England, while capabilities outside of these will be classed as progressive or transformational. The strategy will be refreshed annually and bids, or business cases, from BHR as a system will be placed against these capabilities, making the roadmap the gateway to funding. £4.2bn funding had been identified for technology over the next five years, broken down as follows:

- £1.8bn paper free at the point of contact
- £1bn infrastructure
- £750m transforming out of hospital services, including primary care, medicines and social care
- £400m enable NHS to become digital, e.g. nhs.uk, wifi, telehealth, apps
- £250m outcomes and research

Since the publication of the LDR guidance, CCGs have been informed that the £4.2bn (to be spent nationally) has been reduced, though the new figure has yet to be announced.

2.2 It is expected that the roadmap for each footprint will be aligned to that locality's Sustainability and Transformation Plan (STP), which will feature 'digital' as a key theme. The Outer North East London footprint includes the following organisations and is aligned to the STP for North East London (which includes Waltham Forest and East London, and City and Hackney).

- Redbridge CCG
- Barking and Dagenham CCG
- Havering CCG
- Barking, Havering, Redbridge University Hospitals NHS Trust
- North East London NHS Foundation Trust
- Partnership of East London Co-operative
- London Borough of Havering
- London Borough of Barking and Dagenham
- London Borough of Redbridge

2.3 CCGs have been tasked with leading the development of the LDR but engagement from partner organisation has been crucial in successfully delivering a local Digital Roadmap that incorporates the ambition and vision of the system, as well as at an organisational level.

3.0 Developing the LDR

3.1 In December 2015, Integrated Care Coalition (ICC) members from each organisation were asked to nominate a representative to work with the CCGs on the LDR. An LDR Working Group was established shortly after, through which initial engagement began. Members of this group identified leads within their organisations that would be able to provide clear business requirements that would form the basis of the five year strategy.

3.2 The result of individual meetings, workshops and organisational strategies is over 150 user stories and a catalogue of over 280 specific requirements. The CCG was asked by the Accountable Care Organisation (ACO) Executive Committee to identify the priorities for delivery, in line with the STP and ACO's vision for health and social care. A workshop was subsequently held, with representatives from each of the eight organisations, along with Healthwatch, patients and patient representatives to prioritise the requirements for the LDR and agree a vision for a digitally enabled transformation. The following capability groups were prioritised and ratified by the ACO Executive Committee on 25 April 2016:

- IG for direct patient care
- Records, assessments and plans
- Asset and resource optimisation
- Business Intelligence, decision support & population health management

Requirements and capabilities were refined and reconciled with the technical design and Universal Capabilities (Appendix 2), and a timeline for delivery was drafted. The draft Capability Deployment Plan (Appendix 3) was agreed with the LDR group and individual organisations in early June 2016.

3.3 During the April workshop, a Vision seen below, was identified which is currently being reviewed by BHRUT communications and engagement team, as per request from the ACO Executive. This vision is intended to sit above the individual organisations visions; to act as a unified vision for integration and interoperability.

"We will bring citizens, health and care professionals and commissioners into the 21st century with exceptional digital experiences wherever they interact, using technology to improve outcomes and lives. Accurate, real-time data will be used throughout our system to support well informed decisions. We will co-ordinate and focus resources and skills on fewer projects to deliver the best possible value."

3.4 Additionally a set of unifying principles has been engaged upon which builds from national and regional guidance and local strategies. These principles are intended to guide the development of future infrastructure, systems and applications to ensure that they work across the BHR system, whilst also ensuring that the users of the systems, in particular service users and care professionals, gain the benefits of them. These principles are shown in figure 1 below.

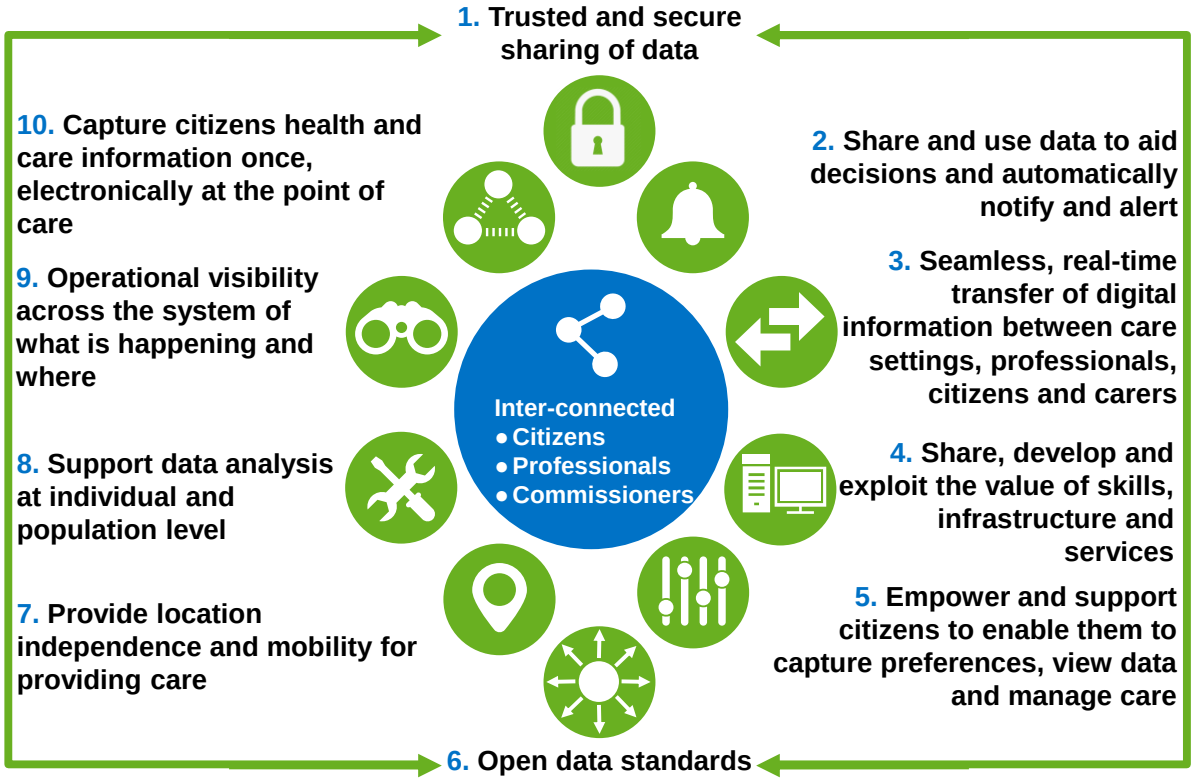

Figure 1 - Principles for development of integrated and interoperable systems across Barking and Dagenham, Havering and Redbridge.

4.0 Delivering a digital platform for BHR

4.1 BHR have a strong track record in the delivery of innovative and forward-thinking technology that supports the NHS future priorities and directly aligns to patient and user outcomes. The LDR builds on our substantial existing developments and learning of delivering complex technology solutions across BHR, including:

- The development of an operational solution for sharing the full GP record with our Urgent Care Hubs, including the ability to read and write to the record, which is currently fully functional and being deployed.
- The development of a full, real time shared care plan (for Integrated Care and end of life patients) that is visible to health and social care professionals.
- The London NHS 111 Patient Relationship Manager pilot which uses the telephone number to retrieve crisis information, care plans and Special Patient Notes and enables sharing of this key information with LAS.

4.2 In designing a solution for integrated and/or interoperable systems across the system, it was crucial to establish common values and use the design principles to guide the process. BHR organisations are at different stages of digital maturity, have different system architectures, and systems have historically been disparate with limited ability to communicate or exchange information. Based on the requirements and priorities across the system, three options for delivery were identified.

- Connecting systems using point-to-point integration engines
- Connecting systems via a hub
- Using open source development tools to define and create regional shared services

Clearly, any option would need to have the ability to interoperate with the pan-London solution as delivered by the Healthy London Partnership. Technical leads from each of the organisations will need to collectively agree on an approach for delivery.

5.0 Risks

5.1 There are a number of risks to the delivery and sign off of the LDR. These are shown below.

Ref.	Risk	Mitigation
R001	There is a risk that leads/representatives are not available on time and to the levels planned	We will plan the leads availability and ensure that their priorities are set and maintained.

Ref.	Risk	Mitigation
R002	There is a risk that the information needed for the LDR is not available on time	We will support and work closely with partner organisations to ensure their products are appropriate to the needs of LDR development.

Appendices:

1. List of Universal Capabilities
2. ACO priorities and LDR capabilities
3. Capability Deployment Plan

APPENDIX 1 – UNIVERSAL CAPABILITIES

Universal Capability	Capability Group	Aims (in terms of take-up and optimisation) [and specific16/17 targets where applicable]
Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions	Records, assessments and plans	Information accessed for every patient presenting in an A&E, ambulance or 111 setting where this information may inform clinical decisions (including for out-of-area patients) Information accessed in community pharmacy and acute pharmacy where it could inform clinical decisions
Clinicians in U&EC settings can access key GP-held information for those patients previously identified by GPs as most likely to present (in U&EC)	Records, assessments and plans	Information available for all patients identified by GPs as most likely to present, subject to patient consent, encompassing reason for medication, significant medical history, anticipatory care information and immunisations Information accessed for every applicable patient presenting in an A&E, ambulance or 111 setting (including for out-of-area patients)
Patients can access their GP record	Records, assessments and plans	Access to detailed coded GP records actively offered to patients who would benefit the most and where it supports their active management of a long term or complex condition Patients who request it are given access to their detailed coded GP record
GPs can refer electronically to secondary care	Transfers of care	Every referral created and transferred electronically Every patient presented with information to support their choice of provider Every initial outpatient appointment booked for a date and time of the patient's choosing (subject to availability) [By Sep 17 – 80% of elective referrals made electronically]
GPs receive timely electronic discharge summaries from secondary care	Transfers of care	All discharge summaries sent electronically from all acute providers to the GP within 24 hours All discharge summaries shared in the form of structured electronic documents All discharge documentation aligned with Academy of Medical Royal Colleges headings
Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care	Transfers of care	All Care Act 2014 compliant Assessment, Discharge and associated Withdrawal Notices sent electronically from the acute provider to local authority social care within the timescales specified in the Act

Universal Capability	Capability Group	Aims (in terms of take-up and optimisation) [and specific16/17 targets where applicable]
Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly	Decision support	Child protection information checked for every child or pregnant mother presenting in an unscheduled care setting with a potential indicator of the child being at risk (including for out-of-area children) Indication of child protection plan, looked after child or unborn child protection plan (where they exist) flagged to clinician, along with social care contact details The social worker of a child on a child protection plan, looked after or on an unborn child protection plan receives a notification when that child presents at an unscheduled care setting and the clinician accesses the child protection alert in their record
Professionals across care settings made aware of end-of-life preference information	Decision support	All patients at end-of-life able to express (and change) their preferences to their GP and know that this will be available to those involved in their care All professionals from local providers involved in end-of-life care of patients (who are under the direct care of a GP) access recorded preference information where end-of-life status is flagged, known or suspected
GPs and community pharmacists can utilise electronic prescriptions	Medicines management and optimisation	All permitted prescriptions electronic All prescriptions electronic for patients with and without nominations - for the latter, the majority of tokens electronic Repeat dispensing done electronically for all appropriate patients [By end 16/17 – 80% of repeat prescriptions to be transmitted electronically]
Patients can book appointments and order repeat prescriptions from their GP practice	Remote Care	[By end 16/17 – 10% of patients registered for one or more online services (repeat prescriptions, appointment booking or access to record)] All patients registered for online services use them above alternative channels

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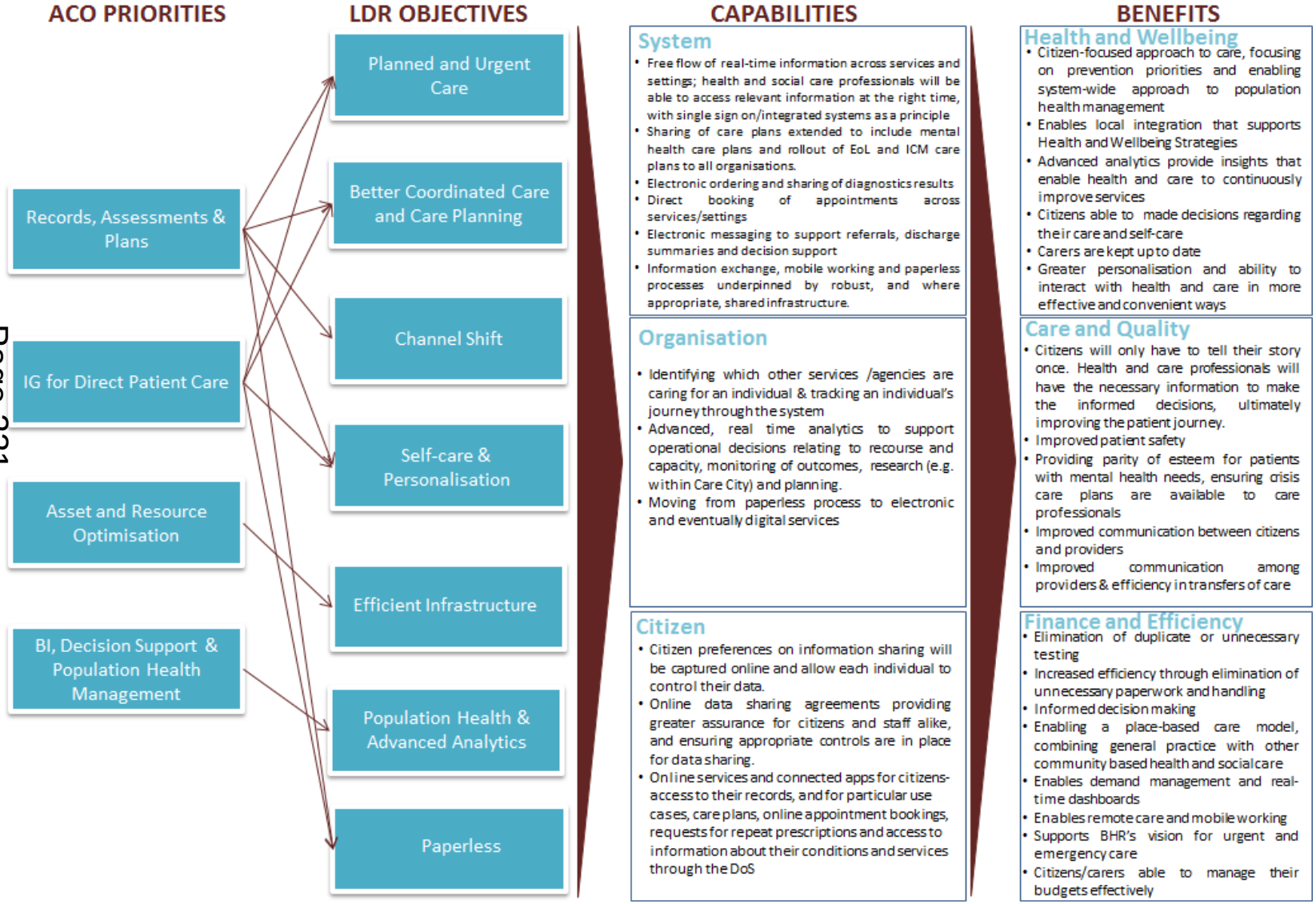
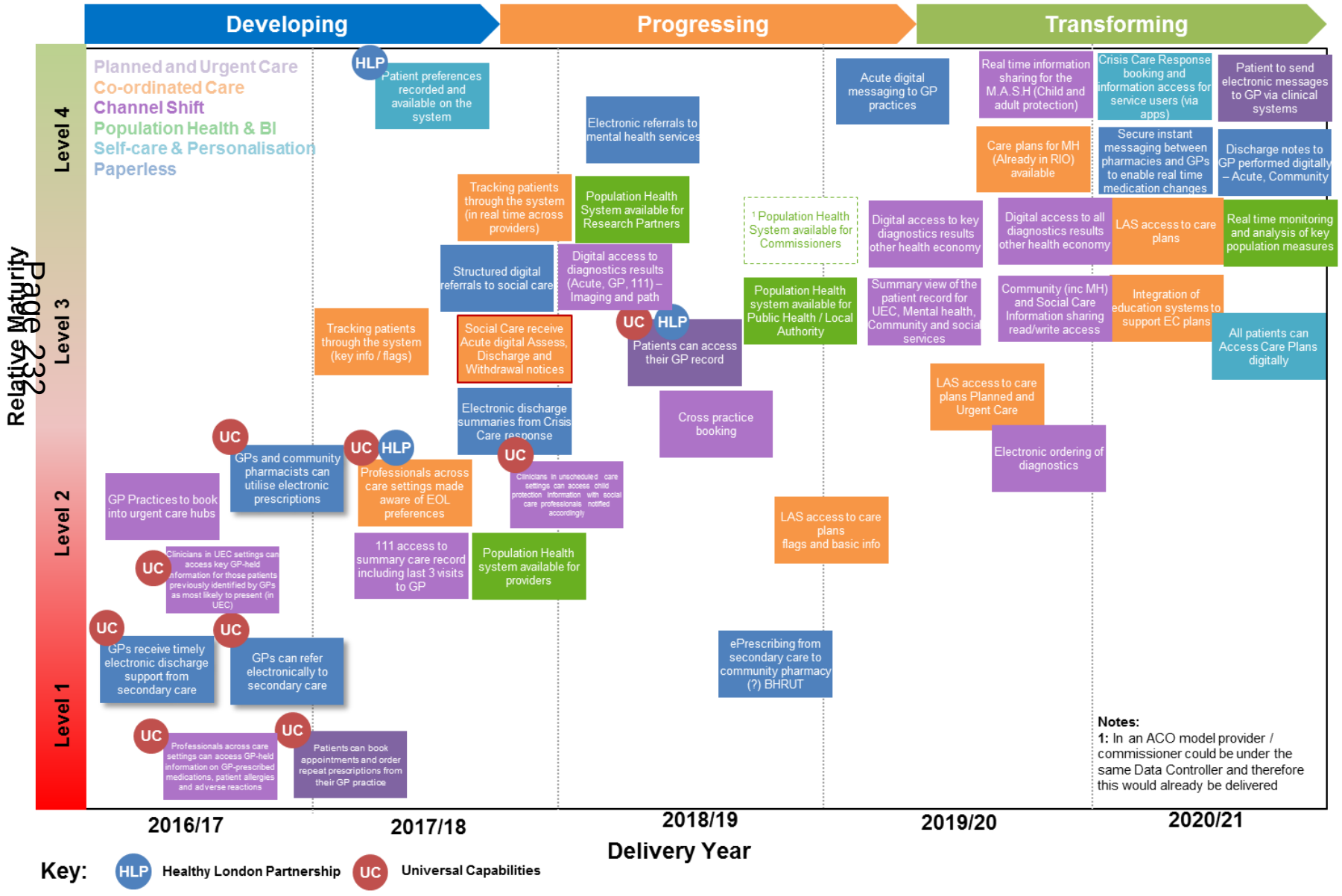
APPENDIX 2 – LDR OBJECTIVES & CAPABILITIES MAPPED TO ACO PRIORITIES



APPENDIX 3 –CAPABILITY DEPLOYMENT PLAN



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BACKGROUND PAPERS

1. Barking and Dagenham, Havering and Redbridge Local Digital Roadmap 2016/17 – 2020/21 (June 2016 submission)

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Barking and Dagenham, Havering and Redbridge Local Digital Roadmap

2016/17 – 2020/21

Contents

1. Executive Summary

Barking and Dagenham, Havering and Redbridge organisations, including the Clinical Commissioning Groups, local London Boroughs, North East London NHS Trust and Barking, Havering and Redbridge University NHS Trust have historically made headway in developing their organisational systems in relative isolation of others in the region. Whilst progress has been made, for example real-time GP records with read/write access, interoperable care planning tool, organisational health integration environments established and channel shift and amalgamation of services into user friendly portals in Local Authorities, as a collective group of health and care organisations we recognise we have not worked closely together and are therefore not exploiting the sheer potential of interoperation across health and care.

In order to achieve better outcomes for service users, better connectivity of health and care services and a far better and more modern working environment for our care professionals we recognise this must change. We now need to work together, sharing our resources and skills and delivering against a common and agreed portfolio of changes which move the maturity of our organisations around digital services significantly forward.

To achieve this we have engaged organisations and individuals across our region, from care professionals to service users. We have agreed to a common vision which centres on our citizens, services users and patients and recognises the importance of equipping our front line staff “bringing citizens, health and care professionals and commissioners into the 21st century with exceptional digital experiences wherever they interact”. We reinforce this with a set of ten key principles under which change will happen, for instance, ensuring that we build on our existing successes and investments (including those being made within the London Digital Programme and at national level), keep data safe, and operate systematically and to consistent standards.

A set of some 150 plus ‘user stories’ were gathered, analysed and prioritised. These were developed to work alongside the Sustainability and Transformation Programme (STP) and have coalesced into seven themes under which each will support organisations to enhance their own plans and to become better connected. The themes are Planned and Urgent Care, Co-ordinated Care and Care Planning, Channel shift, Population Health Management, Self-care and Personalisation, Paperless and Efficient Infrastructure.

We are also alive to the complexity of the task ahead of us. Implementation will take c. five years and be formulated into a programme where, at its core will reside new technology and systems to form an interoperable layer between the key organisations, and more broadly the London region and nationally. This core system technology will include an interoperability broker, master directories and indexes, common care record, citizen portal and care planning systems. It will then be built on through an agile development, using a team of technical specialists and business change agents, which will prioritise key functionality and capabilities and deliver this in an agile development fashion, exploiting new advances in health technology as they become available (e.g. to accelerate delivery cost and reduce cost).

An estimate of the total cost of the five year programme is £42.24M which is a mix of both capital and revenue funding. Further to this it is estimated that c. £4.32M of reoccurring revenue may be required to fund new technology (e.g. licenses), maintenance (e.g. of systems and of training) and an important new set of skills to continually work to exploit the new environment, build new capabilities and respond to changes (e.g. regulation). These new skills may be an amalgamation of existing and new resources and will be defined during implementation.

1. Local Context

The Barking and Dagenham, Havering and Redbridge (BHR) health and care economy covers three boroughs and serves over 750,000 people. With pockets of high deprivation and some of the very youngest, oldest and most transient populations in London, the system is faced with significant challenges in managing the health of

the population. Along with national challenges, such as an aging primary care workforce and difficulties recruiting and retaining staff, key system challenges across BHR include:

- High rates of admissions for acute and chronic conditions
- Fragmented health and care commissioning system
- Increasing spend across urgent care and planned care
- Difficulties generating robust data and intelligence on interventions and outcomes across whole pathways of care

The three local boroughs vary greatly in their demographic make-up, and therefore face their own challenges.

Redbridge

- One of the highest **rates of stillbirths** in London and England
- **Health and social care needs** arising from temporary accommodation and large family size and effects of welfare reform
- An upward trend of **excess winter deaths** in recent years
- High prevalence of **diabetes**
- Poor one year **cancer survival**
- **Communicable diseases**: a relatively high prevalence of HIV and TB and travel-associated infections.

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- 110,000 adults registered with a local GP (and with a recorded BMI) are **overweight or obese** and Public Health England's estimated prevalence of adult obesity is 63.3%, significantly higher than the London average of 57.3%
- **Rates of children classified as overweight or obese** (25.8%) is significantly higher than for London (23.1%) and England (22.5%).
- **Male life expectancy** at 65 (18.8 years) is lower than the London average (19.1 years)
- **Largest net inflow of children** across London boroughs (4,606) between 2009-14
- Estimated to have one of the highest rates of **serious physical disabilities** among London boroughs.
- One of the largest proportions of the population in the country with **dementia**

Barking and Dagenham

- **Rapid population increase**: now 198,294; forecast to increase by 25% to 250,500 by 2031
- **Life expectancy** among the worse in London
- **Child poverty** 30.2% compared to London value of 23.5%
- **Highest proportion of smokers** in London: 23.1% compared to 17.3% in London, resulting in the highest number of chronic obstructive pulmonary disease (COPD) unplanned admissions in London and twice the number of expected COPD deaths
- Highest prevalence of **childhood overweight and obesity** in London
- Increasing proportion of the adult population diagnosed with type 2 **diabetes** with 1969 unplanned admissions
- Lowest one year **cancer survival rates** in London.

Figure 1. Key challenges for Barking and Dagenham, Havering and Redbridge CCGs

The effective use of technology can aid in addressing some of these challenges; patients can take a more proactive approach to managing their care, clinicians can be supported to make informed decisions, and the system can provide a better patient experience by ensuring patients only need to tell their story once. These benefits will not only lead to better health outcomes for our population but will also create efficiencies in a system that is under increasing financial pressure.

2. Developing BHR'S Local Digital Roadmap

Through the establishment of our Integrated Care Coalition, organisations across BHR have an emerging track record of effective partnership working, leading to notable improvements for our local population. The BHR health and social care economy is comprised of the organisations below, each of which have contributed significantly to the development of the Local Digital Roadmap (LDR) through the LDR Working Group and numerous engagement events and workshops.

- Barking and Dagenham, Redbridge and Havering Clinical Commissioning Groups (CCGs)
- Barking, Havering, Redbridge University Hospitals NHS Trust (BHRUT)

- North East London NHS Foundation Trust (NELFT)
- Partnership of East London Co-operative (PELC)
- London Boroughs of Havering (LBH), Redbridge (LBR) and Barking and Dagenham (LBBD)
- London Ambulance Service (LAS)

Other organisations that have also been involved in developing the LDR include:
- Healthwatch, citizens and service users
- London Digital Programme
- Age UK
- UCL Partners
- Primary Care

The BHR LDR is aligned to the North East London (NEL) Sustainability and Transformation Plan (STP) footprint, which covers two other LDRs: Waltham Forest and East London, and City and Hackney. Organisations in NEL have a strong history of working collaboratively and share a number of key challenges, including high A&E usage, low dementia diagnosis rates and poorer cancer survival rates.

Alignment with the STP and other LDRs has been critical through the LDR development process, and has been maintained via the Accountable Care Organisation (ACO) Executive Committee and the STP Programme Board, which provides collaborative leadership for the NEL footprint. LDR leads and SROs for the three NEL LDRs have also been working closely to ensure that each LDR addresses its local challenges and priorities, whilst ensuring a cohesive approach across NEL.

The NEL STP Programme Board has agreed that the STP will undergo a formal approval process via the appropriate boards at organisational level once it has been assured by NHS England. The LDR has been endorsed by senior representatives of the ACO Executive Committee and will align with the STP sign off process following NHSE assurance (see timeline in figure 2).

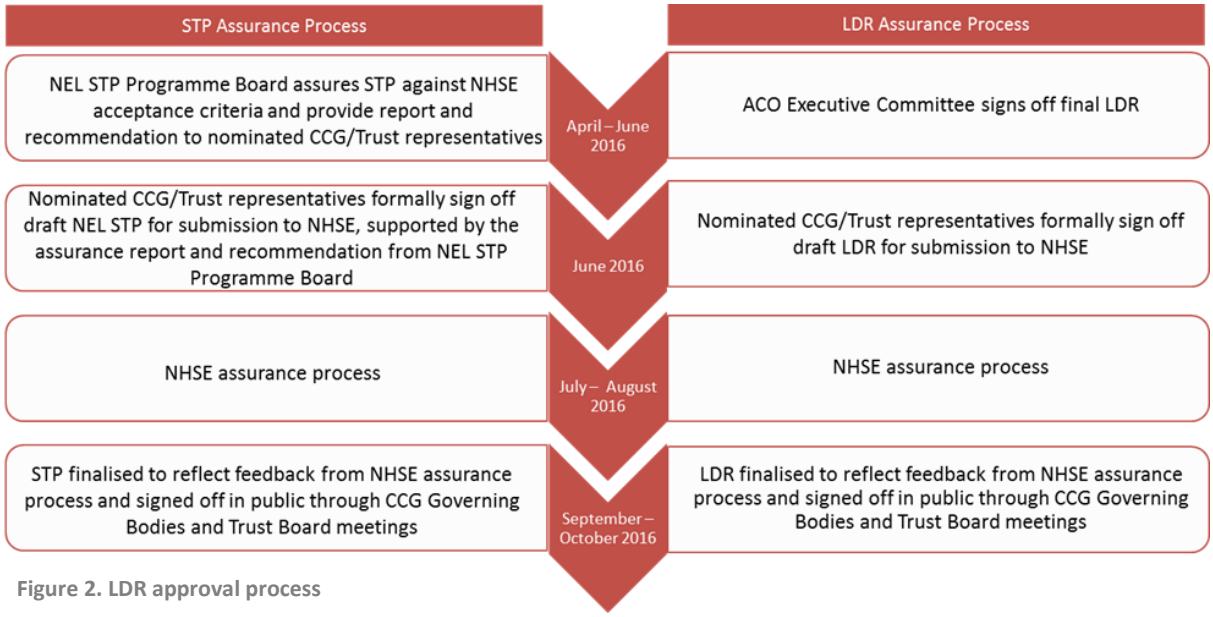


Figure 2. LDR approval process

3. A Vision for Digitally Enabled Transformation

Over the last 6 months extensive stakeholder engagement across the system has been carried out, including three Local Authorities, three healthcare providers, local clinicians, service users and patient representatives. Through this process we have collectively agreed a vision for a digitally enabled future for health and social care-

We will bring citizens, health and care professionals and commissioners into the 21st century with exceptional digital experiences wherever they interact, using technology to improve outcomes and lives. Accurate, real-time data will be used throughout our system to support well informed decisions. We will co-ordinate and focus resources and skills on fewer projects to deliver the best possible value.

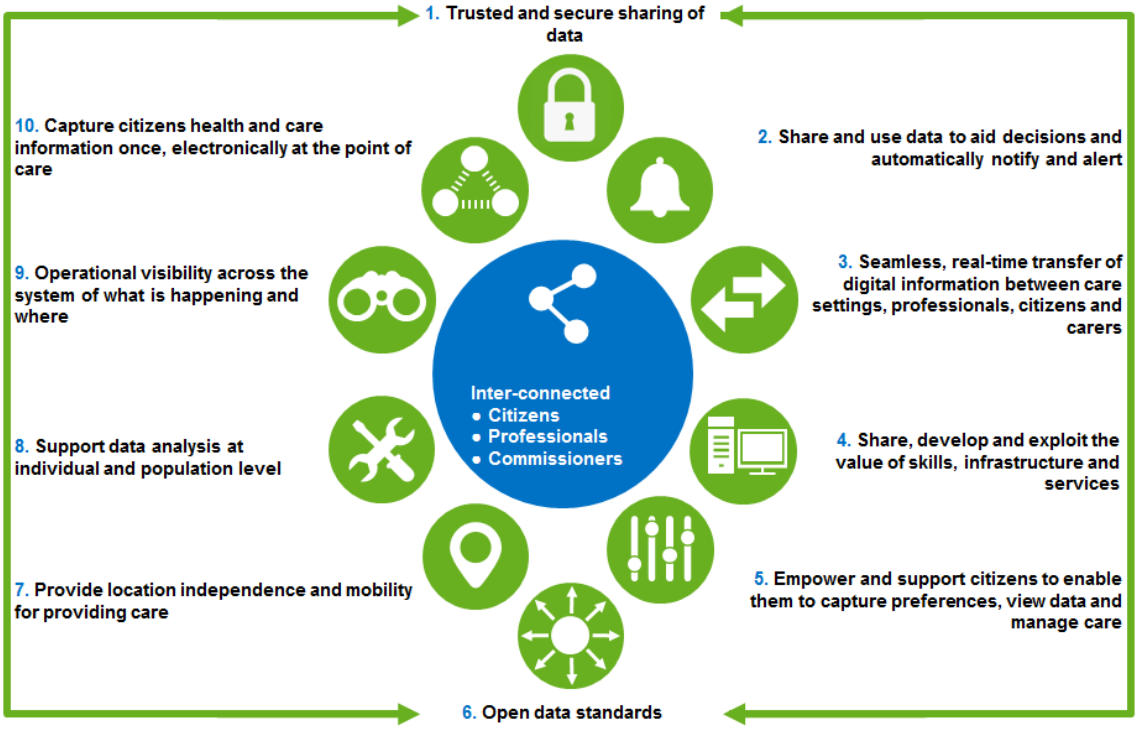


Figure 3. BHR design principles

The vision is underpinned by a set of principles (figure 3 above) which builds from national and regional guidance and local strategies. These principles are intended to guide the development of future infrastructure, systems and applications to ensure that they work across the BHR system, whilst also ensuring that the users of the systems, in particular service users and care professionals, gain the benefits of them.

The LDR is defined by seven themes that describe BHR's objectives in achieving our vision:

Planned and Urgent Care
With unprecedented levels in demand and growing financial pressures, it is imperative that we improve access and create efficiencies in pathways and the process for citizens and professionals. A key focus for BHR will be supporting parity of esteem for Mental Health patients, as well as enabling new models of care, such as placed-based models combining primary care with other community-based health and social care, and Integrated Urgent Care (IUC).

Co-ordinated care and care planning
Integrated and coordinated health and social care is a fundamental objective of NEL's STP and BHR's LDR. Integration of health and social care systems is required to enable more efficient transfers of care, for example, palliative and end of life care, reduce safeguarding risks and better management of patients in crisis. Safer and more effective care is also supported by the use of alerts and notifications for proactive care and prevention, and a directory of services for appropriate clinician referrals. BHR has recently piloted the use of MiDoS and is currently evaluating the pilot, the outcome of which will inform our direction. It is expected that BHR will deploy a solution that enables enquiries into health and social care services.

Population health and advanced analytics
BHR CCGs currently access linked datasets via Health Analytics, a solution that has developed to provide risk stratification for local GP practices, and finance and performance monitoring tools for Continuing Healthcare. With the use of this analytics solution, the CCGs were able to analyse and segment the population, and identify the cohort of patients that would be recruited to Health1000, a new model of care borne out of the Year of Care

Programme dedicated to addressing the health and social care needs of complex patients in BHR. A capitated payment approach is also currently being piloted with Health1000. While significant progress has been made in this area, further work is required to develop the solution to provide access to real-time, linked data sets at patient and population level to support population health management, monitor outcomes and effectively evaluate the impact of improvement programmes.

Self-care and personalisation
Emerging evidence suggests that patients who are more activated have better health outcomes and care experiences. Patient activation is an important factor in supporting patients to self-care and can be promoted through better access to, and more personalised, information, resources and advice. The STP and LDR's objective to support self-care will be achieved through the delivery of digital tools aimed to increase patient activation, some of which will be delivered pan-London, such as My Health London.

Channel shift
Implementing channel shift measures will encourage a more effective service and provide a better and more engaged experience for citizens. Delivering channel shift is one of the most challenging building blocks of this BHR LDR and requires user insight, trend anticipation, flexible and agile development and the determination to make the most of the user's drive to make their own approach to their health care easier, more informed and more timely.

Efficient infrastructure
Digital transformation must be underpinned by responsive and sustainable infrastructure that provides users with access to high performance, high speed networks in a protected and secure environment. Where appropriate, partner organisations across BHR will explore options to share infrastructure (see Annex 10 for further information on infrastructure).

Paperless
The move towards real-time digital record-keeping/sharing will mean all information required to support direct clinical care and analytics needs of health and care is collected once, and only once, at the point of care[1].

4. Baseline Position

BHR have a strong track record in the delivery of innovative and forward-thinking technology that supports the NHS future priorities and directly aligns to patient and user outcomes. The LDR builds on our substantial existing developments and learning of delivering complex technology solutions across BHR, including:

- The development of an operational solution for sharing the full GP record with our Urgent Care Hubs, including the ability write back into the record, which is currently fully functional and being deployed
- The development of a full, real time shared care plan (for Integrated Care and End of Life care) that is visible to health and social care professionals across settings
- Commissioning solutions to allow automated payment of Continuing Health Care and Nursing Care payments
- The fact that BHR CCGs are among the few CCGs who have achieved the Accredited Safe Haven (ASH) status
- The London NHS 111 Patient Relationship Manager (PRM) pilot which uses the telephone number to route a caller directly to a clinician, and the NHS number to retrieve crisis information, care plans and Special Patient Notes. The PRM also enables sharing of this key information with LAS and OOH.
- Integrated Case Management (ICM) Multidisciplinary Team (MDT) meetings taking place via online conferencing to enable all appropriate professionals to take part in discussions about patients on the ICM caseload
- BHR are currently developing a solution to enable direct booking from 111 into GP practices, and from GP practices into the Urgent Care Hubs, as part of the Urgent and Emergency Care (UEC) Vanguard. In addition, BHR is hoping to be a pilot site for NHS Online to support our UEC Vanguard.

[1] National Information Board, Personalised Health and Care 2020, Using Data and Technology to Transform Outcomes for Patients and Citizens, A Framework for Action

5.1. Digital Maturity

In November 2015, provider trusts nationally were required to complete a Digital Maturity Assessment (DMA) which measures the extent to which healthcare services in England are supported by the effective use of digital technology. The self-assessment framework is structured around three themes- readiness, capabilities and infrastructure- and provides a score by sub-section, such as strategic alignment and resourcing. Within the BHR footprint, the DMA was undertaken by NELFT, BHRUT and LAS.

While a difference in digital maturity between the organisations is expected, the DMA results do highlight the gaps in our providers' ability to deliver paper-free at the point of care. One obvious gap exists in the Acute Trust around records, assessments and plans, however this is addressed in the Trust's Digital by Design Strategy, and is outlined later in this document, along with its projected maturity for the next five years. As the LDR is implemented, organisations will monitor their improvements in digital maturity against their projected scores, shown in Annex 2.

A similar exercise has been carried out for social services and primary care, which will help in understanding where the strengths lie and where there are opportunities to improve. The results of the primary care assessments, along with summary scores for healthcare providers are shown in Annex 2. Social care assessment results are expected in July 2016.

5.2. As-Is Systems Landscape

Primary care in the three boroughs has been managed centrally for a number of years, and therefore national programmes have been rolled out across the three areas at the same time. As a result, general practices in BHR have made considerable progress in the move towards paperless practices.

BHRUT however, are currently heavily reliant on paper records, manual data input and manual intervention in information transfer with over 70 clinical and non-clinical applications in use. NELFT also have a number of clinical systems but are currently in the process of implementing a clinical portal and an integration engine to enable the sharing and viewing of real time information, reducing their reliance on paper records. Further details can be found in the summaries of the orgnisations' digital strategies in Annex 1.

NELFT

EPR system: OpenRiO
Document exchange: WindDIP, OpenRiO, Systm1
Decision support: OpenRiO
Care planning: Health Analytics
Pathology: Cyberlab
PACs: Digora
Community Learning Disabilities system: AIS
Upney Lane Walk in Centre system: OpenRiO, ICAN
GP data viewing: Summary Care Record, RiO 'one-click' enabled for some services
Electronic Prescribing: undergoing procurement
Spine compliance: All systems compliant
Electronic referrals: enabled
Analytics: Midas, Ardentia

Primary Care

GP system: 40% Vision, 50% Emis, 10% SystmOne, 0.01% Mircrotest
Document exchange: Docman
Decision support: ScriptSwitch
Risk stratification: Health Analytics
Care planning: Health Analytics, currently integrated for practices using Vision
Order comms: tQuest
Appointment reminder service: NHSmail
Electronic Prescribing: EPS 2 enabled
Spine compliance: Enabled
Electronic referrals: E-referral system in use
Analytics: Health Analytics

Local Authorities

Redbridge
Social Care system (Adults): CareFirst
Social Care system (Children): Liquid Logic
Citizen portal: MyLife
Integration with healthcare: piloting national adapter service
NHS number primary identifier: 80% match adult

B&D
Social Care system: Northgate
Citizen portal: MyAccount
Integration with healthcare: CP-IS enabled
NHS number primary identifier: 65% match adult, 95% children's (LAC & CP only)

Havering
Social Care system: Northgate
Citizen portal: none
Integration with healthcare: none
NHS number primary identifier: 85% for adult social care, 93% for children's social care*
*subject to validation

LAS

Clinical system: Northrup
Care Planning: alerted of EOL care plan and able to view critical information, e.g. DNACPR decision and preferred place of death, if call routed via NEL 111 service

111/Out of Hours

Clinical system: Adastra
Document exchange: Adastra/NHSmail
Decision support: Pathways
Directory of Services: National DoS
GP data viewing: Extended Summary Care Record within Adastra
Care Planning: View of care plans via Health Analytics (integrated), flagged via PRM

BHRUT

EMR/hospital information system: System C, Medway
ED system: Symphony
Clinical note taking: ePRO/Medway
PAS : System C, Medway
Document exchange: none
Decision support: none
Order comms: Clinisys Cyberlab
Care planning: none
Pathology: Cyberlab/WinPath
Cardiology information system: HD Clinical
Oncology Management software: Infoflex & Somerset
Laboratory information system: WinPath
PACS: SECTRA PACS
Electronic Prescribing: none
Spine compliance: spine mini service enabled
Electronic referrals: eReferral
Analytics: Bespoke data warehouse
GP data viewing: Summary Care Record

Figure 4. BHR landscape

6. Delivering Digital Transformation

In designing a solution for integrated and/or interoperable systems, it was crucial to establish common values and use the design principles to guide the process. BHR organisations are at different stages of digital maturity, have different system architectures, and systems have historically been disparate with limited ability to communicate or exchange information. Interoperability in BHR can be significantly improved through the use of a shared platform and service approach, coordinated at the BHR level extending HLP and National service, and through consistent adoption of BHR agreed interoperability standards for health and care. This will require co-design of interoperability standards, digital services that enable the flow of information for integrated health and care services, and exploitation of opportunities from adopting standards for health and care. Alongside this, a significant change programme will need to be implemented, and additional capacity within BHR will be required.

Figure 5 shows the Integrated Digital Services comprising:

1. Master Indexes – required to coordinate all BHR Organisations and the health and care services commissioned and provided. Master Indexes are proposed to be implemented as Directories which are optimised for high reading performance over writing.
2. Integration Broker – to **unify Services** in BHR, providers and consumers will be connected using policy controlled rules to ensure that future work flows and events can be developed into new applications, services and solutions to support care professionals and patients.
3. Common Care Record – a Common Care Record for a person with a consistent record of care status and history must be made available and accessible to authorised professionals. This Care Record (or Care Records) would be updated from the extant clinical systems and in real time to bring together information at the point in time and the place that it is needed. Different views of patient/care data would be required, e.g. care plan, care preferences, summary care record, and episode care record.
4. Data Warehouse – there must be capability to securely and appropriately store all required data to understand the flow of care of the person, flow of information to the professional and flow of resources to the service. There is a requirement to develop a capability to perform population health management at an ever more sophisticated level including analysis of large datasets, and eventual capability to develop decision support on near real time data.
5. Using Digital Services – innovation and supported exploration by care professionals and (some of the BHR) population are needed to redesign services using Integrated Digital Services. Trying the new services using real people, processes, information and technology will give the most accurate feedback for further development of the ideas and concepts needed to standardise, simplify and share for the benefit of the population by improving health and care services in BHR.

The development of the capabilities throughout the five year programme requires strong, upfront investment in interoperability and will require key interoperability solution components which will provide the backbone of the digital services, applications and systems.

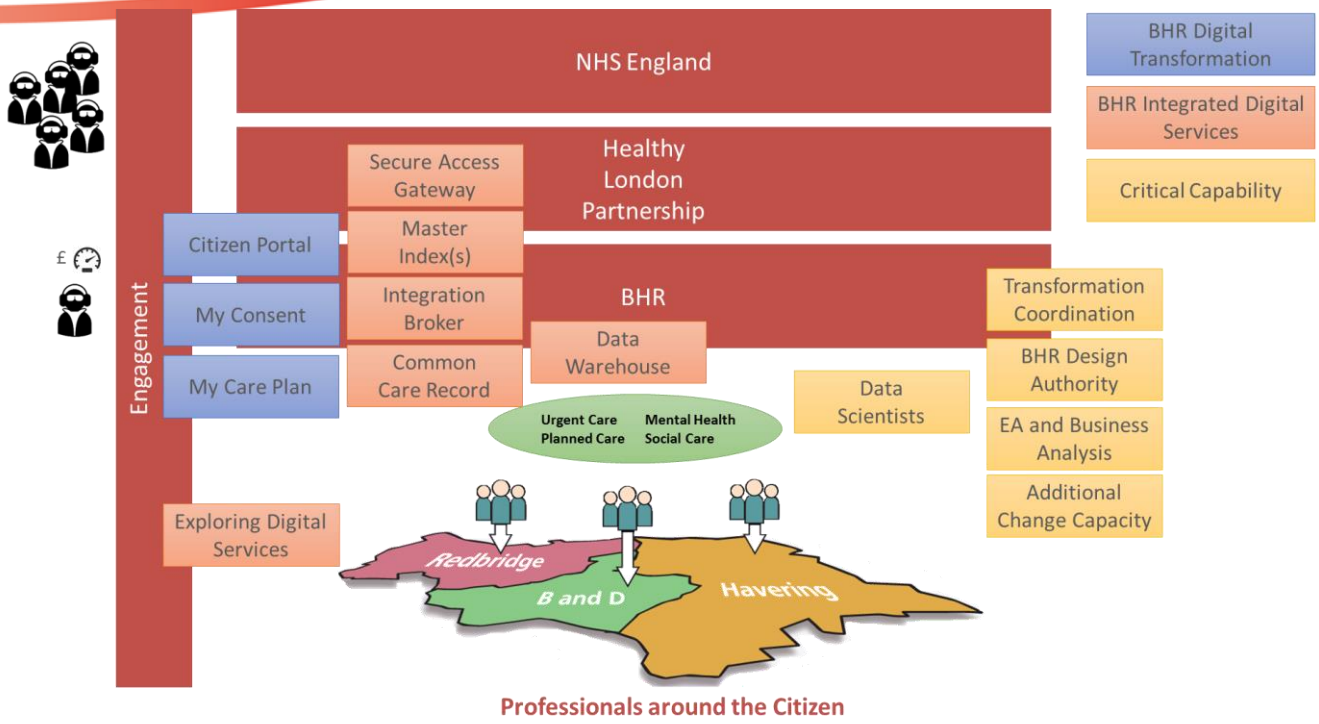


Figure 5. Integrated Digital Services

6.1. Local Capabilities

In the process of understanding and prioritising requirements, and subsequently capabilities, we have mapped the key change benefits assumed against each use case. The majority of requirements that have been described to us relate directly to patient or citizen satisfaction – these user stories have generally concerned patients or service users only having to tell their story once, having increased confidence in the level of care being received, or more personalised care. Closely related to this are outcomes identified that improve the quality of care, which includes patients being able to better express wishes and preferences.

Improved efficiency in the care pathway, including improvements in areas such as admissions and re-admissions, discharge planning and care planning, was a clear driver for a number of requirements, as well as a number of other more general areas of efficiency in the form of reductions in letters, phone calls and faxes, carrying out triage and analyses, reduced referrals, reduced assessments, and reduced duplication in tests and orders. Additional efficiencies related to the cost of legacy infrastructure and systems was also identified as the assumed outcome of a number of requirements.

Requirements that have been captured have been refined and prioritised for delivery, along with the Universal Capabilities. Annex 3 outlines the process through which the priority capabilities were agreed.

Alongside the development of the LDR, new models of care are emerging and are articulated in our STP, supported by the deployment of capabilities set out in the capability deployment plan (figure 7). The figure overleaf describes some of the benefits that could be realised through transformation enabled by these capabilities.

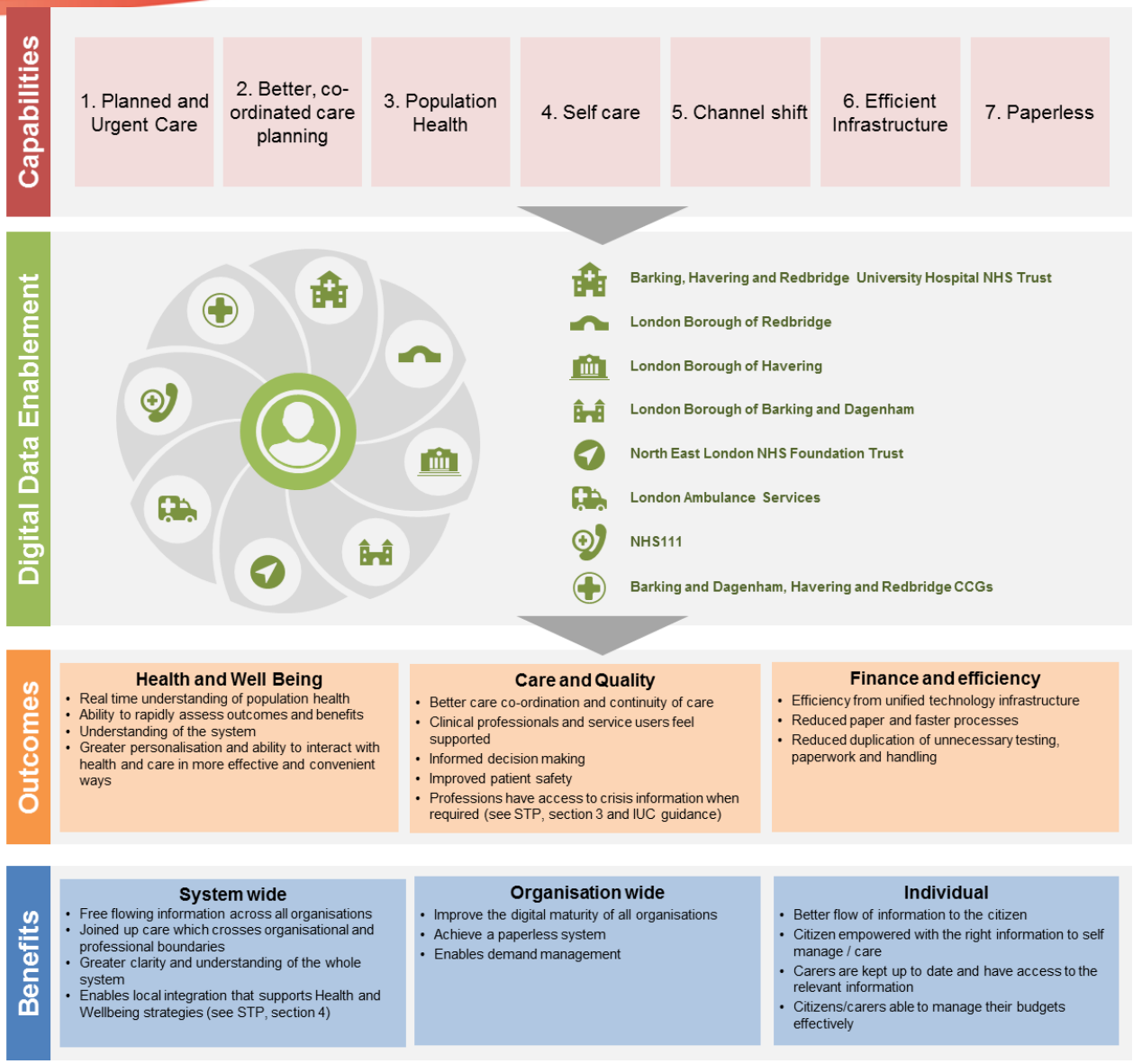


Figure 6. Digitally enabled transformation delivering improved outcomes and benefits for the individual and the system

6.2. Capability deployment

The plan in figure 7 outlines capabilities to be delivered over the next five years, moving partners across the local footprint as a whole towards being Paper-free at the Point of Care, as well as the transformational capabilities required to achieve our objectives. Annexes 4 and 5 contain further detail on implementation.

Capability Deployment Plan

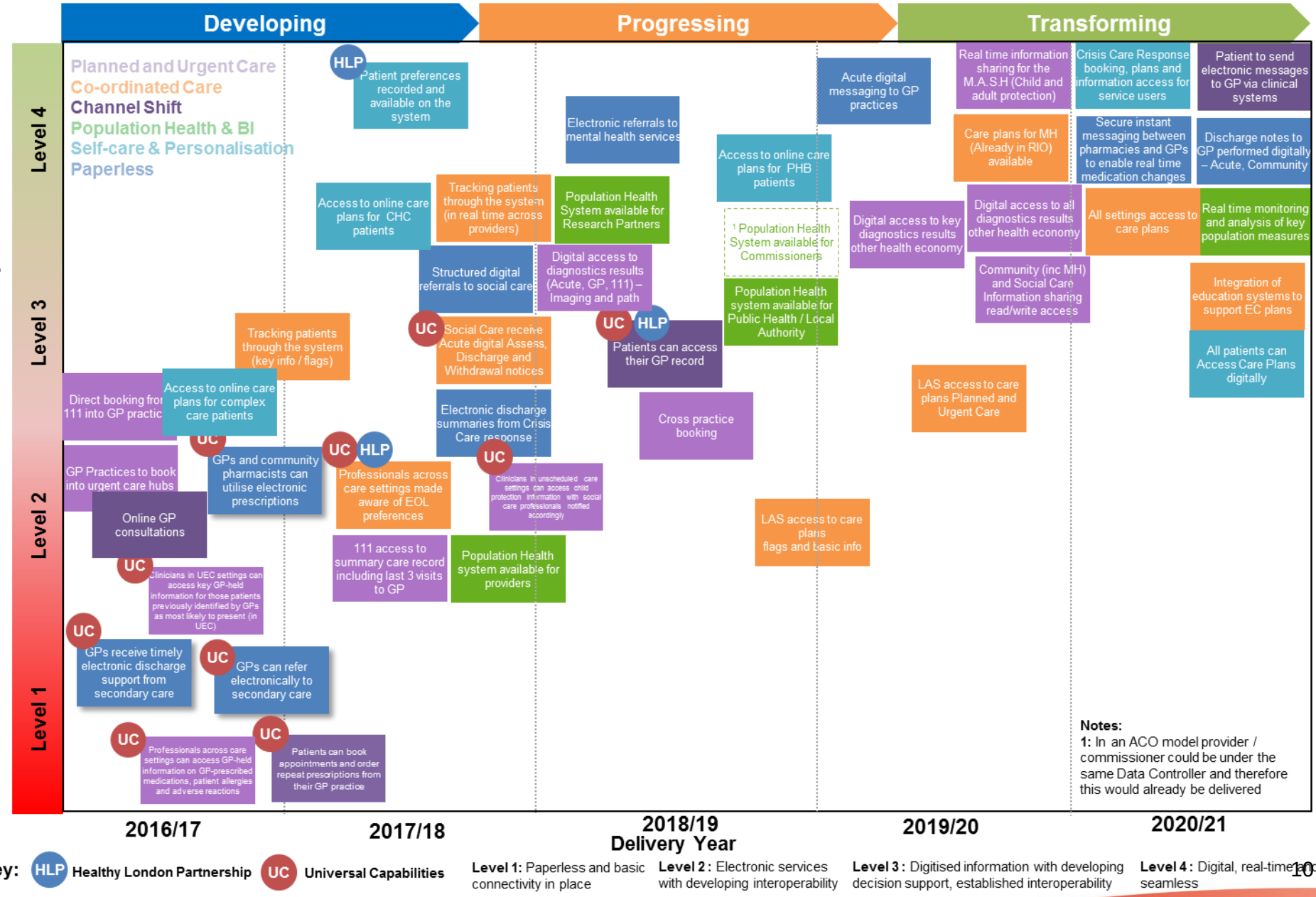


Figure 7. BHR capability deployment plan

6.3. Challenges

The health and social care landscape is a complex one and the challenges in introducing new technologies within that environment are unparalleled. The King's Fund[2] reported the principle factors that influence decisions to adopt technology, and as a system, we will need to identify early on how these challenges will be addressed:

- The level of engagement between technology suppliers and the NHS - over the last 6 years, BHR CCGs, previously ONEL PCTs, have established strong relationships with a number of technology suppliers and have been able to develop technologies and pilot systems in collaboration with these suppliers. BHR will continue to expand and build on those existing relationships.
- The availability of agreed technology standards - we will work at a local level to ensure nationally agreed data standards are used throughout our roadmap deployment.
- Consumer awareness of technology and understanding of the benefits that it can bring – extensive engagement with health and care professionals, service users and carers has begun in order to understand the needs of these groups and increase awareness of technological capabilities and their benefits. This will be an ongoing process as we implement our roadmap.
- Concerns about confidentiality and usability – while we are working with patients and citizens locally to better understand and address concerns, much more needs to be done, both with our communication and engagement colleagues, but also at a national level.
- Government policy - while we are unable to influence government policies, we will ensure our system, processes and people are sufficiently agile in order to respond to policy changes.
- Leadership and direction – partners across BHR have come together to create and pilot an ACO framework that will remove commissioner-provider distinctions and take ownership of the combined health and social care budget to deliver improved outcomes for the population. The ACO Executive Committee will provide collaborative leadership, direction and oversight for our roadmap and its delivery.
- Mechanisms to evaluate technology and encourage adoption – our local innovation test bed, Care City, will aid in informing developments and supporting adoption.
- Effectiveness of procurement and decision-making – the roadmap clearly sets out our priorities, and our design principles ensure any products purchased, or solutions developed, will meet the needs of the system and promote usability.
- Resources: funding and people - with NHS budgets under increasing pressure, funding for technology will be much more difficult to access. Through the development of the roadmap we have been able to prioritise our initiatives and identify where we are able to optimise assets and resources.
- Information governance – perhaps the most significant challenge in developing and implementing system-wide solutions is information governance. The key issues for BHR are no different from those faced across the country, so we will work with regional and national bodies to implement the appropriate standardised measures. In addition, BHR will work towards a standardised fair processing notice until a pan-London approach is agreed.

In addition to system-wide obstacles, each organisation is faced with their own challenges:

- BHRUT are currently in special measures and working with system partners and NHS Improvement on agreed action plants to embed CQC standards, and continued improvement to sustain 'good' or 'excellent' CQC rating
- NELFT deliver community and mental health services to eight CCGs and will need to align to three different LDRs
- LBBD have recently re-tendered for their social care system and is currently in the implementation phase
- LAS cover the entire Greater London region and therefore features in multiple LDRs

A number of risks also arise from implementation of new technology, such as cyber security threats and potential unauthorised access of data. BHR's approach to minimising these risks is described in Annex 8.

[2] The King's Fund, Technology in the NHS, Transforming the patient's experience of care

6.4. Enablers

Faced with considerable challenges, it is essential that we take full advantage of existing enablers to ensure our ambitions are achieved:

- Open data standards - widespread interoperability between health applications is achievable once a useful set of standards is agreed and accepted.
- Information governance is fundamental to the success of this roadmap. Properly implemented and with engagement from service providers and service users, it is key to enabling most of our strategic outcomes. We will continue to adopt national IG standards and work with NHSE to ensure these standards are appropriate and practical. We will invest in our staff to ensure they can promote the benefits of information sharing and will campaign amongst our service users to increase understanding of the benefits of appropriate information sharing.
- A key enabler to achieving our vision is the digital literacy of our workforce. We will ensure that we facilitate learning and support development of our staff so that they feel confident and empowered to utilise any new technologies.
- Digital inclusion – ensuring that access channels for clinicians/carers and service users have the widest possible application
- Digital literacy of patients and carers is crucial, when people are accessing information about their care and especially when implementing digitally-based self-care facilities.
- Maximise the existing capacity of current digital infrastructure and make full use of it before considering further investment. We will explore the option of consolidating both the infrastructure and its organisational support where appropriate.

7. Finance Requirements

We have developed a programme approach which complies with the principles agreed within our LDR and with the organisations therein. The programme, illustrated in figure 8, and its constituent costs (shown in Annex 6) are broken down into logical components totalling approximately £42M. These components will be integrated together and will allow flexibility to use rare skills efficiently, manage the implication of inevitable change, support resource constrained organisations, and deliver against the overall set of functions and requirements agreed. Certain components are time limited, and relate to a requirement to implement the project, some however are endearing, in that new skills and resource are required to monitor, maintain and continually develop and exploit the new technology as strategic and operational needs demand.

The components are as follows:

- **Governance:** The inclusion of a Chief Clinical Information Officer and Director support to free up time to Direct and steer the programme.

- **Programme Management:** Programme management and a PMO structure to provide the control and guidance, manage the plan, the risks and issues, finances and reporting. Project Managers to be allocated to capability projects as required.

- **Core Development Team:** A pool of technical development specialists who will be allocated against an Agile programme to develop new functionality, or ‘seconded’ to capability projects to deliver the schedule of functionality and requirements.

- **Core Technology:** The set of enabling technologies that are used across all capabilities to deliver the new interoperability ‘layer’ that will enable the seamless sharing of data and for consistent and systematic interconnection of systems.

- **Capabilities:** Each capability itself will require support and development and also technology and system change to enable functionality and requirements. The detail of these changes is currently under development, but the complexity has been estimated along with an estimate of costs of change.

- **Business Change and Culture:** Technology itself is only an enabler for change. It needs to be integrated into the operational approaches and processes of the organisation and care pathways. This provides necessary support to build on the broader transformation work and ensure the necessary processes, skills and cultural change aspects are delivered alongside the technology.

- **IG/IS:** Information Governance and Security of data remain a paramount requirement and of critical importance to the timely delivery of the project. This component provides additive skills to work jointly with the wider organisations to address the necessary changes and put in place the necessary governance and assurances required.

- **Capability Teams:** These are long term skills and roles which will be required to manage the new technology environment

As time moves in the programme, it is recognised that new technologies and solutions will become available for use that may expedite delivery and reduce cost. The agility of our approach above allows us to absorb these changes, and the overall programme financial envelope will need to adjust accordingly to take advantage of these opportunities. Details with assumptions made can be found in Annex 6.

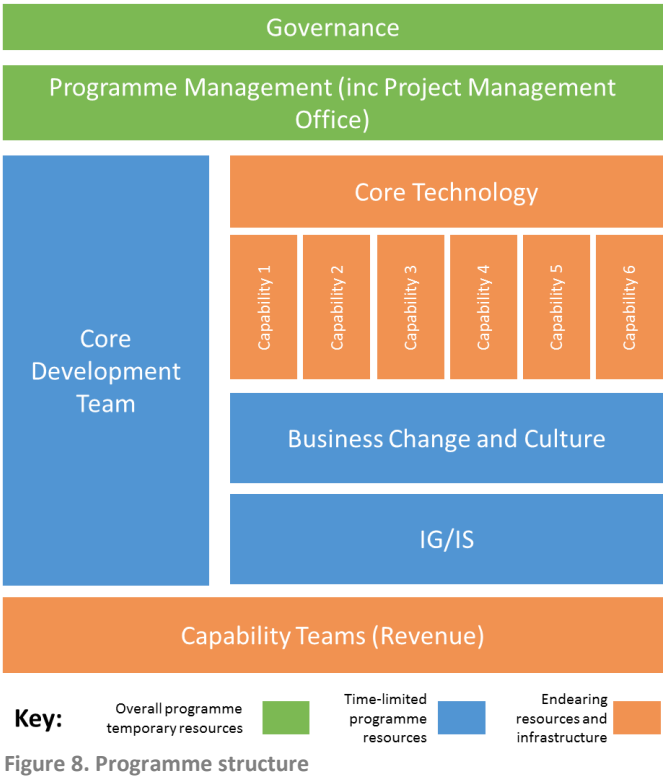


Figure 8. Programme structure

A comprehensive review is currently being carried out to identify funding streams that we may be able to apply to over the next 3-5 years.

8. Governance and Programme Management

In order to ensure successful delivery of programmes, strong leadership and alignment with organisational and system objectives must be maintained. The system wide executive will ultimately hold accountability for delivering against the LDR, while a steering group with technology leads from each organisation will take the lead on delivery. The steering group's mandate will be to deliver against the agreed LDR. This mandate will be backed up by an approved operational plan, which includes funding and roll-out plans, to ensure that projects can proceed over at least one year at a time. The group will also provide a mechanism for ongoing prioritisation of investment in technology and support initiatives through to implementation.

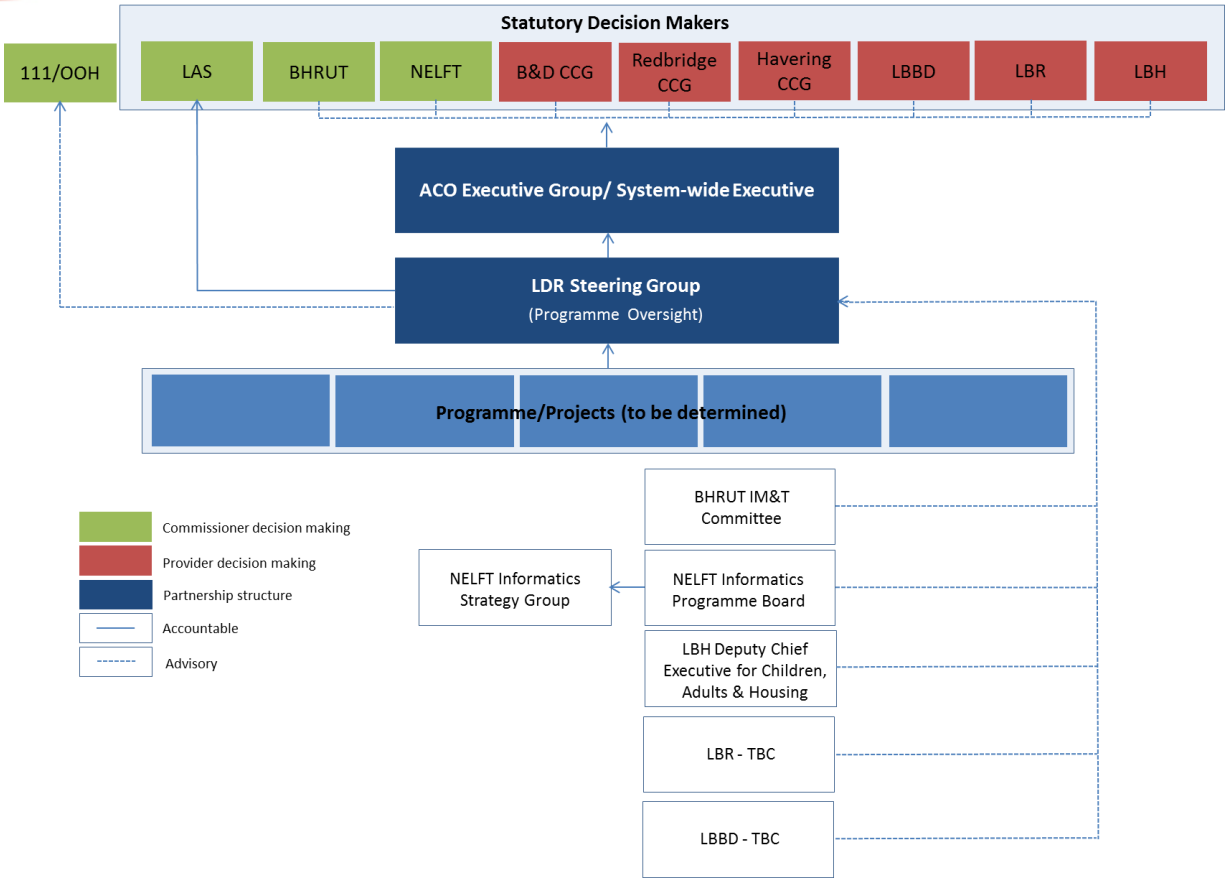


Figure 9. Governance arrangements for delivery against the LDR

Projects delivering against the LDR will be established under a unified programme and operate in line with project management best practice. Where possible, an agile development approach will be taken to ensure benefits are delivered early and are assured by users (see benefits realisation approach in Annex 11). Projects will report to the central steering group as well as local governance for the responsible organisation. A central team of resources with specific skills will be shared amongst the projects (e.g. Information Governance, Security, Business change) which will enable knowledge and skills to be shared across organisations and also ensure a consistent change management approach (see Annex 12 for details).

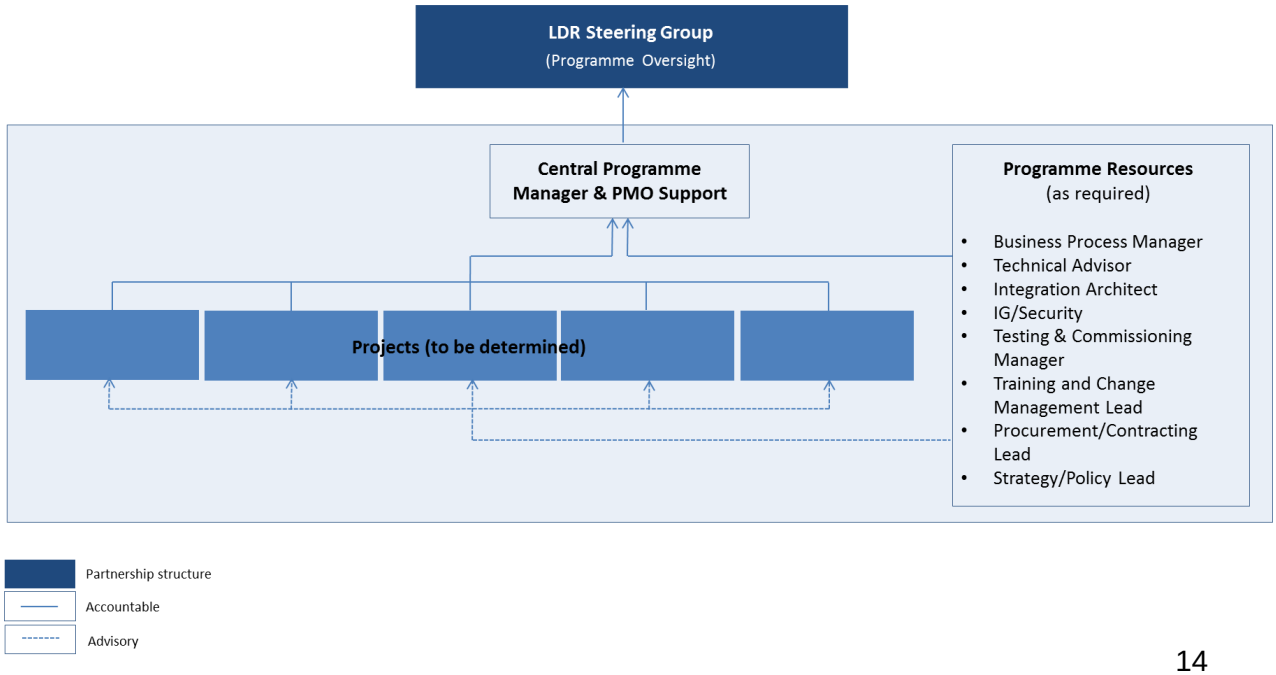


Figure 10. Programme management structure for delivery against the LDR

The following risks to delivery against the LDR have been identified, along with mitigating actions:

Ref.	Risk	Mitigation
R001	Sharing information and records within and between health and social care, addressing Information Governance issues and resolving the conflict between the duty to share and confidentiality	Continued investment in the IG agenda with dedicated specialist(s) working alongside programmes and with NHSE to identify options/potential solutions.
R002	Uncertainty around funding may affect decisions on long-term investment	BHR will take an agile approach to development which will enable us to deliver capabilities rapidly and adjust to changes accordingly
R003	Digital literacy of the workforce and patients	We will invest in facilitating development of our workforce and ensure solutions for patients are have been co-designed and allow for widespread adoption.
R004	Capacity of organisations to manage and implement change to exploit digital technologies	Our shared resource pool will provide flexibility to use skills efficiently and support resource constrained organisations
R005	Delays by system suppliers to engage and develop	Maintain pressure on system suppliers via NHS Digital and our partner organisations

ANNEX 1 – Summary of Organisational Strategies

1.1. NORTH EAST LONDON FOUNDATION TRUST

Locally and Nationally the NHS needs to move with the “digital revolution” and NELFT will support and be at the forefront of technology solutions in supporting the delivery of care. NELFT’s 5 year ICT plan has been developed with the recognition that patients and carers use technology on a daily basis and expect to be able to access information online, book and change appointments and in the near future have access to their care record. The Trust’s plans are to move towards being an organisation that enables its staff and patients to be able to access the web in any of its buildings whilst ensuring that the appropriate security safeguards are in place to protect all whilst making access easy.

NELFT Informatics will play a central role in supporting the achievement of the organisation’s proposed strategic change in the way health and social care services are delivered.

The Trust covers a wide geographical area which has expanded due to the successful bidding for additional contracts; the Trust currently employs approximately 6,500 across the organisation. . NELFT, formed from three organisations that spanned six boroughs: Barking and Dagenham; Havering; Redbridge; Waltham Forest; Basildon and Brentwood; and Thurrock. It now covers aforementioned London estate and SW Essex. These mergers/acquisitions have resulted in an Informatics Department supporting a variety of Information and Communication technology (ICT systems).

NELFT has changed from being a provider of mental health services to delivering 60 per cent of the Trust’s total services in the community health arena. NELFT ICT Strategy has been developed to ensure it delivers the outcomes identified by the Trust Clinical Strategy, Trust Strategy, Quality Strategy, Estates Strategy and operational plans. These strategy/plans will ensure that current and future technology is fully and effectively developed. The NELFT ICT Strategy programme will facilitate delivery against national and local targets as well as operational requirements in order to achieve the principle aim of providing access to the right information at the right time.

NELFT IM&T strategy covers the following main themes:

- A Robust Service Strategy to support NELFT services
- A connected service portfolio across corporate services
- A drive to build skills across ICT and invest into people
- A modern, reliable, scalable, secure infrastructure
- Promote, transform and support optimisation of ICT and EPR applications.
- A paperlite environment.
- A shared and comprehensive clinical record covering present and past clinical information to support clinicians in delivering best care at the point of care.
- Support an Agile work force by providing the right devices that will support the provision of care at home
- Innovative, integrated and interoperable systems that support clinicians with accessing real time information in a single care record containing cross organisational data feeds.
- A strategy to bridge the digital divide across NELFT
- Build, Enhance and strengthen Strategic Partnerships aligned to local digital roadmaps

To deliver the above requirements the Capital investment programme implemented the following projects over 13/14 to 15/16 years:

- Merger of NELCS and SWECS infrastructure and NELFT's IM&T systems
- IM&T systems for Applications Software, Data Warehousing/Reporting,
- Investment into WANs and LANs across multiple sites
- Wi-Fi (corporate and guest) across All NELFT sites
- A Unified single Telephony solution across NELFT estate
- Investment into EPR systems and subsequent development of the systems
- Converged Data Centre integrating Data Centres at Goodmayes and Beckett's House.
- Replacement/upgrades of core switches, utilising the Cisco Nexus range of switches within Cisco's Data Centre portfolio; delivering converged Core and Aggregation Layer Model and a low latency network.
- The extension of the network to SW Essex to replace the BT COIN that NELFT previously used
- A single network domain covering all of NELFT's sites
- A single- mail and telephone system covering all of NELFT's sites
- New C7000 Server blades and 3PAR SAN systems
- New wireless infrastructure
- New DR site for the Goodmayes/Beckett House Data Centre
- Migrating NELFT, ONEL and SWECS sites from MEVPN services to more secure IPVPN services to achieve compliance to PSN requirements.

The national contract between LPfIT and BT which provided NEFLT's London estate with RiO, an electronic patient record solution terminated in October 2015NELFT undertook

An EPR system procurement via the 2015 Consortium, consisting of 30 Trusts working together under LPfIT project management. In 2012/13, this consortium conducted a rigorous Official Journal of the European Union procurement to create a "Framework Contract" resulting in 9 suppliers capable of replacing the current BT/RiO EPR system. The successful procurement resulted in the Trust entering a 5 year contract with Servelec to deliver OpenRIO; under the contract the Trust moved from 5 single instances of RiO to a single instance of OpenRiO. The national contract between the Department of Health (DH) and Computer Sciences Corporation (CSC) which currently provides electronic patient record solution to the South West Essex estate will expire in July 2016. NELFT utilised the existing 2015 Consortium to undertake procurement for a replacement EPR. NELFT are currently engaged in contract negotiations with the preferred bidder.

Over the next 2 years NELFT EPR systems will continue to be developed and enhanced in order to meet the needs of patients, clinicians and commissioners; delivering benefits through interoperability.

NELFT will continue to improve care pathways using information technology by;

- Ensuring that at the point of care, clinicians can access real time information past and present clinical information held by internal and, external systems.
- Configuring internal EPR systems to meet changing clinical requirements.
- Improve EPR usage through training and clinical transformation.
- Improving data quality
- Implementing a Clinical portal and integration engine to enabling the sharing and viewing of real time information
- Developing a strategy for document management and procuring/developing and deploying the solution across NELFT
- Developing a strategy to for electronic prescribing and deploy EPMA solution across NELFT services
- Utilising the EPR to support the Paperlite initiative.
- Deploying a Single Sign on Solution to allow faster, more efficient access to applications

- Supporting clinical delivery via the Agile programme by maximising the IM&T portfolio and supporting services
- Support the LDR by enabling professionals across care settings to access GP-held information at the point of care using the Clinical Portal; e.g. GP prescribed medications, patient allergies, adverse reactions
- Support the LDR by enabling GPs to refer to secondary care electronically
- Support the LDR by providing GPs 'real time' electronic discharge summaries from secondary care
- Support the LDR by providing Social care 'real time' electronic assessments, discharge summaries and Withdrawal Notices from acute care
- Delivering Digitised Notes (EDMS) to support the paperlite agenda by 2020 covering Corporate and Clinical Services.
- Enabling clinicians in unscheduled care settings to access child protection information with social care professionals being notified accordingly
- Implementing Tele health / Patient Access pilots in conjunction with Care City across LTC and Dementia services
- Developing/procuring an Offline EPR solution for the London estate and deploying the SystmOne offline solution across Essex
- Deploying SystmOne Inpatient Unit in Essex.

NELFT was successful In 2014/15 in achieving funding from safer wards safer hospital tech funds to investment in a clinical portal and integration engine.

This integration will deliver 3 main products;

1. A compliant Integration Platform to meet national NHS standards.
2. A Clinical Portal delivering a single integrated record/view of patient information.

The proposed solution will address;

- IG Compliance and auditability
- NHS Interoperability Compliance
- Creation of single views of patient data which are relevant to the user to support the care pathway
- Sharing of NELFT data securely within the Trust and the wider Healthcare community

The aim is connect all relevant internal, external, (local and national systems) to provide a single care record view to NELFT clinicians.

1.2. BARKING, HAVERING AND REDBRIDGE UNIVERSITY TRUST – DIGITAL BY DESIGN STRATEGY

The Trust's 5 year IT strategy aims to significantly upgrade and transform how IT will enable the Trust to achieve its overall vision, which is to provide outstanding healthcare.

The Digital by Design Strategy aims to:

- Deliver excellence in IT basics, with an up to date, highly available, highly reliable, high speed infrastructure and computer estate.
- Build an integrated electronic patient record, accessing data from multiple systems to create an integrated care record. Internally created and externally created data about patients will be available whenever and wherever needed for clinicians and patients.
- Remove the need for paper, redesigning business processes and replacing paper based processes with simplified, leaner, keyboard based processes and a '3 clicks and you're there' approach.
- Deploy key safety technologies such as observations and e-prescribing.
- Ensure the business systems, skills and expertise and governance processes within the IT department are robust and fit for purpose.

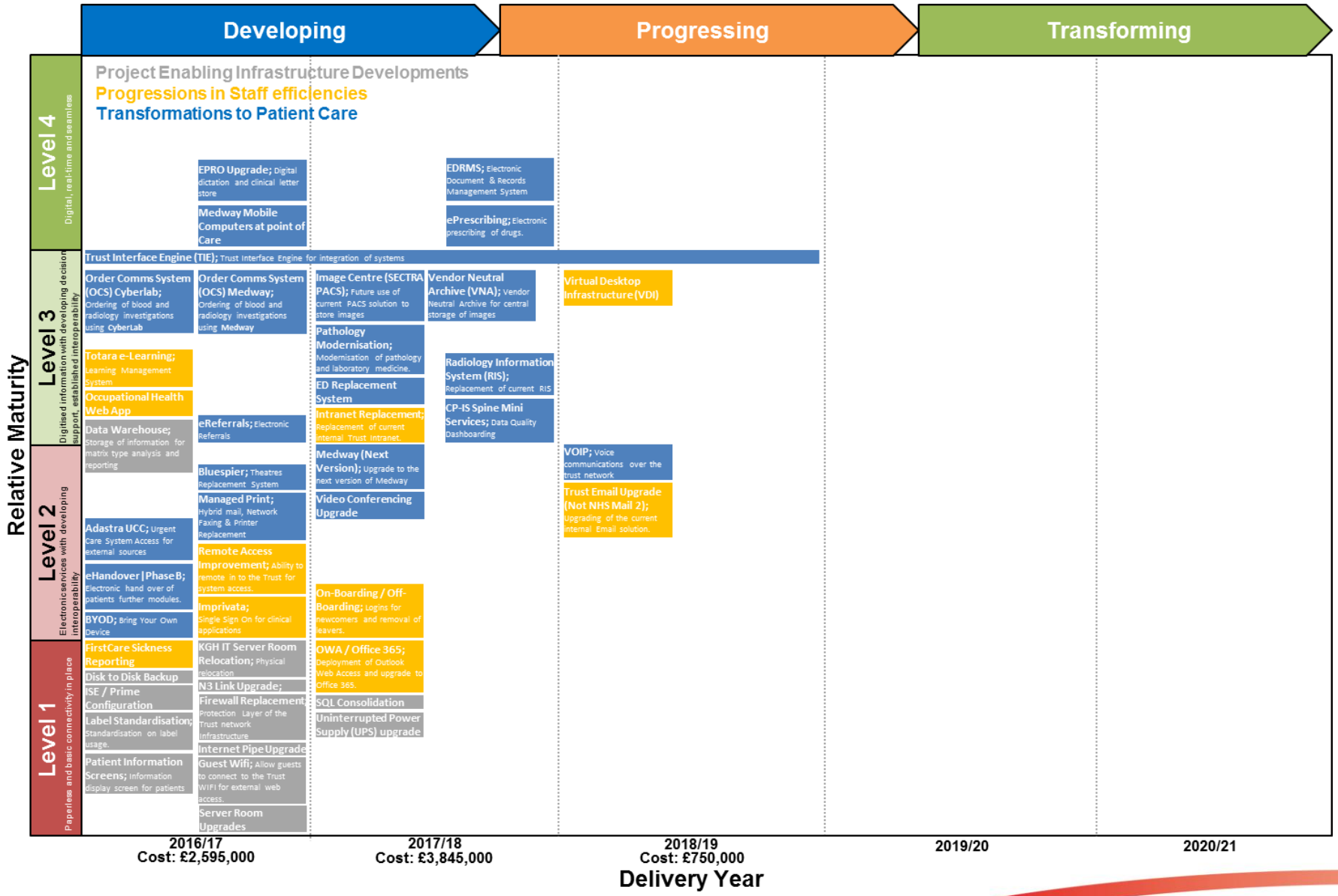
- Ensure that IT is embedded within the delivery of clinical and non-clinical services so that the strategy and any projects are aligned to and driven by business need, and led by clinicians.
- Ensure that the applications in use within the Trust are up to date, and no application is more than one version behind the latest release.
- Develop innovation as a core competency to ensure that the Trust keeps pace with technological advances.

The implementation of the strategy should enable business process transformation which will improve efficiency, reduce the cost of delivering care, and improve the effectiveness of care delivered. Often, IT systems are implemented to replace existing business processes, and whilst this strategy envisages a move from paper to digital, it does not propose a simple replacement of existing processes.

Much of the efficiency gain lies in the redesign of workflow and business processes. The approach to implementing this strategy through the deployment of technology will start from analysing and redesigning business processes, and using IT to support simpler, more efficient, more reliable and less costly processes which will ultimately improve care and reduce cost.

IT will become a change agent for business processes, rather than simply acting as an enabler.

Digital by Design Capability Deployment Plan



1.3. BARKING AND DAGENHAM, HAVERING AND REDRBIDGE CLINICAL COMMISSIONG GROUPS

The CCGs' collective ambition is to support the delivery of improvements in the quality of care from the services commissioned, by moving activity out of acute settings and into community settings. This long term vision, along with the move to better integrated health and social care services, will be supported by an effective IM&T strategy

Implicit in this ambition is:

- accurate, understandable, comprehensive, timely and secure information, appropriately accessible where and when needed for the development and provision of high quality health services;
- improved adoption and exploitation of technology delivering seamless information enabling all users to interact with information and online services using email, telephone calls, text messaging and multimedia, in a consistent and integrated manner;
- a progressive information culture that delivers increasing levels of skills, understanding, enthusiasm and innovation in the analysis and use of information to support business and clinical decision-making;
- a cohesive team of customer-focussed IM&T professionals employing acknowledged best practice methods for the delivery of IM&T based solutions.;
- effective IM&T leadership, governance, policies, standards and architectures that are well communicated, understood and adopted across the CCGs';
- continuously developing the IM&T asset base and human resources whilst consistently delivering optimum value for money;
- an outward looking IM&T service that exploits initiatives at all levels across the NHS as well as meeting statutory and mandatory requirements

During the last 12 months the CCGs have moved some way up the efficiency curve by delivering significant efficiency gains through technology, this has involved some changes in processes and technology e.g. the Continuing Healthcare service transformation. The ambition of this strategy is to secure further efficiency gains through the use of technology but then move on to the next stage of using technology as a catalyst for change. In some cases this will require fundamental changes in our processes, working practices and systems.

1.4. LONDON AMBULANCE SERVICE

The LAS IM&T strategy will play a key enabling role in ensuring that the patients U&E care journey from dialling 999 or 111, through to treatment, referral or conveyance and handover, is digitally enabled and is joined up with their overall care record in this and the other six local London digital footprint roadmaps.

The LAS's IM&T Strategy provides a framework and roadmap for the focus of LAS IM&T service design, delivery and development over the next five years. IM&T plays a critical role in the day to day delivery of LAS services and a central role in supporting the achievement of strategic change in the way the LAS delivers health care services, particularly in the Urgent and Emergency care arena.

The organisation is looking to develop strong foundations and move on to become more agile both in its delivery of services as well as its business processes and capabilities. The IM&T Strategy will play

a key role as an enabler linking IM&T services and developments to the LAS's strategic objectives as a shared purpose. The aim is that the Strategy will help place the LAS in a strong position by the end of 2020, harnessing information, through the advent of digitalisation and the transformative impact of system wide linked data, to improve delivery of patient care, clinical excellence and innovation.

To enable this the internal LAS's IM&T function will be organised to evolve, from what could be seen as a reactive solutions provider into an effective value adding partner in the LAS and beyond. A partner with a shared purpose that will jointly, with sponsoring business owners and external commissioning, deliver services and work programmes to facilitate desired improvements in patient care. This will be achieved through a range of initiatives to assist in delivery against national and local targets, address operational and organisational needs and provide new digital patient centric solutions with digital access at the point of care delivery, linked to the overall patient care information journey.

The principle informational aim is to provide our staff and care partners access to the right information and services at the right time, within structured workflows, wherever they are, effectively, efficiently, and safely for the benefit of patients.

It is essential that investment in LAS IM&T services is driven by the LAS's business and operational needs and plans for change. These plans will increasingly focus on the LAS becoming more effective and efficient partner in a joined up way through changes in service delivery that minimise cost and drive out overall inefficiencies, whilst still providing quality holistic services to patients. Reinvestment of LAS efficiencies will perpetuate programmes of change. The delivery of benefits will be increasingly dependent on stable, consolidated and innovative IM&T solutions, designed and built in partnership with the business and external partners. Successful delivery and adoption will require improvements in IM&T capabilities, organisation and engagement with other areas of the LAS and the London care footprints.

The LAS covers a large and dense population in mainly urban and suburban landscapes and consequently has a large mobile workforce as well as a range of dispersed operational based cross London. The Trust does not differentiate the informational or technology architecture across the London footprints so the IM&T strategy needs to provide a standardised way of linking with the seven footprints. A changed emphasis on providing improved linked-up operational clinical and welfare information solutions fit for a mobile workforce is key. This can only be achieved on a strong foundation of stable and interlinked background services using common standards to manage workforce information and assets.

With a challenging financial situation predicted over the next few years, and a changing and more informationally rich health and emergency service landscape, it is vital that the LAS strategy focuses initially on getting the basics right and that there is strong and well managed engagement from staff in exploring existing and optimising new processes, embracing technology and making it work.

To meet the challenge the LAS will:

- Recognise the key issues for our patients, colleagues and partners, and change what we do, which means altering how we do some things in IM&T and as a Trust
- Recognise the world and our patients are changing; embrace the digital revolution to transform healthcare and emergency service delivery before it is changed for us, whilst continuing to provide secure information services for our patients.
- Systematise how our patients and their information can be part of the care system, interacting differently with our staff and care partners and Systematise and improve support for our staff and organisational functions.

The shape and scope of the LAS Strategy reflects views gleaned over many months both internally and externally, within IM&T, with LAS Departments, the local health community and beyond. It responds to:

- The LAS's five year plan,
- Initiatives and emerging factors identified through engagement with senior managers across all areas of the LAS
- The Association of Ambulance Chief Executives vision for the future of Ambulance healthcare 2020,
- The NIB priorities to be able to operate and integrate digitally with the full range of healthcare and social care partners,
- The advent of digitalisation and system wide linked patient data and its transformative potential of to improve delivery of patient care, clinical excellence, and innovation.
- The continuing need to interoperate with our Emergency Service partners locally and nationally.

It supports and is enabled by wider initiatives, such as the Healthier London Information partnership and the implementation of the national mobile Emergency Services Network and provides an approach to enable the emergence of next generation 999 initiatives. The LAS strategy is also positioned to assist in the development of emerging collaboration initiatives in both the health and emergency service arenas.

The LAS IM&T Strategy promotes development of the LAS's electronic clinical information services and the reduction and where possible elimination, of paper driven process to create a digital healthcare capability. It advocates a digital culture; a culture that embeds the use of technology within its live processes and consequentially inputs, processes and extracts data in real time.

With a focus on supporting the desired Operational and Clinical processes by getting the right information, for the right patient, in the right place, at the right time, the Strategy will ensure relevant information is available whenever and wherever it is required in a secure way.

Digital Gaps in the 999 Patient Journey

The LAS currently operate paper based systems for the capture of patient care information and transferring information to Emergency Departments and other care pathways and referrals.

The LAS operates a data warehouse which contains "call records" based on the event in the Computer Aided Dispatch System as a result of a 999 telephone, automatic transfer or healthcare professional call. The Patient data which is largely collected and recorded by crews on paper is retrospectively scanned in as images, with some data entry, and is then stored and linked to the CAD call record in the data warehouse. The protocols, pathway and other useful information used by paramedics to assess, refer and treat patients is also largely paper based.

There are risks related to the accuracy and intelligibility of hand written documents, the timeliness of information being provided to EDs and other care pathways in the patient journey, and the potential loss of paper clinical records in a distributed and mobile environment. In addition there are risks to the organisation and patients through the current use of manual paper based processes to manage and report on medicines usage and other assets adequately.

In order to improve patient care and use of the most appropriate care pathway for patients, paramedics should have access to up-to-date digital patient and supporting information, and a real time awareness of other NHS services available to them. The requirement for the mobile workforce to access, link and share information with other care agencies and to contribute patient data back into urgent and

emergency care records needs additional technology in the form of a “patient” based information systems and mobile applications.

The LAS has developed business cases in the past, however affordability has been an issue. Whilst previously there has been some discussion of the merits and affordability of electronic patient records in the LAS, the NIB strategy makes it clear that the LAS is expected to integrate by 2020. The LAS will re-establish a programme board under an executive team lead, which IM&T will support, to deliver the changes needed.

In practical technical terms the LAS will need to:

- Digitally identify patients we treat during their journey with us, this may be at the EOC call handling stages or once there is patient contact.
- Adopt the use of the NHS number as the key patient identifier using one of the available methods through the spine once the patient is identified.
- Introduce mobile e-PRF technology to digitise our patient record processes, with staff using integrated mobile devices to verify patient identity, record treatment and improve decision making on conveying, referring or treating patients. This will require significant integration with other’s processes, information and systems.
- Provide mobile access to the patient summary care record (initially) the patient’s Digital care record (as it becomes available) through the HLP approach, continuing care plans, and generic care protocols and information
- Introduce a patient centric back end digital patient record system to store and to access our (and others) records,
- Integrate this with the patients centralised and dispersed digital health care record.

With the demand for external integration, adopting existing and emerging standards and changes in the topology of our care partners we do not believe this can be achieved within our existing CAD and will need to be adjunct system or set of systems, closely integrated, along the lines of a patient information system with applications for mobility.

We will not be able to individually integrate with all our care partners but will look to consolidate integration and linking up of information through initiatives and standards borne from the joined up working of the Healthier London Partnership U&E Care real time information sharing initiative.

There are a number of technology options to deliver this overall capability, from in house development, through traditional ePRF solutions, emerging innovative App base solutions to introducing a fully mobile clinical and patient and information system. Whilst the LAS solution will be defined through the LAS Business case process, under the Business and IM&T governance approaches and hence incorporate IM&T architectural control, the approach to the design and evolution of the mobile solutions in particular are likely to follow modern mobile application design and development approaches.

It will be challenging for the LAS to invest Capital and absorb increased initial Revenue costs associated with the introduction of these additional services, in the desired timescales, so applications will be made to central funds, with the support of our local Digital Roadmap partners to assist the LAS to deliver their part of the digital London U&E Care journey

1.5. BARKING AND DAGENHAM, HAVERING AND REDBRIDGE CCGs

The CCGs' vision for IM&T is:

"To harness, information, integration and innovation to drive the CCGs towards a culture of active IM&T users, enabling efficiencies and excellent patient care across boundaries."

Implicit in this ambition is:

- Accurate, understandable, comprehensive, timely and secure information, appropriately accessible where and when needed for the development and provision of high quality health services;
- Improved adoption and exploitation of technology delivering seamless information enabling users to interact with information and online services using email, telephone calls, text messaging and multimedia, in a consistent and integrated manner
- A progressive information culture that delivers increasing levels of skills, understanding, enthusiasm and innovation in the analysis and use of information to support business and clinical decision-making;
- A cohesive team of customer-focussed IM&T professionals employing acknowledged best practice methods for the delivery of IM&T based solutions.;
- Effective IM&T leadership, governance, policies, standards and architectures that are well communicated, understood;
- Continuously developing the IM&T asset base and support staff, whilst consistently delivering optimum value for money;
- An outward looking IM&T service that exploits initiatives at all levels across the NHS as well as meeting statutory and mandatory requirements;

The intention of the IM&T strategy is to continue the development of IM&T to improve the way medicine is practiced and healthcare is delivered within the Health Economy. Our aim is to provide an environment where the patient is at the centre and empowered to control and interact with clinical information held about them in order to participate in their own care. Information and tools to plan, model, and proactively manage services using data collected during the care process will be further developed and enhanced. Finally, the research and audit agendas will be supported through building on the previous investments in information systems and development of the business intelligence tools.

Critical to the success of this strategy is the acknowledgment that technology-based information and communications are an increasingly important part of all the CCGs' services. Although the responsibility for ensuring that the CCGs get the most from IM&T is led by the Innovation directorate, it requires shared ownership of this strategy and effort and commitment from everyone across the CCGs and partners to achieve a successful implementation.

1.6. LONDON BOROUGH OF HAVERING

A high level summary of the oneSource plans to exploit ICT (Information and Communications Technology) and Digital opportunities to achieve the following outcomes is outlined below:

1. Radical transformation of Councils service delivery models in order to achieve its stated outcomes at dramatically lower costs. This opportunity will be realised by advances in technology, customers connected to the internet and commodity cloud services. It will also come from partnership working with other public or private sector organisations, voluntary groups or oneSource Councils residents and businesses.

2. Increased self-service by residents and businesses where more radical transformation is not possible. This should be accompanied by end-to-end process review and automation wherever it is cost effective to do so.
3. Improved outcomes for local people, place and businesses where affordable within the Council's spending capacity.

It is important to recognise that high quality ICT systems and services alone are no more than an overhead if they are not used effectively. Therefore all of the ICT and Digital developments must be accompanied by people and process change in order to be really effective.

The costs of ICT systems and services generally make up 3-5% of the operating costs of an organisation and so while this document necessarily covers plans to reduce the overhead of running the ICT operations, it also focusses on the greater opportunity which is to improve the efficiency and effectiveness of the 95%+ of the Council's running costs.

Other Related Documents
This summary should be considered in combination with the oneSource Digital Principles Guidance (originally published by oneSource ICT in May 2015) and the annual Service Plans which contain the more detailed annual plans which underpin service plans from all other council departments. At the more detailed level, ICT also maintains PCN (Programme Critical Network) diagrams which show individual project timelines within themes shown as "swim lanes". These diagrams are easy to understand, providing a visual representation of ICT activity at any point in time.

ICT Strategy Content
The following sections break down the major elements of the Council's ICT and Digital activities and describe how they are expected to evolve during the next four years. This term was selected less for ICT reasons, as ICT changes very frequently, but because of the funding cycle associated with local and central government.

It is envisaged that this document will be updated regularly in order to reflect the inevitable changes that will occur in relation to such elements as technological change, demographic/demand change, evolving new delivery models, devolution, the Care Act, shared services and various other possibilities.

On-line Self Service
Over recent years oneSource and the councils have steadily build up the technological capability, the business processes and the marketing and customer awareness to start to move significant volumes of transactions online. This has allowed residents and business users to self-serve reducing the cost to the council while making services available 24/7 from a location of the customers choosing. It is our intention to continue to drive customer contact away from the much more expensive face to face and telephony channels. At the same time we are working with Customer Services and back office services in order to provide healthy challenge to traditional processes and delivery models. Initial priority areas in 2016/17 include high volume transactions such as Newham's Council Tax and Housing Benefits (but only where the transactions are suitable for online self-service).

The technologies used in this area will need to be regularly reviewed as online service presentation must reflect developments in end-user device usage and customer usage patterns. We will therefore be redeveloping the web site to make it "responsive" this means that it will look good and be used on mobile phones and tablet computers of a variety of shapes and sizes as well as on the traditional PC browser. Subsequent development will entail a change of CMS platform, new Portal and upgraded CRM (2016 online).

We will also be enabling Havering smart phone users to report issues to the Council using photos and geographic location information provided by an "App" like interface. This will provide the opportunity for the end-to-end process to be automated and remove all council staff involvement up until the point where a physical activity, such as clearing up graffiti or fly tipping is required. The quality of the user interaction can also be improved with automatic confirmation of receipt of the request, along with service level information and ultimately confirmation that the service has been delivered. Because the contact handling will be automated, 50 or 100 residents alerting the council to an issue such as a dangerous pot-hole will not cause the council any more work than a single request. This will provide a significant

capacity improvement on the current situation where Customer Services staff often have to be involved in each and every customer interaction. Customer service standards should be published online for all services delivered to residents and businesses. Indeed technology should be used to increase the transparency of the organisation with a default position being that all information accessible via an FoI request should be published online.

Business transactions will also continue to be a focus for shifting online and going self-service. As well as reducing costs this will make Newham and Havering better places for businesses to do business with us. These transactions will build on the Havering led work carried out in 2014/15 to introduce a business portal to compliment the resident portal.

Although the focus of this section of the document has been on the Council's customers consuming services via on-line self-service, the same principle is intended for staff (and Havering's elected members through the Members Portal), 1Oracle ERP, the new Intranet and ICT & HR self-service portals as well as a variety of other systems. As we are expecting residents to operate this way, then there is no reason why our staff should not do the same.

All council communications and processes should be reviewed in line with the oneSource Digital Principles in order to maximise channel shift, process automation and improvement. The ICT service will support these reviews as well as any resulting digital transformation improvement opportunities that arise as a result.

Business Intelligence and Performance Management Newham's Data Warehouse & BI Programme and Havering's Corporate Brain Programme

Closely linked to the Channel Shift work is the need to better understand the demand placed on council services based on its current and changing resident and business demographics.

The capability to develop and interrogate this understanding, to ask "what if" questions and conduct predictive analytics as well as see operational performance is being developed under the banner of a programmes called the Data Warehouse & BI / Corporate Brain. In support of this programme the ICT service has built and is iteratively developing the Data Warehouse and a variety of user interfaces including an Intranet search function and GIS capabilities to analyse the data.

The Data Warehouse will be used in conjunction with 1Oracle OBIEE performance management dashboards and reports in order to process and visualise the councils business intelligence and performance management requirements.

Corporate Systems

The 1Oracle ERP (Enterprise Resource Planning) system is the main system used by the Councils for transactional processes and staff self-service (for managers and all employees). The Oracle ERP system is used by many of the biggest and most successful organisations on the planet. It is already used in Havering and Newham (from April 2016) for finance, payroll, procurement, HR, staff-self service, manager self-service and ERP related elements of performance management. In order to get the maximum return on this significant investment, any other systems which perform functions which it is capable of delivering should be decommissioned unless there is a compelling reason not to do so.

The performance management element of the system is capable of carrying out highly complex analysis of council demand and performance, then reporting via dashboards and a variety of report styles. This capability will be developed in conjunction with the Data Warehouse & BI / Corporate Brain activities described above.

Support costs for the system should be minimised through pooling of support arrangements with other boroughs which use the system, improved commercial arrangements and migration to commodity cloud versions when the market has matured sufficiently.

Other corporate systems will be reviewed to determine if they are still required and either decommissioned, functionality migrated into 1Oracle or replaced with an improved solution, preferably a commodity cloud service.

Line of Business Systems
In order to minimise costs associated with line of business systems we will work towards the following principles.

1. Decommission if no longer required.
2. Move the hosting to a commodity cloud / SaaS (Software as a Service) model as soon as it is available at a better total cost of ownership than through current on premise hosting and support arrangements.
3. If a SaaS model is not available, is not cost effective or sufficiently secure and available (based on up-time and response time). Then we will seek to share support costs with other public sector organisations.
4. Consider moving functionality into Dynamics CRM or 1Oracle in order to reduce the number of systems being maintained.
5. Renegotiate contracts to get best value for systems still required.
6. Develop our own solutions if the market is failing and particularly if there is a commercial opportunity to share costs or generate revenue through re-use.

Line of business systems should be integrated with the Data Warehouse in order to improve data quality by linking master data sets for people, businesses and properties and also to allow the data to be analysed through the Data Warehouse in line with requirements developed by the Data Warehouse & BI and Corporate Brain programmes and service specific needs.

Some line of business systems are already effective and cost efficient and will receive relatively little development. In these cases the focus will be on minimising running costs. Other such as Havering's Housing system and Newham's Social Care System are in the process of being replaced and there are significant projects underway to improve effectiveness of the service through the implementation of the new system and associated processes. These are being treated as change management exercises with significant ICT components rather than the other way around. In between are systems such as Havering's Social Care where we are not yet ready to specify a new system due to radical changes to the service requirements evolving caused by the Care Act and the need to work increasingly closely with local health service providers. Each systems development needs are captured and planned for delivery through the applications systems roadmap documentation.

End user devices and experience
Over the last 5 years the use of ICT by staff in their day to day working lives has come a long way. Many more staff now use ICT to improve their productivity and they are generally able to do so using a variety of devices from a variety of office locations, from home or while travelling using mobile devices. The use of the iPad as a companion device to a "hot desk" PC has already enabled a variety of staff and elected members to be more effective and work more flexibly, Windows 10 will be rolled out to newer tablets and laptops with Direct Access in order to enable further mobile working capabilities, this may be complemented by Total Mobile software where field workers require online and offline forms capabilities.

oneSource has used Microsoft Lync telephony, presence and instant messaging along with secure remote access from council laptops and personally owned PCs at home to reduce its office accommodation costs through 3 rounds of "COPS" office space usage transformation programmes in Havering. In Newham the Dockside move was accompanied by Microsoft Lync and Cisco IPT to support its flexible working objectives. The efficiencies enabled by reduction of total office footprint as well as collocating staff for greatest benefit and assisting work/life balance through flexible access to council systems based on location and time will continue. Further office consolidation exercises will be carried out and oneSource shared service arrangements with Newham and Bexley are providing increased demand for mobile and flexible working technologies and interoperability of systems.

The oneSource shared service Councils of Havering, Newham and Bexley will be reviewing end user (desktop and mobile) telephony provision in order to replace the current complexity of Cisco & Microsoft based unified communications in Newham and Havering and Avaya in Bexley..

Mobile working is a key area where services can readily see that they can become more effective and efficient. In order to unlock this opportunity ICT will work continue to work with service areas in order

to provide a variety of device types which are suitable for the needs of the various functions and the staff that perform them.

As well as providing fit for purpose devices, the ICT service will work to ensure the devices are secure and to continuously improve both the ease of use and functionality provided by the software on the devices. For some workers this will simply mean improved access to corporate systems such as email, calendars, ERP and for others it will also involve access to line of business systems. In the latter case some line of business systems already have good mobile working modules, but for others we plan to deploy software solutions which separate the forms and displays used by staff on these systems from the back office systems where the data is processed and stored. This will allow interactions to be simplified and made quicker and easier to use. This will potentially reduce skills levels required so that one council officer could potentially conduct social work, benefits entitlement checks, or other functions in a single visit.

We will review records and document management arrangements in the borough to ensure we only retain the useful data, stay in line with data protection laws and help staff to access the information they need as quickly and easily as possible. This will involve ICT lead activities such as rationalisation of document management systems, use of SharePoint and Yammer in Microsoft 365 and collaborative activities with the councils to replace or upgrade Intranets, implement new retention and archiving policies.

Networks and Telephony

As well as the review and re-provisioning of desktop telephony mentioned above, we will upgrade the Avaya contact centre telephony system used by Customer Services as a temporary measure, leading onto a review of longer term requirements for both Newham and Havering. The expectation is that this will lead to the joint procurement and management of a single commodity cloud contact centre solution if this technology is assessed as being sufficiently mature by 2017 or 2018.

Council in-office wireless systems are in the process of being replaced with newer higher performance solutions which will allow oneSource staff to roam seamlessly across the boroughs (Newham's upgrade is now complete and Havering replacement is in progress).

Data Centres, Hosting & Cloud Computing Services

We will move to consume commodity cloud services progressively over the period of this strategy such that Newham and Havering either no longer need to run their own data centres, or alternatively oneSource may do so on behalf of multiple organisations for those systems and services which do not lend themselves to cloud delivery for security, performance or commercial reasons.

The migration to commodity cloud services will be a continuous process over this period, adopting a vanilla/keep it simple principle to minimise costs arising from solution complexity and bespoke development. The migration should be made seamless and cost effective through partnership working arrangements across London with other local authorities, procurement communities and global strategic suppliers such as Microsoft, Google and Amazon as well as the government solution providers such as Northgate, Capita and Civica. Where the market fails to provide quality products at affordable prices or fails to innovate sufficiently for our needs we will work with others from local and central government to commission or directly develop software solutions which meet our needs.

Data storage capacity will leverage cloud computing services in 2016/17 in order to further improve disaster recovery capabilities and provide greater flexibility as well as improved day to day performance is currently underway. This builds on the oneSource enterprise agreement with Microsoft which will also see Office 365 being used later in 2016/17 for cloud hosting of eMail, day-to-day document storage and access to the latest Microsoft Office products and services including SharePoint and Yammer, Word and Excel as well as services new to oneSource such as Delve. This will be a hybrid design which provides the best of cloud and on premise full client deployments to maximise flexibility, performance and availability.

Social Inclusion

Just as internal council systems are ineffective if staff do not have the skills, devices or connectivity required to access them, this is also the case for our residents. If residents and local business users do not have the knowledge, skills, devices or connectivity required then we will not be as effective in

channel shifting customer contact as we would wish. Although we have already made a great start in shifting transactions and have been more successful in getting older people online than many people anticipated we know there are areas where is a significant gap in capabilities of our residents and businesses to go online and benefit not just from online access to our services, but to online shopping (and savings), job and commercial opportunities, social contact and various other benefits. We are therefore working to better understand where these gaps exist and what these groups need to get online (either themselves or via friends, family or community groups). Our initial priority area identified is council housing tenants where we are working up proposals to help get them online by addressing the missing ingredients, be they devices, connectivity, skills, awareness or desire.

1.7. LONDON BOROUGH OF BARKING AND DAGENHAM

The 'digital revolution' that began in the late 1990's has been transforming the way that many people live their lives; from the way we buy goods and services to the way that we share information, communicate and connect with others. This revolution also presents a major opportunity for local authorities to redesign public services through the adoption of new and emerging technologies, in a way that meets the needs of customers while saving money. To get to this point, however, challenges also exist. Public expectations of what local authorities can deliver through technology are increasing while resources are heading in the opposite direction. There is also a digital skills gap to address, not just in some parts of the community, but also within the workforce.

In spite of these challenges, the digital revolution will continue to transform society and is will deliver greater change within the next 5 years that seen within the last 25. In this age of expectation and rapid digital change the council needs to deliver services that are modern, inexpensive and efficient, and in a way that is inclusive of all our residents.

With the population of the borough increasing, with added demand for council services, the development of digital services is will play a key role in helping to manage demand for our services while meeting evolving customer expectations.

Why do we need a digital strategy?
We need a digital strategy because digital technology has the potential to transform the borough and the lives of residents while generating long-term savings.

Digital delivery of many of our services has been our ambition for some time and we are already responding to this challenge through the launch of our digital customer platform in 2011, when became one of the first councils in the country to provide comprehensive online services for council tax, housing benefit and rents.

This digital strategy sets out the council's approach to the required changes and sets out a clear vision in which we will:

- Provide transactional services, information and data online in a user-friendly and inclusive way that meet the needs of our residents and customers;
- Use technology to change the way traditional face-to-face services are delivered, so enabling us to deliver more effective and efficient services;
- Create a more digital workforce which is agile, mobile and using the most appropriate technologies to support service delivery;
- Enable our residents to use digital technology and enable access to technology for those that do not have it;
- Use digital technology to work and collaborate with our partners, including the effective use of open data;

There is clearly demand for digital council services; a 2012 customer satisfaction survey found that over 55% of customers would use online services if the Council made them simple to use. By December 2014 this figure had risen to 76%.

The approach this strategy outlines will meet this demand while supporting the council's priorities and enable us to realise our ambition of growing the borough.

Our digital vision - making Barking and Dagenham digital
The Digital Strategy outlines our vision for making the borough digital and our approach for realising this.

We have four key priority areas:

1. **Digital Place**
2. **Digital Customer services**
3. **Digital Workforce**
4. **Digital Partnerships**

The Digital Strategy outlines what our vision is for each priority area, where we are now and how we will achieve our vision, looking at some of the key projects within the priority areas. It also includes the principles that we will use to focus our investment and guide our work using technology.

Our key priorities

Digital place
Enabling residents and businesses with the digital skills and technology they need to enhance their lives.
This means enabling residents and businesses in the borough to use digital technology to improve their lives, providing them with access to devices and the internet as well as developing their digital skills, from the children and young people in our schools to our elderly residents.

Digital customer services
Enabling our residents and customers to get the services and information they need through digital services.
This means providing services and information to residents that meet the needs of our customers in a user friendly way.

Digital workforce
Staff will have the digital tools and skills required to deliver services effectively and efficiently.
This means delivering positive outcomes for our residents by giving staff access to the data they need and the best available technology, ensuring they have the skills to use it effectively.

Digital partnerships
Digital technology will enable the council and its partners to tackle complex issues and work together seamlessly.
This means using digital technology to work with our partners to deliver the outcomes we both desire and incorporates aspects of Digital Customer Service, Digital Workforce and Digital Place.

Digital Place
What is our vision?
"Supporting residents and businesses to access the digital skills and technologies they need to lead their lives."

Our residents and businesses will be able to quickly and easily access digital technology will have access to the digital skills required to improve their lives from an early age. We will increasingly be recognised as a digital authority, gaining a reputation as a council that delivers modern, accessible services in digital ways.

Communities, businesses and our partners in the borough will work with the council to design and develop digital solutions to for all to use.

Where are we now?

Internet access across the borough is rising steadily, but there are still those who do not use or access the internet. There is free internet in libraries and internet kiosks and wireless in a handful of locations.

How will we achieve our vision?
We will work to support the delivery of digital skills classes to residents and businesses through our adult community learning and voluntary sector partners.

We will encourage the use of digital technology and internet access across the borough.

Support residents and businesses to access ultra-fast broadband connections and capitalise upon opportunities provided by them.

We will encourage third party platforms, including social media and peer to peer networks, for residents and groups to raise issues and draw support for local initiatives.

Digital customer services
Residents and businesses will be able to access our transactional services 24 hours a day, from any device. Our automated services, those online and over the telephone will be designed to meet the needs of all our customers.

By 2020:

- Those council services that can be made available through digital means will have been made available digitally;
- 80% of day to day transactions will be carried out online or through automated telephony;
- The Council website will be the place that local people, businesses and the voluntary sector "meet" to do their business;
- The Council website will be the main source of information and open data for residents and businesses;
- More complex transactions and engagements will be delivered, in part, through digital means

Where are we now?
More than 1 in every 2 households has signed up for a council MyAccount allowing 50,000 residents to self-serve for Council Tax, housing benefits and rents. The council website uses fully responsive design so it can be viewed on any device, from a mobile phone, tablet to laptop.

What next?
By 2016, we will add many more popular services to MyAccount including bookings, housing repairs and applications and a new Report It function. In all during 2015 a total of 8 new online services will be made available for customers, supporting how people can interact with the Council and transforming of a range of important council services.

By 2016 we will have a greater understanding of our customers together with a new suite of tools to allow us to personalise the online experience, while a further module will add greatly to our ability to work with important local partners such as the third sector and health services.

Digital Workforce
Council staff and elected members will have access to a range of devices and digital platforms and the appropriate skills, to allow them to work remotely while delivering a high level of service and community engagement.

What is our vision?
"Staff will have the digital tools and skills they need to deliver services effectively and efficiently."

Staff will have access to the devices and systems they need to deliver the modern services to our residents, and will be equipped with the skills to use them. Our workforce and councillors will be enabled to work in a mobile and flexible way.

All council services will actively identify opportunities to work digitally as part of the service planning process. The Council will engage with residents in helping them to use, test and design our digital solutions.

We will continue to handle our resident's personal data safety and we will be clear with everyone how we will use their data. Data from our partners will be as accessible and secure as council data while identification verification will be as simple and straightforward via our MyAcccount. We will use this data to help us in our service planning and policy development.

Where are we now?
We are involving our staff in the development of our digital services and are asking for their ideas and suggestions. Where possible all staff will have access to email and digital ways of mobile working.

How will we achieve our vision?
Delivering digitally will become a central consideration in all our service planning and policy development.

Our Ambition 2020 programme will review and lead on the delivery of digital technology across the council.

The technology our workforce uses will more closely reflect that currently being used successfully in private sector organisations, such as smart technology.

Through our workforce we will continue to be a digital test bed, working with our partners to develop and pilot new digital technologies and approaches to delivering services.

Our communication with colleagues and partners will extend beyond e-mail and telephone, using face-time technologies. We will increasingly use our intranet and website to keep work colleagues up to date and informed, with access to the resources they need.

We will ensure that our workforce are given the proper training to deliver services digitally through core digital skills training, supplemented with specialised training where required.

Digital Collaboration
What is our vision?
“Digital technology will enable the council and its partners to tackle complex issues and work together to deliver services to residents”

We will streamline data sharing processes to facilitate simple and secure data sharing with our partners where agreed and appropriate, allowing for a far better picture of multi-disciplinary issues. We will work with our partners in an integrated way, enabling us to work together to identify solutions to issues, provide efficient and effective services and develop well-informed organisational strategies. We will be recognised as an open and transparent council and will publish much of our information and data.

Digital collaboration will extend to the technology we use. We will work with partners to develop and procure established technology for Islington rather than developing new solutions ourselves, ensuring we get the best value for money. In addition to this, the technology in place at the council and our partner organisations will mean that meetings and collaborative working can take place anytime and anywhere.

We will explore commercial opportunities to collaborate with private sector organisations, for example working with utilities companies to harness the use of smart meters for other in-home resident opportunities.

Where are we now?
We have well-established partnerships in place with other public bodies including: the Police, Job Centre Plus and the NHS. Despite the strong partnerships that exist, the potential to harness digital technologies to make them more effective is significant.

Data processes within the council and between partners can be onerous (partly to ensure compliance with data protection legislation) but there are extensive opportunities around accessing data and transforming it into business intelligence which we are yet to capitalise upon.

Many technological solutions are developed 'in-house' rather than sharing or procuring technology with our partners to save money and use established technology.

How will we achieve our vision?
Open non-sensitive data up to our partners and stimulate the innovative use of this data through the organisation of events such as 'hack days'.

Maintain secure systems of internal and external governance of data sharing and storage despite increasing accessibility of non-sensitive data.

Work with other public sector bodies to identify areas to share best practice and increase cross-borough sharing and procurement of technology solutions.

Explore opportunities for collaboration with private sector organisations such as utility companies and technology firms.

Develop an information management strategy which outlines how we plan to: manage data and transform it into business intelligence, protect it appropriately and make it available to partners and the public where relevant.

Communication with our partners will expand to encompass video conferencing, instant messaging and improved data sharing.

Delivering our vision

Our design principles (Gov.uk digital design principles)

- insight – all decisions will be informed by intelligence
- digital take up (channel shift) - by 2020, 80% of transactions will be carried out online.
- user engagement – we will test ideas and services
- digital tools – we will use those products and services that meet the needs of our customers and staff
- innovation – with our partner, Agilisys, we will pilot and test new products and services
- open data – we will publish and share our data
- usability – our products and services will meet the needs of end users

Our delivery principles

- commercial collaboration
- community collaboration
- shared intelligence / best practice
- business case based
- meets end user needs / meets service needs

Governance principles

- Demand management (internal / external)
- Alignment with Council priorities

Our journey in numbers

52,000 MyAccounts registered
315% = the increase in the use of our automated voice recognition telephony from last year
190% = the increase in the use of our webchat from last year
2098 = the number of new customers registering for MyAccount in June 2015

1.8. LONDON BOROUGH OF REDBRIDGE

A digital strategy is needed to transform the borough through digital technology, focusing on:

- Using technology as a tool to innovate and become a digitally driven organisation through adopting smarter more efficient working practices;
- Improving the experiences of the Council's customers (which in many cases will be different) and ensuring that they will be able to access information and services themselves without relying on the Council, enabling us to deliver more effective and efficient services
- Embracing a range of models for service delivery and / or to support service delivery;

Following the technology review – we have started work on the existing equipment & tools staff currently use and are considering a range of options that will provide a much improved user experience.

- Paperless Redbridge' in addition to the EDMS project, we will be looking at a number of other ways to make Redbridge paper free including 'dump it' days and a refreshed clear desk policy
- looking at introducing Change Management framework and comprehensive training programme that supports Managers and Staff in new ways of working
- tender documentation for telephony modernisation and unified communications tender (includes new mobile contracts, instant messaging etc.)
- under Paperless Redbridge Programme – we will be issuing a tender for a supplier to digitalise paper within Children Services and Planning & Regeneration
- working with a specialist on options for the removal of Data Centre when the building is closed in March 2017
- working on the removal of back office Cashiers and Post Room at when building closes in March 2017
- to support and enable smarter ways of working by: providing access from anywhere; providing one device, one number; become digital by default; facilitating online collaboration and sharing of information.

The Smarter Ways of Working (SWoW) Programme

The programme will be a new way of working for everyone and is guided by the principles below:

- work takes place at the most effective locations and at the most effective times, respecting the needs of the task, the customer, the individual and the team
- simplified collaboration and connectivity virtually everywhere means sharing information and working with others regardless of location
- space is allocated to activities, not individuals and not on the basis of seniority
- a flexibility first approach is the norm rather than the exception
- everyone is assumed to be capable of smart working without assumptions being made about people or roles
- a shared and agreed approach to smart working balances the freedom to choose with the responsibility to meet the organisational needs
- the processes people are asked to work with are continuously challenged to make sure they change as the roles do
- managing performance focuses on results and outcomes rather than presence

Customer Access Programme (CAP) Digital

The aims of the CAP programme:

- The CAP Digital work stream (part of the wider **CAP**) aims to ensure our services are Digital by Design so customers can self-serve 24 hours a day, seven days a week.

- Customers will be able to:
- Book appointments online, for example births and marriage notices and bulky waste collections.
- Make payments online, thus reducing the need for cheques and paper-based Direct Debits for rent payments.
- Apply for services online including completing online assessments,
- Report issues to the Council more efficiently via improved Report It forms with drop down lists, mandatory fields, and a reduction in free text fields and improved automated email responses.
- Make appeals online via a parking appeals form.
- Make complaints online via a single form for all services
- Complete consultations online
- Get answers to common questions through meaningful answers to frequently asked questions (FAQs)
- Better manage their appointments with the Council via automated reminder emails to reduce the number of missed appointments
- Better manage their contact with the Council via improved online forms

What's happening now?

- **Parking services:** apply for permits and make challenges online
- **Cleansing:** booking forms for bulky waste, missed recycling and improvements to Report It forms
- **Registrars:** online registrations for births, death and marriages, booking Citizenship Ceremonies online,
- **Planning and Building Control:** requirements gathering
- **Housing:** initial discussions to take place
- **Adult Social Services:** online referral to make a request to Redbridge Adult Social Services, online referral forms to Redbridge First Response Service (provides access to preventative, low-level information, advice and support).

Who's in scope of this project?

The CAP Programme is looking at all customer-facing services. Our primary focus is on the top 10 services in the Council with the highest volume of contact:

- Council Tax
- Housing Benefits
- Parking Services
- Housing Needs and Advice, Income Recovery and Housing Service Charge
- Adult Social Services
- Cleansing Services
- Building Control
- Planning/Development Management
- Registration Services
- Business Rates

We are also working to understand more about the various advice functions offered by our partners across the community so that where we can we are able to offer an integrated approach to serve all our customers' needs.

Adults Social Services and Public Health Transformation

Background
Nationally, there is growing attention on a number of issues relating to the long term sustainability of Adult Social Services, which is increasingly focusing on the NHS and the Local Authority working closer

together. The implementation of the Care Act 2014 also drives changes across the health and social care economy.

The government agenda both now and in the future will be for the NHS and local authorities to work in a way that improves outcomes for service users/patients and residents.
In addition to this, Redbridge Council is also facing its own significant challenge as it seeks to meet a savings target of £70 million over the next three years.

Integrated Health and Adult Social Care Service (HASS)
Managed by a Section 75 partnership agreement bringing together:

- ASS provider, assessment and early intervention services
- Existing Partnerships including mental health and learning disability
- NELFT and adult social care staff within the new Community Health and Social Care Services (CHSCS)

A joint health and adult social care team means services are more responsive to the whole needs of the individual thus providing a more person-centred service.

From the 1st April 2016 the agreed workaround for accessing systems is to continue to use both CareFirst and RiO until an agreed integration solution can be implemented.

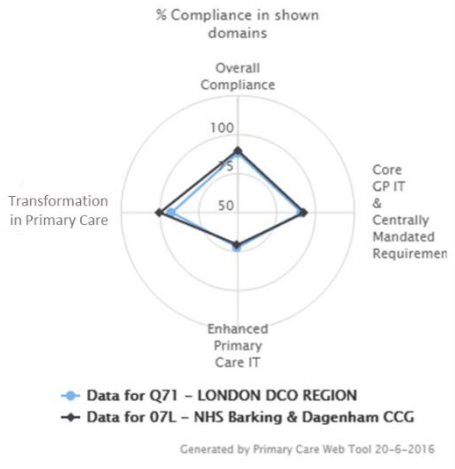
ANNEX 2 – Digital Maturity Assessments and Trajectories

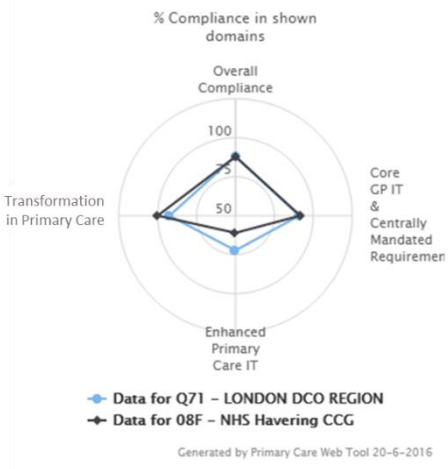
2015/16 Digital Maturity Assessment (DMA) results for NHS healthcare providers:

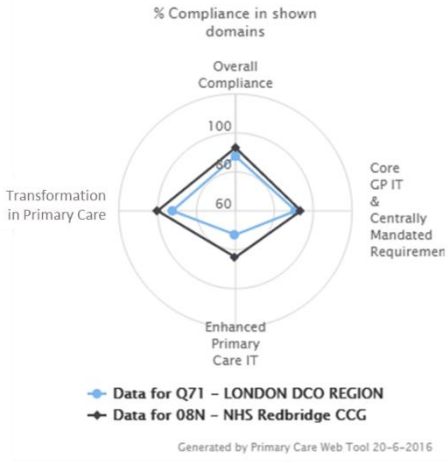
Question	National (Dataset)	BHRUT	NELFT	LAS
Strategic Alignment	76%	70%	90%	31%
Leadership	77%	65%	80%	15%
Resourcing	66%	20%	85%	25%
Governance	74%	45%	90%	30%
Information Governance	73%	67%	92%	67%
Records, Assessments & Plans	44%	0%	61%	18%
Transfers Of Care	48%	43%	43%	10%
Orders & Results Management	55%	35%	48%	0%
Medicines Management & Optimisation	30%	17%	30%	6%
Decision Support	36%	22%	44%	19%
Remote & Assistive Care	32%	17%	58%	13%
Asset & Resource Optimisation	42%	35%	65%	45%
Standards	41%	20%	67%	5%
Enabling Infrastructure	68%	41%	91%	53%

Primary Care Digital Maturity

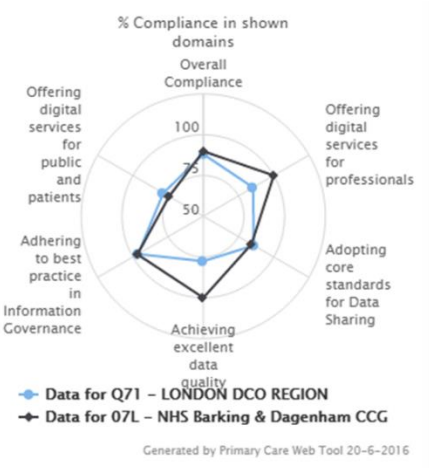
The digital maturity of primary care is generally better than the average for the London region, and is reflected by our existing achievements, both in the move to digital practices and towards interoperable systems. Our digital readiness also puts BHR in a favourable position in delivering digital transformation.

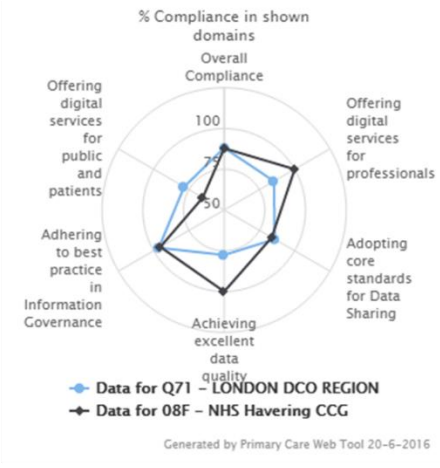


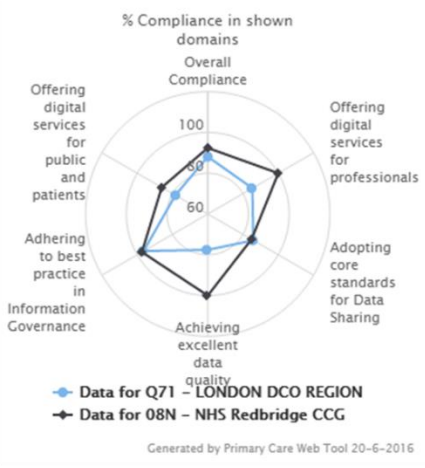




5 High Impact Changes for Digital Readiness

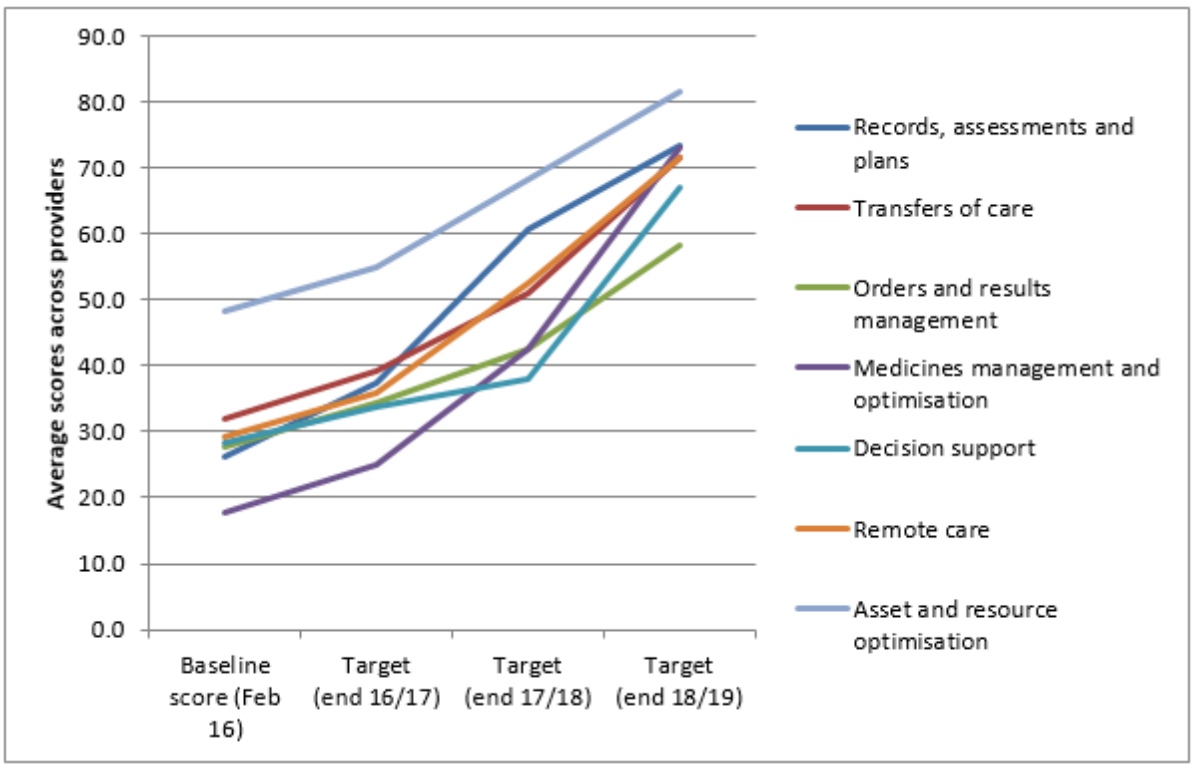






Three Year Trajectory

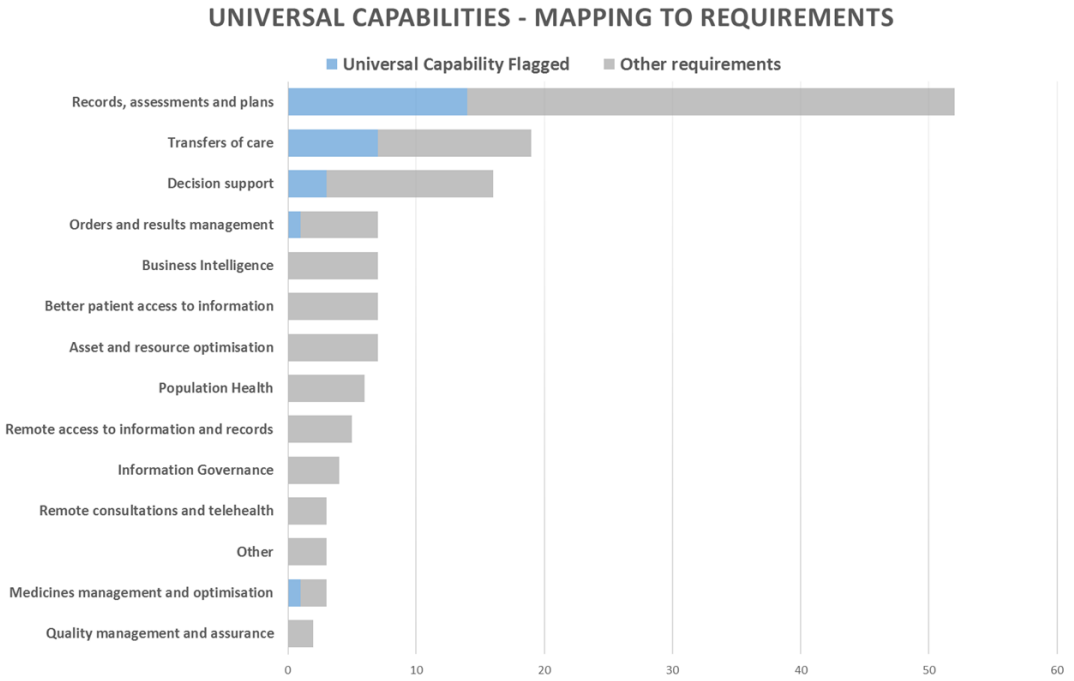
The DMA for BHRUT, NELFT and LAS have been entered into the NHSE Capability Trajectory model which has produced the below aggregate projections for local healthcare providers against the capability groups. Results can be found in the attached document, Annex 2 – Capability Trajectory BHR.



The increase in digital maturity is a result of both organisational and system wide capability delivery, as well increasing digital literacy of patients and professionals, and will take BHR towards digital excellence.

ANNEX 3 – Prioritising Requirements and Capabilities

Requirements that have been captured as part of the development of the LDR have been mapped to capability groups, in line with those of the Universal Capabilities. The figure below shows the extent of overlap between the Universal Capabilities and additional requirements identified locally.



Each single capability group has a mixed priority and complexity with varying breadth of the requirements, for example, there were a significant number of requirements within the records, assessments and plans group, as expected, and fewer requirements relating to medicines management and optimisation.

Prioritisation of requirements and digital capabilities was based on stakeholder feedback in interviews and workshops. Both priority and complexity were summarised under following criteria:
Priority:

- Is this a universal capability?
- Is this an organisational priority?
- Does this drive high benefits (Quality, Efficiency, and Health & Wellbeing)?

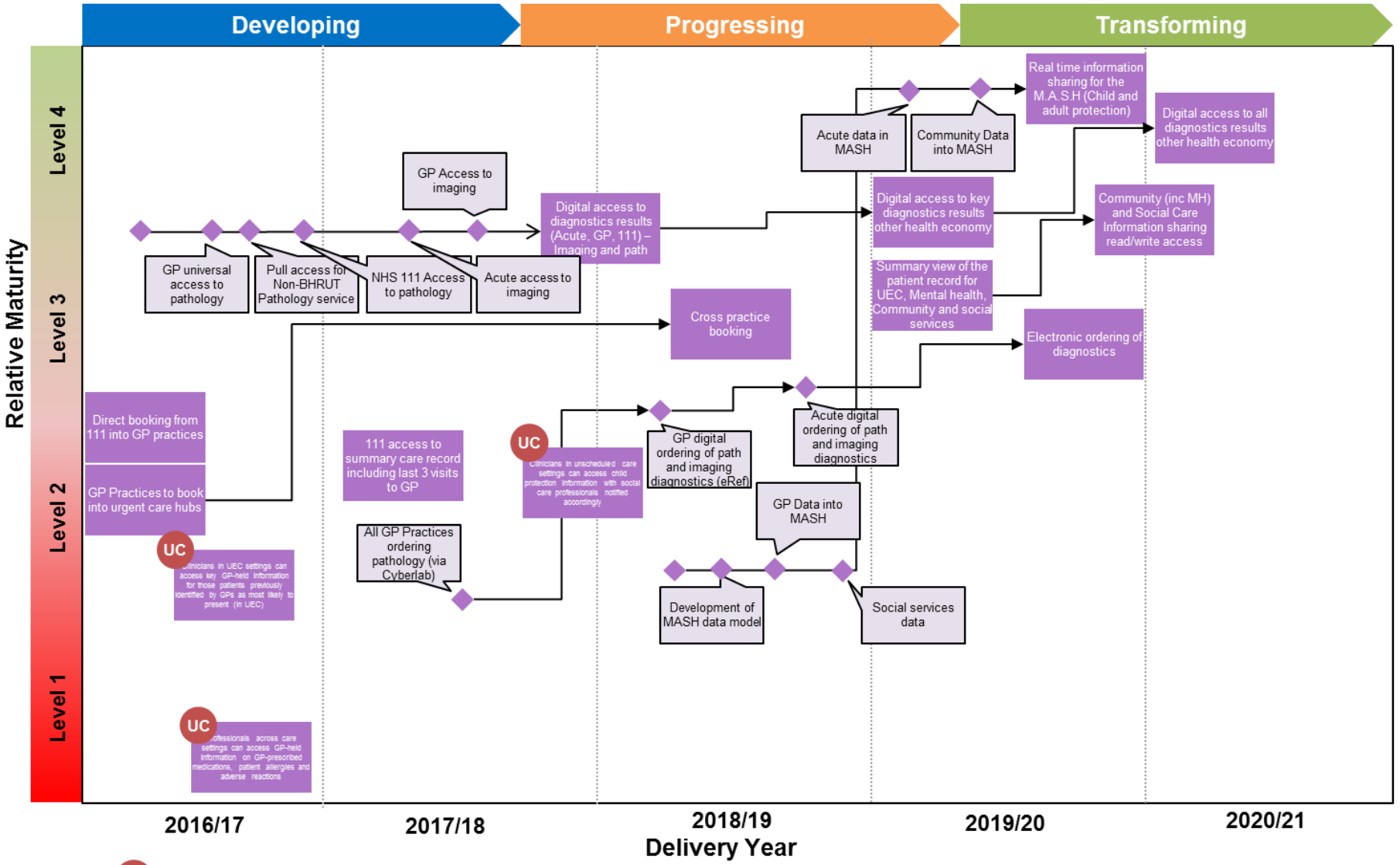
Complexity:

- What is the level of maturity across systems and infrastructure, culture and process, links to existing programmes?
- How many systems are involved?
- Are there legal or IG considerations?

The capability deployment plan then underwent a number of iterations with technical advisors based on what technologies were readily available, which solutions may take a number of years to develop, and which were already being developed on a pan-London basis.

Planned and urgent care

ANNEX 4 – Capability Deployment Plans



Key:

UC **Universal Capabilities**

HLP **Healthy London Partnership**

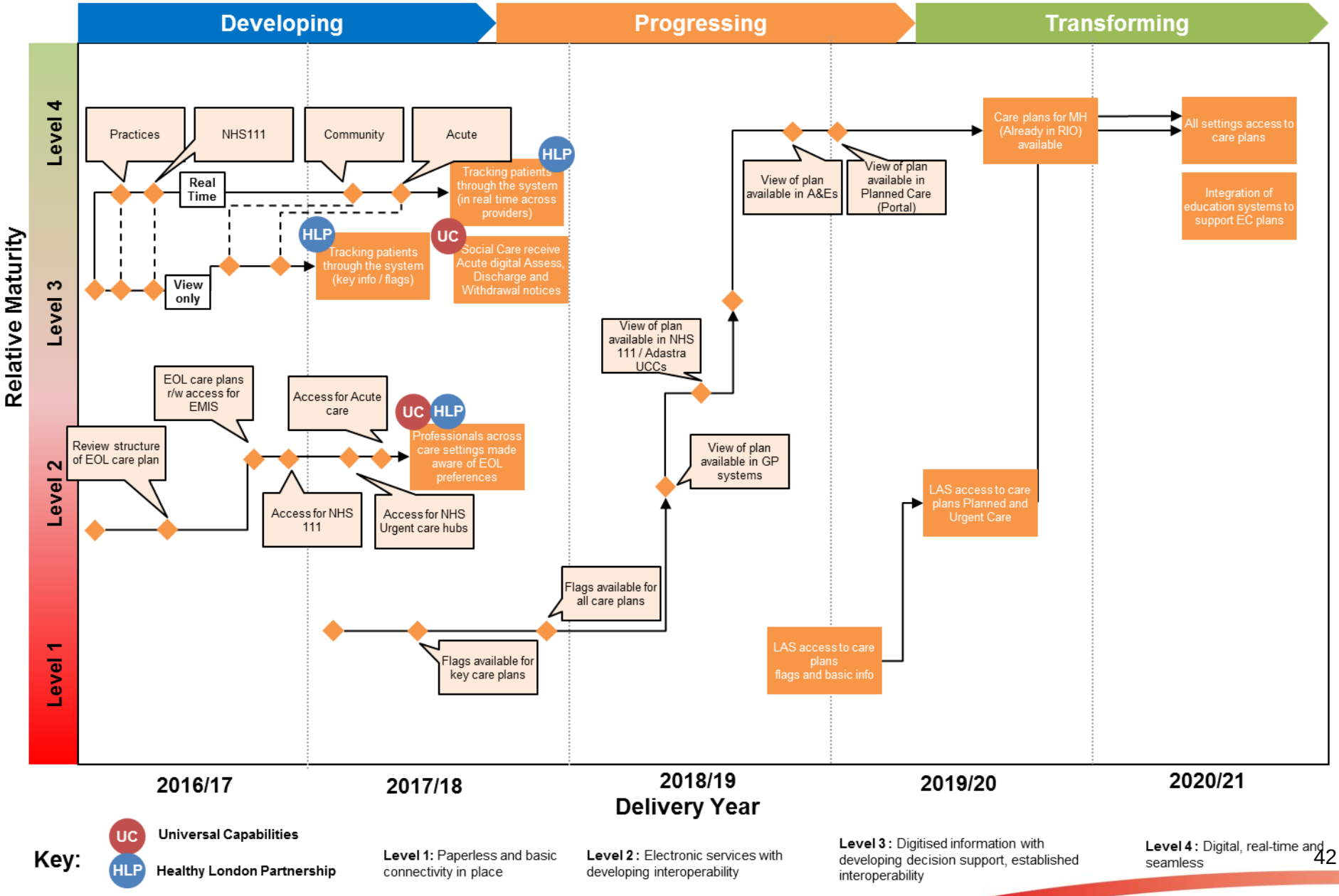
Level 1: Paperless and basic connectivity in place

Level 2 : Electronic services with developing interoperability

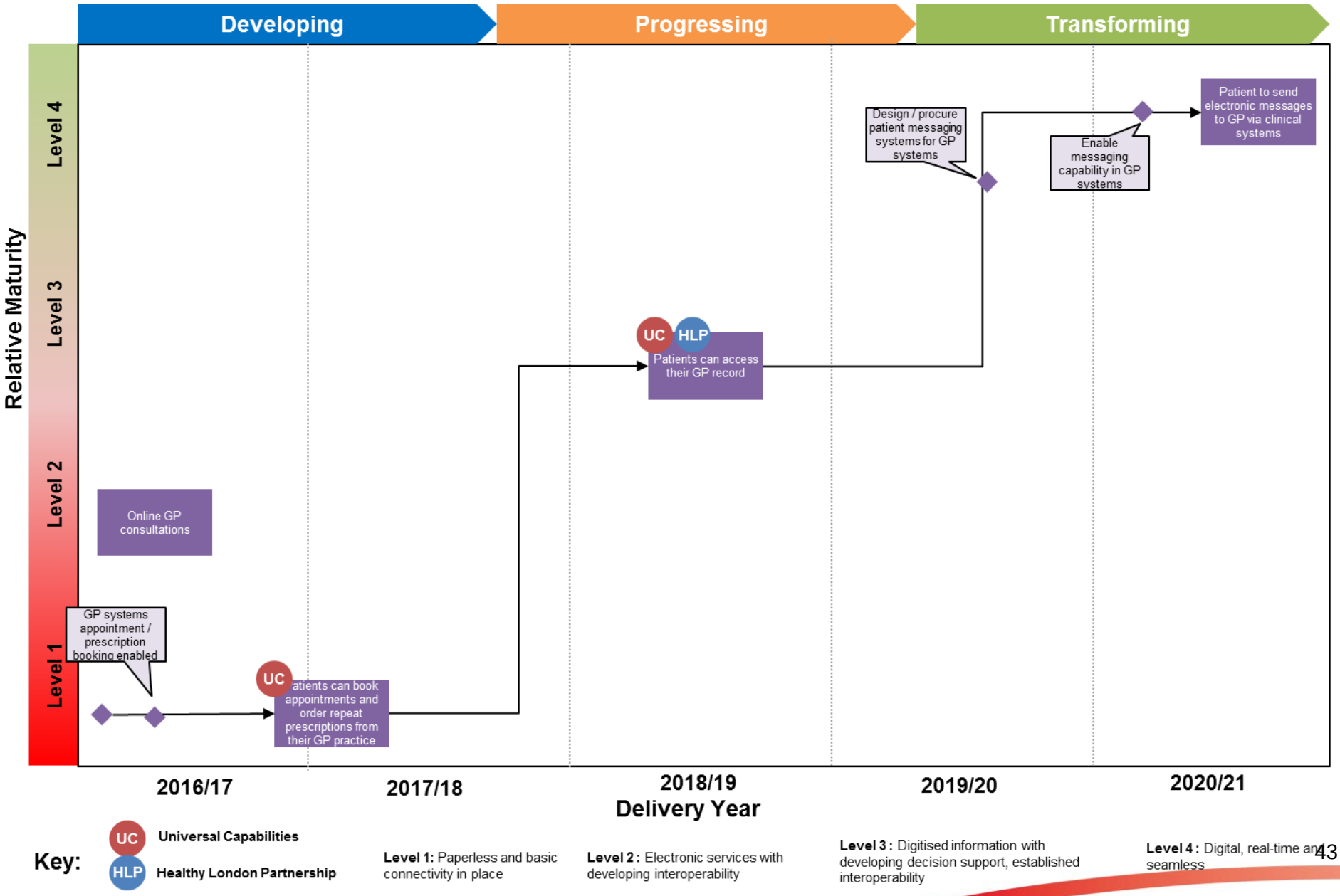
Level 3 : Digitised information with developing decision support, established interoperability

Level 4 : Digital, real-time and seamless

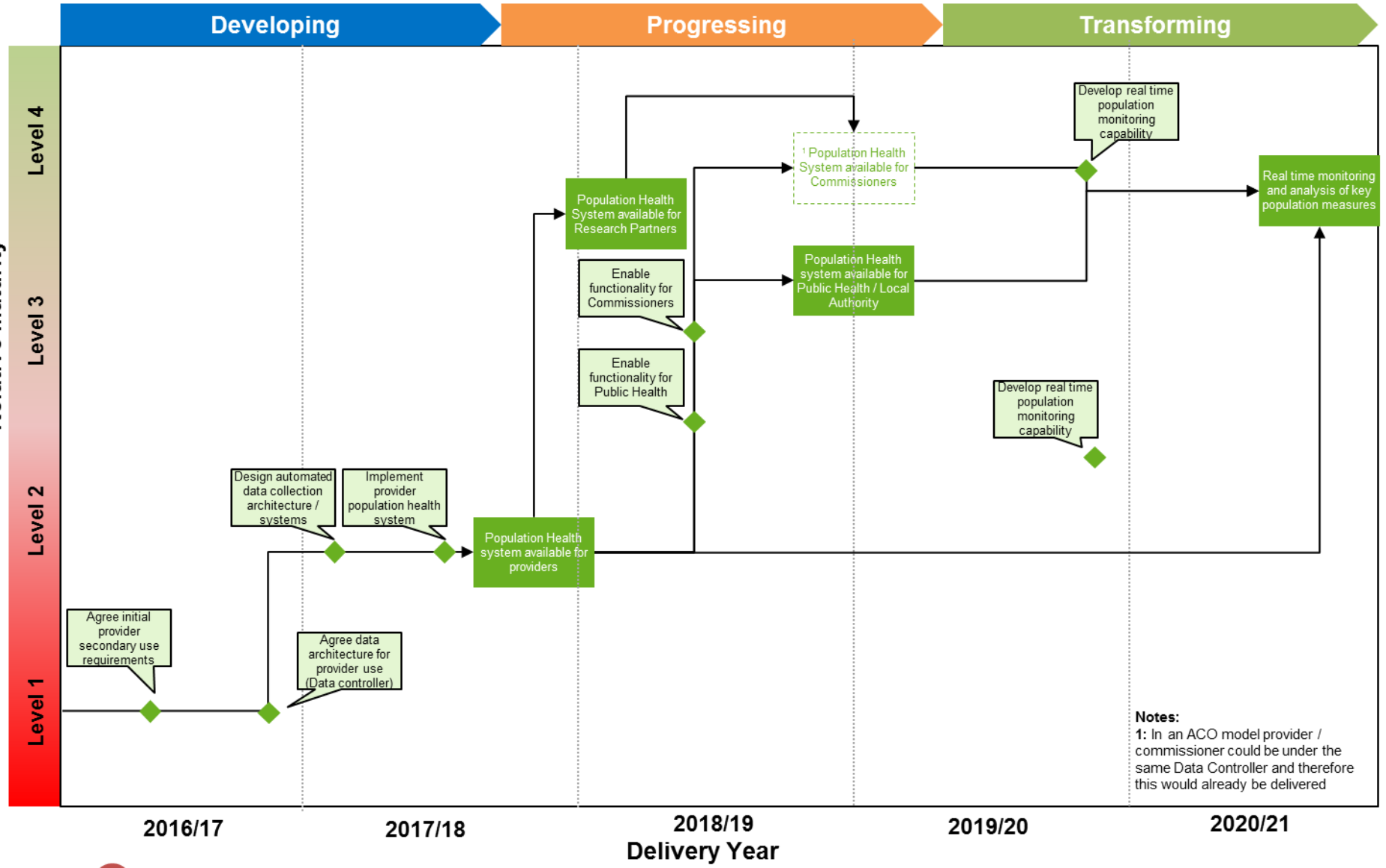
Co-ordinated care



Channel shift



Population health and advanced analytics



Key:

UC **Universal Capabilities**

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Level 1: Paperless and basic connectivity in place

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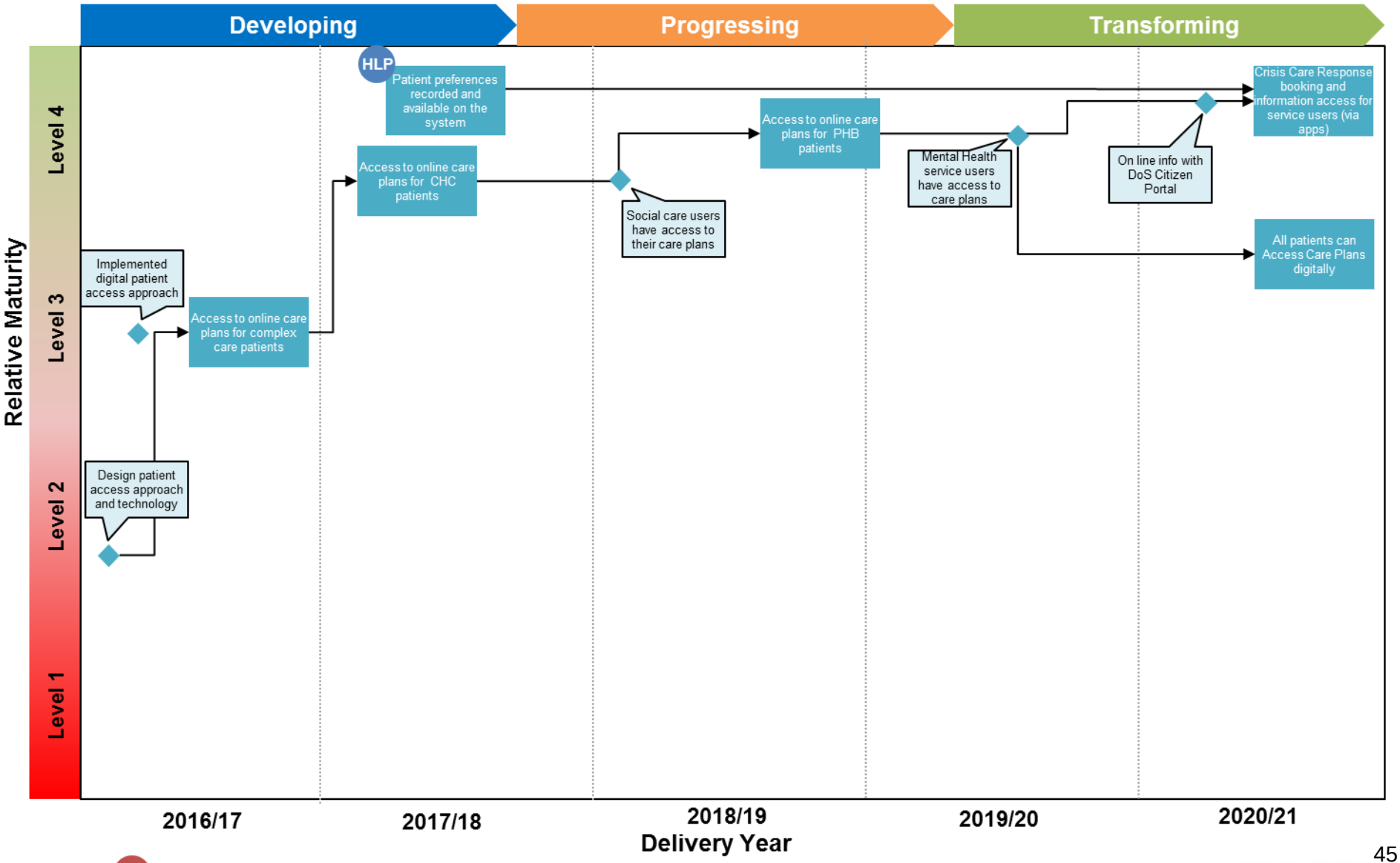
Level 3 : Digitised information with developing decision support, established interoperability

Level 4 : Digital, real-time and seamless

Self care and personalisation



Key:

UC **Universal Capabilities**

HLP **Healthy London Partnership**

Level 1: Paperless and basic connectivity in place

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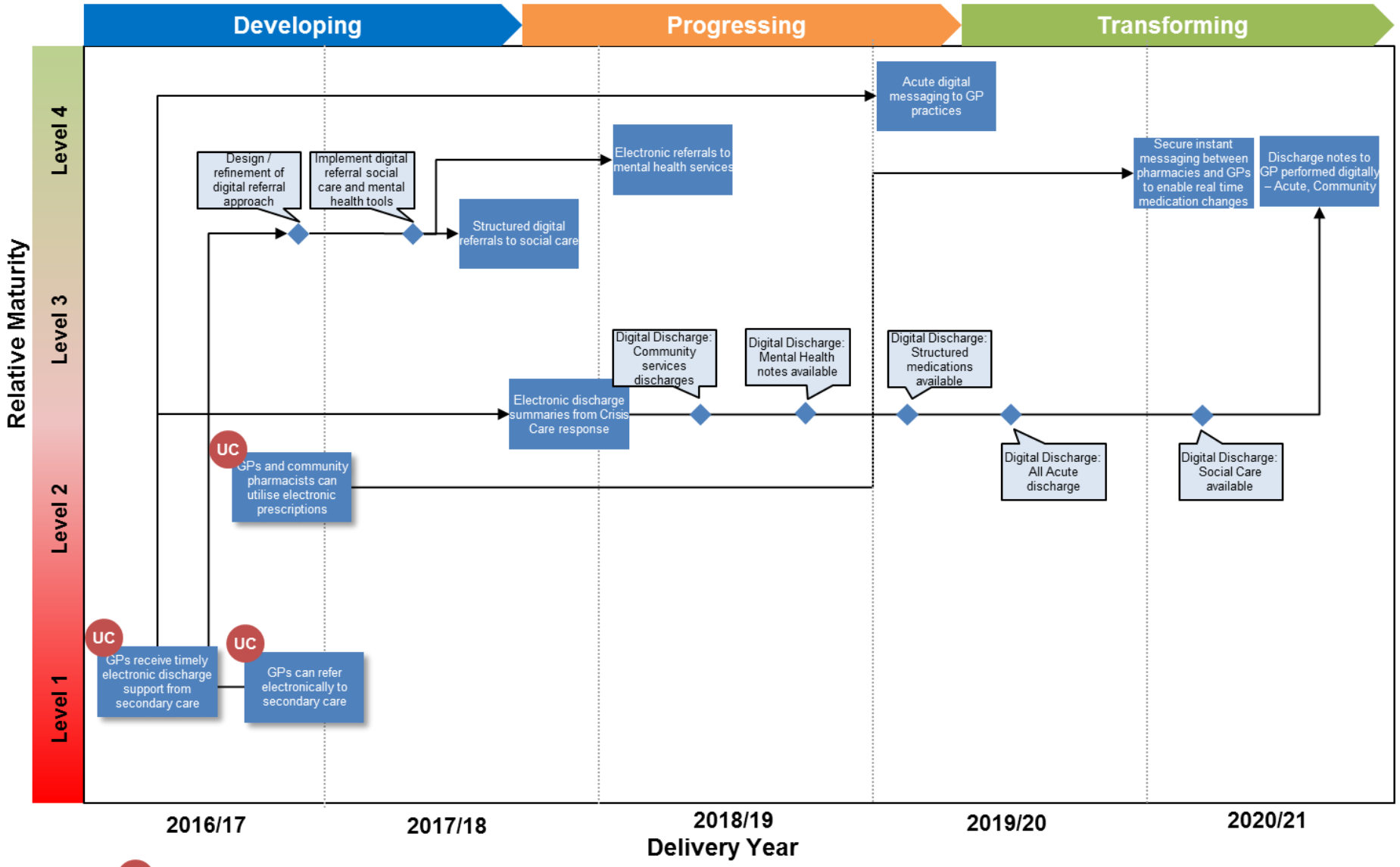
Level 3: Digitised information with developing decision support, established interoperability

Level 4: Digital, real-time and seamless

Paperless



Key:

UC **Universal Capabilities**

HLP **Healthy London Partnership**

Level 1: Paperless and basic connectivity in place

Level 2 : Electronic services with developing interoperability

Level 3 : Digitised information with developing decision support, established interoperability

Level 4 : Digital, real-time and seamless

NHSE template for Capability Deployment

Annex 4 – Capability Deployment Schedule attached.

ANNEX 5 – Universal Capabilities Delivery Plan

NHSE template for universal capabilities delivery plan

Annex 5 – Universal Capabilities Delivery Attached

ANNEX 6 – Finance Requirements

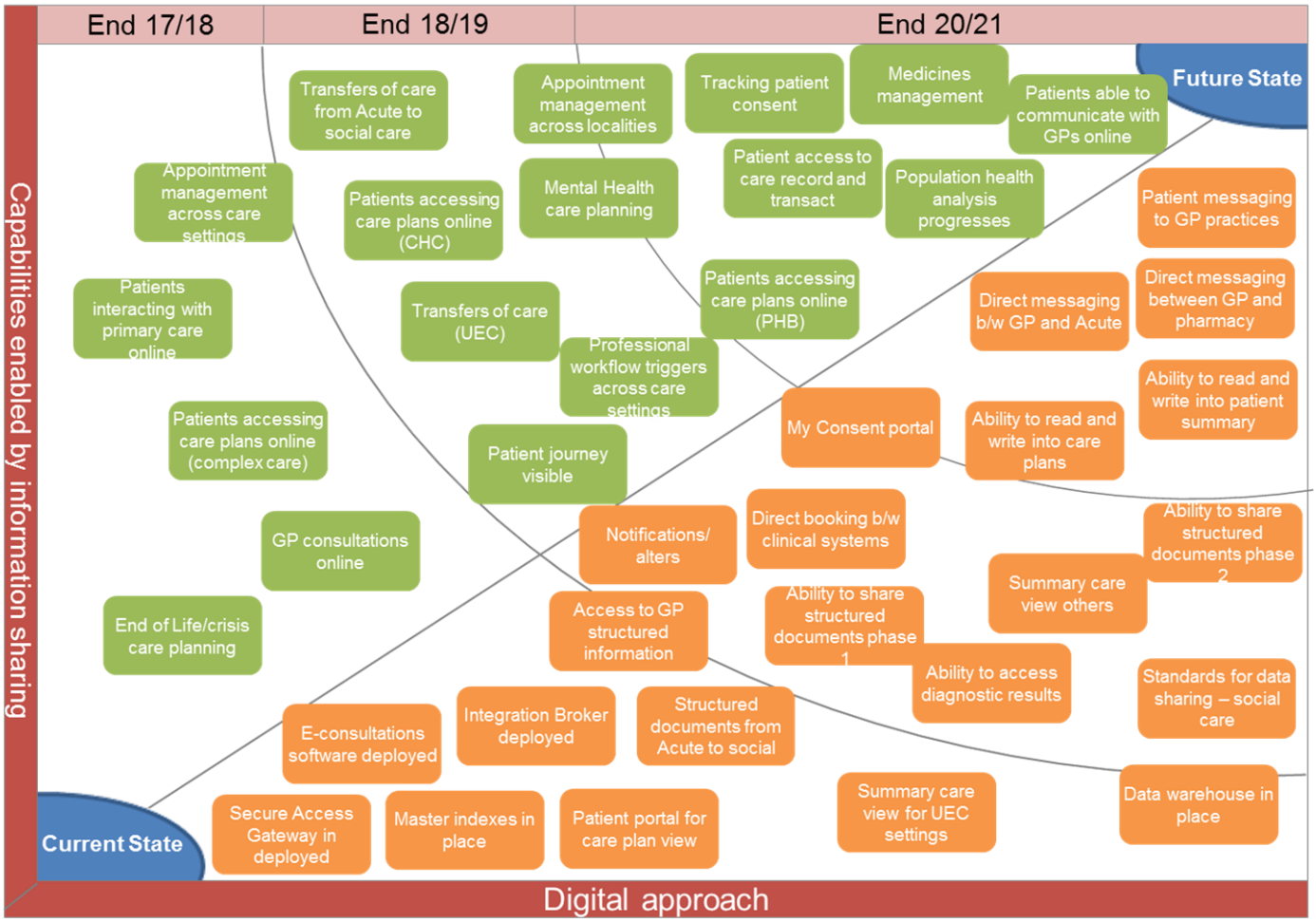
The table below shows the dependency on core technologies and core teams for each of the capabilities. Along with core programme, each scheme has additional costs associated with delivery, shown on the far right of the table, along with estimated savings.

LDR Theme	Capability	Timeframe	Secure Access Gateway	Citizen Portal	My Consent	My Condition	My Care Plan	Common Care Record	Master Index	Integration broker	Data Warehouse	Governance	PMO	Core Development Team	Business Change	IG / IS	Addition Scheme Cost (£000s)	Estimated savings (£000s)
Planned and Urgent Care	GP Practices to book into urgent care hubs	2016/17	X							X								
	111 and BHR OOG direct booking into GP practices	2016/17	X						X	X								
	Clinicians in UEC settings can access key GP-held information for those patients previously identified by GPs as most likely to present (in UEC)	2016/17	X		X		X	X	X	X								
	Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions	2016/17	X		X		X	X	X	X								
	111 and BHR OOH access to summary care record including last 3 visits to GP	2017/18	X		X		X	X	X	X								
	Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly	2018/19	X					X	X	X		X	X	X	X	X	2,180	6,639
	Cross practice booking	2018/19	X						X	X								
	Digital access to diagnostics results (Acute, GP, OOH) – Imaging and path	2018/19	X				X		X	X	X							
	Real time information sharing for the M.A.S.H (Child and adult protection)	2019/20	X					X	X	X	X							
	Community (inc MH) and Social Care Information sharing read/write access	2019/20	X					X		X								
	Digital access to all diagnostics results other health economy	2020/21	X		X	X	X	X	X	X	X							
Co-ordinated Care and care planning	Tracking patients through the system (key info/flags)	2017/18	X		X	X	X		X	X	X							
	Tracking patients through the system (in real time	2017/18	X		X	X	X		X	X	X							
	Professionals across care settings made aware of EOL	2017/18	X		X		X		X	X	X							
	Social Care receive Acute digital Assess, Discharge and Withdrawal notices	2018/19	X				X	X	X	X								
	LAS access to care plans flags and basic info	2019/20	X				X	X	X	X		X	X	X	X	X	3,280	419
	LAS access to care plans (Planned and Urgent Care)	2019/20	X				X	X	X	X								
	Care plans for MH available	2019/20	X		X		X	X	X	X	X							
	LAS access to care plans	2020/21	X				X	X	X	X								
	Integration of education systems to support EC plans	2020/21	X				X											
Channel Shift	Online GP appointments	2016/17	X	X					X	X								
	Patients can access their GP records	2016/17	X	X				X	X	X		X	X	X	X	X	860	810
	Patient to send electronic messages to GP via clinical	2020/21	X	X		X	X	X	X	X								
Population Health & BI	Population Health system available for providers	2017/18	X						X	X	X							
	Population Health System available for Research	2018/19	X						X	X	X							
	Population Health System available for	2018/19	X						X	X	X	X	X	X	X	X	2,565	2,141
	Population Health system available for Public Health / Local Authority	2018/19	X						X	X	X							
	Real time monitoring and analysis of key population	2020/21	X							X	X							
Self-Care & Personalisation	Access to online care plans for complex care patients	2016/17	X		X	X	X	X	X	X								
	Access to online care plans for CHC patients	2017/18	X		X	X	X	X	X	X								
	Access to online care plans for PHB patients	2018/19	X		X	X	X	X	X	X								
	Access to online care plans for MH patients	2019/20	X		X	X	X	X	X	X		X	X	X	X	X	1,250	3,238
	Crisis Care Response booking and information access for service users	2020/21	X						X	X								
	All patients access care plans online	2020/21	X	X		X	X		X	X								
	Patient preferences recorded and available on system	2017/18	X	X	X		X		X									
Paperless	GPs receive timely electronic discharge support from secondary care	2016/17	X				X	X	X	X								
	GPs can refer electronically to secondary care	2016/17	X					X	X	X								
	GPs and community pharmacists can utilise electronic prescriptions	2016/17	X					X	X	X								
	Electronic discharge summaries from Crisis Care response	2017/18	X				X	X	X	X								
	Structured digital referrals to social care	2017/18	X					X	X	X		X	X	X	X	X	2,530	4,675
	Electronic referrals to mental health services	2018/19	X					X	X	X								
	Acute digital messaging to GP practices	2019/19	X					X	X	X								
	Secure instant messaging between pharmacies and GPs to enable real time medication changes	2020/21	X					X	X	X								
	All discharge notes to GP performed digitally – Acute, Community	2020/21	X				X	X	X	X								
Core Development Cost (£000s)			500	500	1,250	500	500	1,000	750	3,550	1,000	825	3,920	9,600	4,300	1,630	**42,490**	**17,922**

Detailed costings and assumptions can be found in the attached spreadsheet, Annex 6 – Finance Requirements

ANNEX 7 – Information Sharing Approach

The diagram below shows the approach BHR will take in the move towards sharing and viewing structured documents across systems and settings, by the end of 2021. BHR will work with the HLP and the implementation of CDA until structured data sharing can be implemented.



ANNEX 8 – Minimising Risks Arising from Technology

While each organisation is responsible for its own IG/IS policies and procedures, a robust piece of work needs to be carried out to assess what the potential BHR wide risks are to the current technology infrastructure. This piece will be part of a workstream for IG/IS that will run alongside development/implementation programmes, and will also consider the recommendations from the Calidcott Review 3.

NELFT and BHRUT have the following policies in place in order to minimise risks arising from technology:

	NELFT	BHRUT
Information / Data Sharing protocol	✓	✓
Information Security Policy	✓	✓
Information Governance Policy	✓	✓
Registration Authority Policy	✓	✓
Data Protection Policy	✓	✓
Information Security and Access Control Policy	✓	✓
Data Quality Policy	✓	✓
Business Continuity Plan	✓	✓
IG Toolkit (March 2016)	70%	67%
Adoption of GS1 standards	Not implemented yet, but the Trust has two EPRs currently in use, with the implementation of the Inpatient Unit in SystmOne, both EPRs will provide inpatient functionality to support the adoption of GS1.	GS1 SLN standards implemented, infrastructure now in place which supports all 7 GS1 Identification Keys for compliance.

ANNEX 9 – Adoption of the NHS Number

BHRUT's Medway system is not currently connected to the NHS Spine, and is only integrated with 18 of the 49 clinical applications in use. Under the Trusts Digital by Design Strategy, their integration engine will be developed to include additional interfaces and allow the PAS to feed into all other systems. Spine mini-services technology will be deployed within the existing integration engine. This will mean that each system will contain the NHS number as the primary identifier and allow the services to directly access the personal demographic service (PDS) held on the NHS Spine in real time. Currently, the NHS number is used in 88% of cases in A&E and 99% in inpatient and outpatient datasets. The Trust are working towards 100% (except for exceptional circumstances, such as non-registered patients in A&E) by the end of 2017.

LBH have been working on the transition to the NHS number as the primary identifier for social care for over two years now. Over this period, NHS numbers have been obtained by submitting batch data requests to Havering CCG (for adults) and the NHS MACS service (for children). The Council has then used automated routines to populate the social care case management system with the results. The match rate is currently 85% for adult social care and 93% for children's social care (correct at time of drafting, April 2016). Users are able to search the case management system using NHS numbers.

A plan is in place to capture NHS numbers at the start of an individual's care pathway automatically. The solution being developed is based on integration between the Council's social care case management system and a Spine Mini Service Provider (SMSP) that is accredited by HSCIC to access the NHS Personal Demographics Service. The solution comprises three functions:

- 'Bulk' look up function – enables a user with system admin permissions to request NHS number lookups for multiple persons and to populate the social care case management system with the results.
- 'Individual' look up function – a NHS number lookup button within an individual's case record will allow users to request the NHS number for a person in context and to populate the social care case management system with the result.
- 'Automatic' lookup function – this will look up the NHS number at the start of an individual's social care pathway and populate the social care case management system with the result

The above solution applies to both adults and children with social care needs. The remaining key phases of work required to ensure that this becomes part of business as usual are as follows:

- Case management system/SMSP – solution implementation – stage 1 ('bulk' and 'individual' look up) – this includes validating and verifying existing NHS number records.
- Case management system/SMSP – solution implementation – stage 2 ('automatic' look up)
- Agree communications plan and staff engagement
- Implement communications plan and staff engagement
- Case management system/amend letters and other outputs (high priority)
- Case management system/amend letters and other outputs (lower priority)
- Case management system/review interfaces with other systems
- Case management system/redevelop interfaces with other systems

It is expected that by 2017/18 there will not be any gaps, and the NHS number will be the primary identifier for 100% of patients serviced by Havering social services.

ANNEX 10 - Infrastructure

Mobile working

Mobile working strategies of individual organisations and BHR wide are going to be key in enabling new models of care. BHR will seek to maximise the existing capacity of the current infrastructure and opportunities for development, before considering further investment. One such opportunity is that of shared Wi-Fi across organisations where connectivity is currently limited, making multidisciplinary and mobile working more difficult. BHR will explore the option of allowing authorised users from across the region to use any BHR organisation's Wi-Fi for connection to the internet.

In addition to the BHR wide initiative, organisations within BHR have their own plans for mobile working. BHRUT's Digital by Design strategy proposes a major upgrade of core infrastructure to ensure the right building blocks are in place to properly support the software applications that are required to deliver strategic objectives and day-to-day business in an effective and efficient manner. The Trust previously had a complex network which was completely replaced in the last quarter of 2014/15. The new network provides a significantly greater bandwidth to desktop, as well as between the two hospitals, Queen's Hospital (QH) and King George Hospital (KGH). Many applications are now delivered over the internet and therefore, over the next five years, connections to the NHS N3 and internet will be upgraded and a separate dedicated internet connection will be provided for patient access to ensure it does not impact on staff using corporate applications.

As part of the network programme access points have also been installed to allow for a wireless environment at QH and KGH, supporting mobile working such as computers on wheels, and enabling clinical data to be viewed and captured the patient's bedside.

In addition to the upgrade to the network, the Trust will be expanding their Virtual Desktop Infrastructure (VDI), moving to 80% of servers being virtual. This will allow users to access their desktops over the network from any location, but also provide a more centralised, efficient client environment that is easier to maintain.

Across both adults and children's social care in Havering, mobile devices are increasingly being rolled out to staff, together with mobile data capability, to accommodate news ways of working and increase productivity. Secure remote access is available for all staff in Havering from both Council-managed devices as well as personal devices with two factor authentication where appropriate. Adult social care staff are also being co-located with NELFT community health staff as a prelude to integration. These staff have been issued with NELFT-build laptops and connect to LBH systems using PSN/N3 Closed User Group via MS remote desktop, giving access to the full set of applications and information that they had when physically based within the Council.

LBH piloted a mobile version of its social care line of business system for the two months to February 2016; evaluation of this pilot is currently underway. The Council is also looking at other potential solution for off-line, mobile working including TotalMobile which has been implemented in Newham Council, which shares ICT services with Havering.

Unified Communications

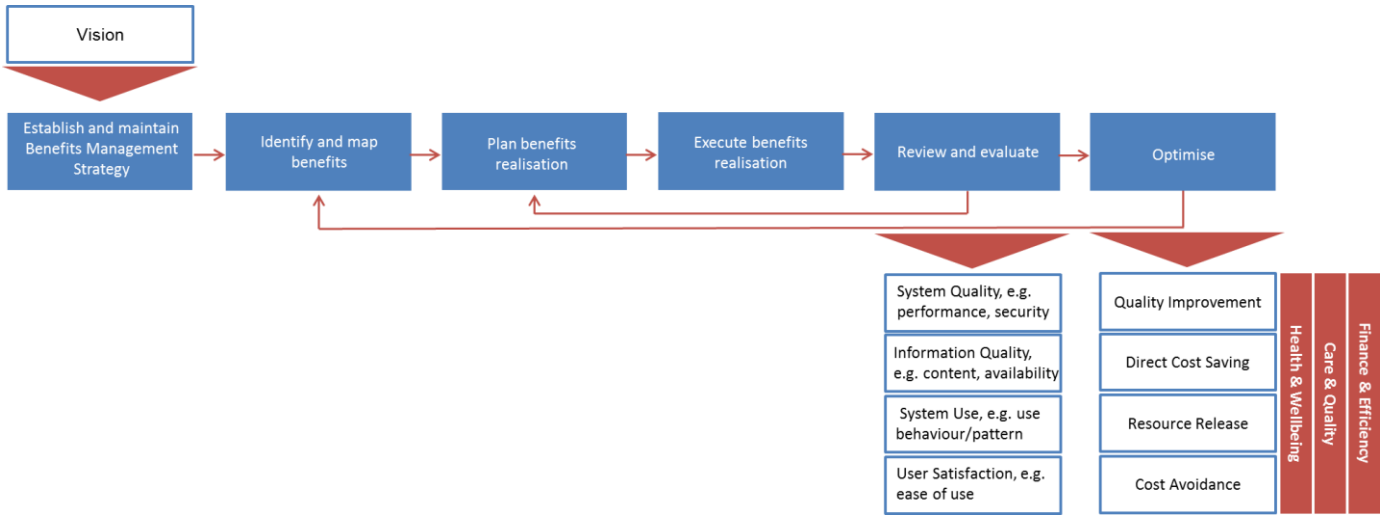
Within the LDR there is the ambition to move to electronic messaging between the Acute Trust and GP practices, and between pharmacies and practices. In the interim, NHSMail will continue to be used as the mechanism for secure messaging.

BHRUT are currently implementing hybrid mail which will allow correspondence to be sent electronically from end users PCs either directly to an email account or to an offsite mail provider, reducing the amount of correspondence such as appointment letters and discharge summaries that are currently printed.

The Trust are also exploring the models for levering the investment made in their network and moving to a unified communications system using Voice over IP technologies integrated with presence management, instant messaging and videoconferencing to replace the end of life telecommunications system at King George Hospital and the analogue phone service provided at Queen's Hospital.

ANNEX 11 – Benefits Realisation

A comprehensive benefits realisation programme will operate alongside the implementation of new technology and linked directly to the delivery of the overall business change. Significant benefits realisation will occur after conclusion of project delivery, and therefore the benefits management will form part of the overall programme.



For each project, the above approach to benefits realisation will be adopted, and the following will be required:

- Key Performance Indicators and metrics in order to set realistic trajectories for change
- Relevant data will need to be captured. Organisations will need to work together to provide this where it is not already available
- Regular reporting via agreed governance route
- Identification, analysis and remedial action plans where benefits are not achieved as expected
- Representation of benefits in financial terms wherever possible so as to measure the actual return on investment

ANNEX 12 – Change Management Approach

Competing priorities, lack of familiarity with the technology, resistance to change and risk aversion are all barriers to digital transformation, however the most significant is culture; the acceptance and willingness of staff to use an innovation is a major factor of success. The system will need to develop a digital culture that is patient-centred, collaborative, data driven, innovative and agile in order for technology to achieve widespread acceptance and adoption. Creating the right environment for digital transformation will require strong leadership, alignment of the digital strategy with the system's goals, and collaboration based on concrete needs, benefits, and support.

Each project will be required to adopt a formal approach to change management (described below) to ensure successful implementation and optimisation of capabilities.

System wide executive will ultimately hold accountability for delivering against the LDR, and will be supported by a BHR steering group who will support delivery from initiation through to implementation.

A Training and Communications lead at the centre will work with communications and engagement leads within each organisation to ensure a coordinated approach and consistent messaging. The central pool of recourses will also be responsible for identifying and sharing lessons learned from successful innovations from elsewhere

Engagement and co-design will be carried out via a design group for each project. Patient representatives/service users and systems users will be recruited to a design group to enable requirements to be captured and refined, and allow for user input throughout the development cycles. Constant feedback will also allow the project to manage and mitigate unexpected problems

Taking an agile approach to delivery will enable us to:

- Deliver the right capabilities using regular feedback
- Understand the strengths and weaknesses of the processes
- Apply benefits of learning and adapt

The local health and social care economy faces a significant financial challenge; radical transformation will need to occur to ensure services are safe, effective and sustainable. This has already begun with our UEC Vanguard, establishment of an ACO framework, and development of new models of care, such as Health1000. technology is a key enabler for each of these programmes.

Each project will be established under a unified programme and operate in line with project management best practice, e.g. Prince II. Projects will report to the central steering group and local governance for the responsible organisation

A formal approach to benefits realisation will be adopted and will measure progress of change and value delivered as a result

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	The Director of Public Health Annual Report
Board Lead:	Dr Susan Milner
Report Author and contact details:	Dr Susan Milner Susan.milner@havering.gov.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

The Director of Public Health (DPH) is required to produce an independent annual report on the health of the population. The Havering DPH annual report 2015-2016 focuses on the topic of childhood obesity.

RECOMMENDATIONS

The Board is receiving the report for information only.

REPORT DETAIL

No further detail to add.

BACKGROUND PAPERS

Annual Report of the Director of Public Health, London Borough of Havering 2015-16

ANNUAL REPORT
OF THE DIRECTOR OF PUBLIC HEALTH
LONDON BOROUGH OF HAVERING 2015-16

Havering
LONDON BOROUGH

WWW.HAVERING.GOV.UK

PREVENTING CHILDHOOD OBESITY

INTRODUCTION
BY THE DIRECTOR OF PUBLIC HEALTH

Obesity is a threat to the health of residents and the continued affordability of health and social care services.

This generation of children and young people is more obese than any previous one and yet we must tackle the problem with limited and reducing resources.

Nonetheless, the Havering Health and Wellbeing Board has agreed a strategy consistent with the best available local and national evidence.

The recently published "Childhood Obesity: A plan for action" outlines the current Government's approach to tackling obesity, by encouraging voluntary action from industry and emphasising the role of schools in supporting children to be active and eat healthily.

Our local strategy sets out how we can best complement and build on this by marshalling the total assets available to the local partnership to: -

- **shape the local environment to promote healthy eating and physical activity**
- **support a culture that presents healthy choices as the norm**
- **prompt individuals and their families to eat well and be more active**

... thereby reducing the risk that our children and young people become obese in the first place.

My annual report highlights some examples of the good work that is already happening across the borough relevant to these three themes and suggests further priorities for action.

I'd encourage everyone who is interested in the wellbeing of local children to read the full strategy and consider what you can do as a parent, grandparent, neighbour, teacher, health or social worker, market trader, town planner etc. to make Havering a healthier borough in which to grow up in.

Obesity is the public health challenge for the 21st century. It may well take a generation of sustained action before we see significant progress. But the sooner we start, the sooner our children and grandchildren will be protected.

Sue Milner, DPH

Acknowledgements

The Director of Public Health in every Local Authority is required to produce an independent annual report on the health of the population. My report this year focuses on childhood obesity.

I would like to thank Mark Ansell (Consultant in Public Health) and Claire Alp (Senior Public Health Specialist) for their help and support in producing this year's report.

What is obesity and why is it important?

What is obesity?

Obesity is the excessive accumulation of fat that may impair health.

Why is obesity important?

Obese and overweight children are more likely to have physical and mental health problems and, as a result, have a third more sick days than those with a healthy body weight.

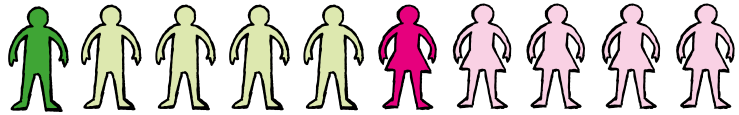
Obese children are between 2 and 10 times more likely to be obese in adulthood.

Obese adults are more likely to die prematurely, develop limiting long term illness and experience mental illness.

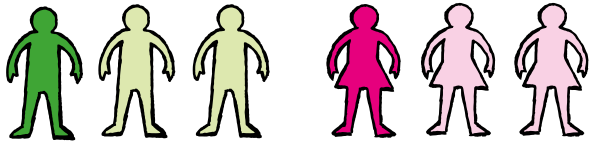
Nearly one tenth of the total burden of disease in the UK is due to excess weight.

The total cost to the UK economy is estimated to be £27bn per year.

How many of our children are obese?



1 in 5 children in Reception Year (age 4-5) are overweight or obese.



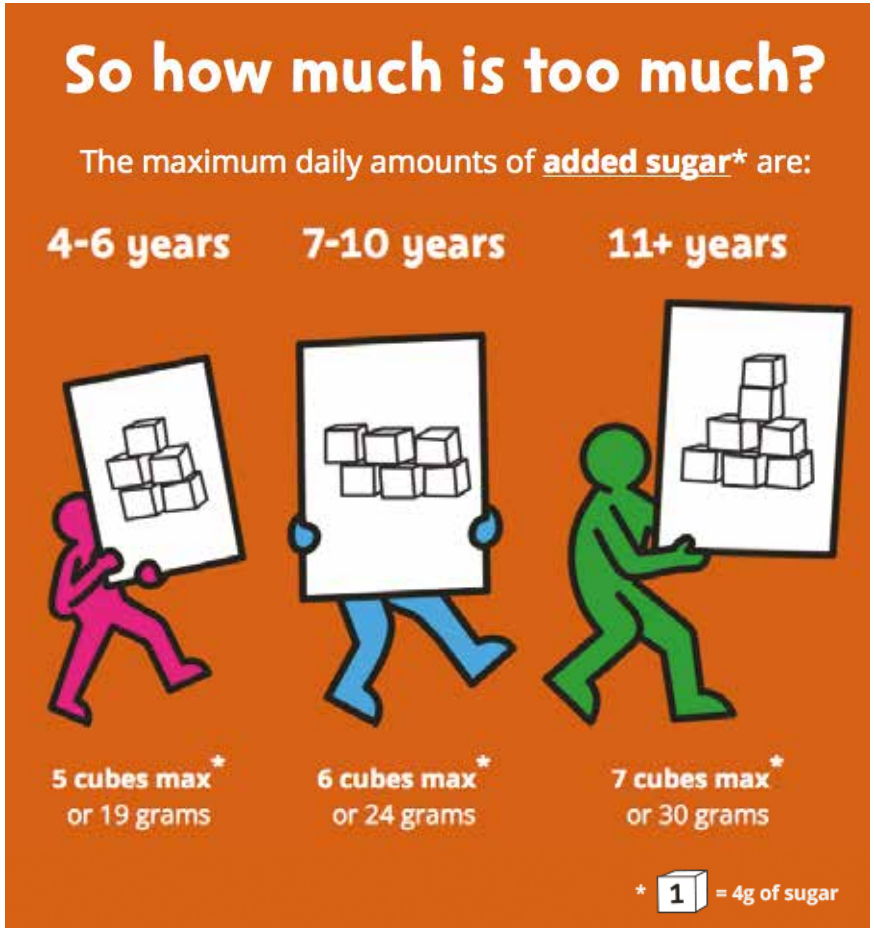
1 in 3 children in Year 6 (age 10 - 11) are overweight or obese.

- Levels of obesity double over the primary school period.
- Obesity is an issue everywhere and for everyone but some children are at greater risk including children with a limiting illness, children with a learning disability and children living in disadvantaged communities.

What is obesity and why is it important?

Why do so many of us and our children struggle to maintain a healthy weight?

- Obesity occurs when energy intake from food and drink is greater than energy expenditure through the body's metabolism and physical activity over a prolonged period, resulting in the gradual accumulation of excess body fat.
- Humans evolved in a world of relative food scarcity and hard physical work but now live in a world where energy-dense food and labour-saving technologies abound. As a result, the majority of us are now predisposed to gaining weight.
- Children who are active and eat well are more likely to maintain a healthy body weight and will benefit in many other ways besides.
- Under–fives should be active for three hours, spread throughout the day and 5–18 year olds should get at least 60 minutes activity per day, which should be a mix of moderate intensity (e.g. walking to school) and vigorous intensity aerobic activity (e.g. playing football). But only 1 in 10 children aged 2-4 and 1 in 5 children aged 5-15 years get the recommended level of activity.
- To achieve balance, free or added sugars should make up no more than 5% of energy intake, which equates to the maximum daily amounts in the picture.



But 96% of children consume too much free sugar – the average young person consumes three times the recommended amount.

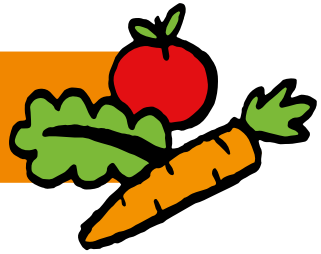
What is obesity and why is it important?

What can we do to reduce levels of obesity?

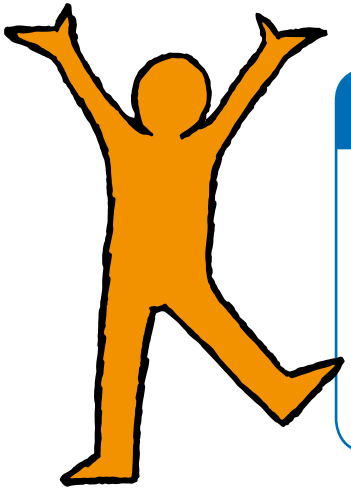
It's not enough to tell people to live more healthily and hope for the best.
We need to:-

shape the local environment to promote healthy eating and physical activity

support a culture that presents healthy choices as the norm



prompt individuals and their families to eat well and be more active



It makes sense to focus our efforts on our children because:-

- weight is difficult to lose once gained hence prevention in childhood is the best approach to tackling obesity across the population as a whole
- we take the attitudes and behaviours established in childhood into later life
- many of the interventions to prevent childhood obesity will benefit the community as whole

There is no single 'silver bullet' - but there are numerous opportunities to intervene.

Shaping the environment to lower the risk of obesity...

...by increasing levels of physical activity

Creating 'healthy streets'

For many young people, walking, whether for pleasure or travel purposes, represents the most likely sustainable form of physical activity. All of us, irrespective of age, are more likely to walk when commonly used amenities are relatively close by and the street scene is 'inviting'. The Council can therefore foster healthier streets by: -

- Undertaking structural improvements to the street scene, as in Hornchurch Town Centre
- Maintaining the current high standards of street cleaning and maintenance
- Using spatial planning to ensure new housing is well served by public transport and has a range of high quality amenities in walking distance
- Encouraging new enterprises to locate to local centres etc

Improving road design and the public transport offer

Actual and/or perceived safety influences decisions about whether individuals choose to walk or cycle or whether parents allow their children to do so. Good road design, including the use of 20mph limits in priority areas, coupled with cycle skills training, such as the Bikeability scheme offered in Havering schools, reduce the likelihood of accidents and their severity should they occur.

As part of an Accident Reduction Programme, a 20mph restriction zone and traffic calming measures have recently been put in place outside Brookside Infant and Junior Schools on Dagnam Park Drive.

A quarter of Londoners get their recommended daily physical activity as part of a longer commute by public transport. But Havering has the lowest percentage of commuting by public transport of any London borough. The Council and Transport for London have a number of priorities for improving public transport and a shift in the way parents choose to travel could normalise a more active choice of travel for their children too.

Shaping the environment to lower the risk of obesity...

Maintaining and improving access to high quality green space

Parks and green spaces provide safe and attractive spaces in which to walk, cycle and play. Ten of Havering's parks also contain outdoor gyms which are free to use. Access to good quality green space is associated with a range of positive health outcomes including lower levels of overweight and obesity. We need to preserve and further improve the large number of parks and open spaces that make Havering one of the greenest boroughs in the capital.

Providing access to high quality and affordable leisure services offer

Havering has excellent leisure services. Work has commenced on development of a new centre in Romford to include a swimming pool and an ice rink. The recent procurement exercise secured these services for the foreseeable future and generated additional benefits for the wider community.

Shaping the environment to lower the risk of obesity...

...by increasing levels of healthy eating

Central to tackling obesity is creating an environment where it is normal, easy and enjoyable to eat healthily.

To this end, action is needed to: -

- promote healthy choices to the consumer over unhealthy ones by managing the availability, cost and placement of healthy options at the point of sale
- effectively market healthy choices over unhealthy ones
- shape the type and location of food outlets within local communities

The major levers are within the gift of central government but local partners, such as school catering services, can amplify and complement national action in a variety of ways.

SugarSmart app

The availability, cost and promotion or placement of foods to the consumer

Public Health England (PHE) has stated that the evidence supports the use of mandatory financial levers to tackle the over consumption of free sugars. Subsequently, the then chancellor, George Osborne, announced a 'sugar tax' on soft drinks. This was confirmed in the recent Government plan, and a consultation on the intended approach is now underway. The plan also includes a sugar reduction programme that aims for industry to voluntarily reduce the sugar content of products children eat most by 20 per cent by 2020. Our strategy commits to looking at how we can promote and support these measures locally.

As a result of the 2016 **Change4Life SugarSmart** campaign, Havering Catering Services has sourced reduced sugar alternatives to popular items sold in secondary school canteens. By reformulating recipes and changing portion sizes, suppliers have reduced the sugar content by 30per cent in some products.

Despite this, single portions still contain around a quarter of the recommended daily amount of added sugar, so these efforts will be coupled with continued work to raise awareness and promote behaviour change. To this end, the catering team is bringing the **SugarSmart app** to life by displaying sugar cubes next to products, and encouraging pupils to use the app when purchasing other foods outside of school.

Shaping the environment to lower the risk of obesity...

Limiting fast-food outlets

Food businesses are an essential part of a vibrant, healthy and prosperous high street. However, a balance needs to be struck between commerce and health. Too many fast food outlets selling cheap, energy-dense, nutrient-poor foods, served in larger portion sizes are detrimental to the health of local communities. Analysis by PHE demonstrates that Havering has a relatively high concentration of fast food restaurants. PHE recommends that authorities restrict planning permission for new takeaways to protect sensitive areas or population groups e.g. within walking distance of schools.

Given that Havering already has a high number of fast food outlets, such an approach would need to be coupled with action on the part of schools to restrict pupils to school premises at lunchtime and provide pupils with the knowledge and motivation to make healthy choices so that they 'vote with their feet'.

More positively, the Council should actively seek to attract food outlets offering healthier options e.g. as part of the ongoing regeneration of Romford Town Centre & Market.

At St Edward's CE Primary School, as part of their Healthy Schools London silver award, the School Council surveyed the food on offer on their routes to school. They took photos of healthy and unhealthy options, then presented their findings in an assembly.

Supporting a culture that makes healthy choices easier

To complement changes to the physical environment, we must work to change attitudes such that the healthy choice is viewed as the norm by local residents.

Havering Adult College is working with the Public Health team to offer a new family healthy lifestyle course that will utilise and promote Change4Life branding and resources, thus helping to increase local recognition of the national campaign.

Supporting national health improvement campaigns

Effective campaigns have the aim of changing social norms such that the healthy choice becomes the usual choice for the majority. National bodies, primarily PHE, have developed a number of increasingly sophisticated and successful campaigns. Local agencies can amplify these messages and use them to promote local resources.

Implementing the 'making every contact count' approach

The Council and NHS should further amplify healthy living messages by implementing the 'making every contact count' approach in Havering whereby every contact between staff and resident is seen as an opportunity to promote health and wellbeing. MECC is equally applicable to council services e.g. social services or housing as it is the NHS. It would also complement the Health Champions model already being implemented locally under the 'My Health Matters' banner whereby local residents are recruited and trained to prompt family members, neighbours, work colleagues and clients to consider opportunities to make healthier choices.

The new suite of MECC resources launched by Health Education England includes training on influencing behaviour change and initiating difficult conversations about health and wellbeing, plus training for Health Visitors and School Nurses which enables them to identify weight issues in children early on.

Supporting a culture that makes healthy choices easier

Supporting the community and voluntary sector

Recognising and fostering the contribution of the community and voluntary sector to health and wellbeing is essential. Most obviously, supporting the contribution made by volunteers working within third sector organisations to provide a huge range of sports and active leisure opportunities for children in the borough.

Havering Council's Health and Sports Development team supports local clubs to offer opportunities for young people to get involved in sport. Coaches from the clubs run holiday programme activities, and are ideally placed to signpost participants to future sessions at the club's main base or at satellite clubs in local schools.

The annual Havering Sports Council Awards, supported by the Council, recognise and celebrate the huge contribution these clubs, coaches and volunteers make in inspiring and supporting Havering residents to be active.

Integrating Health Impact Assessment into decision making

Partners also need to be aware of the risk of inadvertently undermining efforts to support healthy culture within the borough. One way of doing so is to integrate health impact assessment (HIA) into decision making. HIA is a process whereby significant decisions are assessed to identify potential health impacts so that any benefits can be maximised and harms mitigated.

This can be done at the macro level e.g. on the Local Plan which will shape housing development in the borough for the foreseeable future or the service specification for the leisure services procurement or at the micro level by teams or individual officers e.g. to ensure people are directed to the stairs rather than lifts and encounter fruit rather than confectionary when waiting to pay by the checkout.

An HIA of plans to re-procure the leisure service contract identified the opportunity to give the new provider a greater role in promoting and sustaining residents' participation in physical activities, as the capacity of the council to do so reduces as a result of budget cuts.

Potential providers were required to submit a Sports Development Plan and Community Health and Wellbeing Development Plan. Targets within these aim to ensure that all members of the community have the opportunity to use the facilities, through direct provision and outreach.

Supporting a culture that makes healthy choices easier

Promoting a healthy culture in schools

Schools offer a unique opportunity to establish healthy attitudes and behaviours. Schools already receive a PE and Sport Premium from the Government and this will be doubled as a result of the introduction of the 'sugar tax'. A number of different facets of school life can be brought together to establish a healthy culture: -

- The school PE curriculum and extra-curricular sport opportunities help to ensure that children are active for significant periods and develop the knowledge and attitudes that underpin an active life in adulthood. Government suggests schools should deliver at least 30 minutes of physical activity every day through active breaktimes, PE, extra-curricular clubs and active lessons.

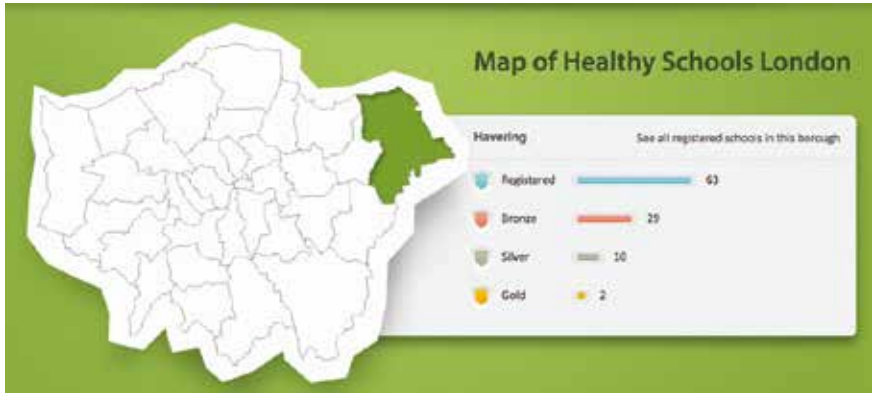
The Havering Sports Collective supports schools to deliver high quality physical education and activity. In addition to curriculum development, the Collective has supported primary schools to run Change4Life Sports Clubs which focus on encouraging less active children to become more active and provide 'Champion' roles for older children.

- The recent integration of cooking and nutrition into the national curriculum has been supported locally through delivery of training for primary school non-specialist food teachers.
- Havering Catering Service's school meal menus follow the Government food-based standards thereby ensuring that children can achieve dietary recommendations. Further work is needed to encourage greater uptake and help to ensure children consume the fruit and vegetables that are served.
- The Council's Smarter Travel team supports schools to develop school travel plans and achieve Transport for London STARS accreditation. Increasing active travel increases levels of physical activity for children and parents and reduces congestion around schools.
- The National Child Measurement Programme, carried out by our School Nursing Service, is an opportunity to raise awareness and prompt action by parents.
- The Healthy Schools London programme provides a framework enabling schools to review their contribution to the health of their pupils and how it can be improved. Committing to this programme helps school to demonstrate their commitment to the Ofsted requirement for promoting and supporting pupils' knowledge of how to keep themselves healthy. Sixty three of Havering's 80 schools have registered for this programme and we will continue to encourage them to progress through the awards. We hope the programme will take on even more meaning and value when the Government's plans for a new healthy rating scheme for primary schools is introduced in September 2017.

Supporting a culture that makes healthy choices easier

- The views of peers can be particularly important to children and young people and we should consider how we involve young people in improving their own health. Change4Life Champions in primary schools lead activities for younger children and the Havering Sports Collective has recently begun offering the Young Health Champions programme in secondary schools.

At Scargill Infant School, food grown by children in the school garden is served in the canteen. Teachers, catering staff, midday supervisors and children in the role of "mini middays" have worked together to successfully increase the amount of vegetables eaten at lunchtimes. This project earned the school their Healthy Schools London gold award and they gave a presentation to other schools at the annual pan-London celebration event.



Promoting a healthy culture in early years settings

A number of opportunities are also arising to promote health in the early years:

- The new government plan commits to relaunching Early Years Voluntary Guidelines for food and drink. There will be a national campaign in early 2017 campaign to raise awareness of these amongst EY practitioners and parents.
- The Early Years Foundation Stage framework will be updated to make specific reference to the UK Chief Medical Officer's guidelines for physical activity.
- Plans are also underway at a pan-London level to develop a Healthy Early Years London programme, and once further details are available we will consider how we can promote and support this locally.

Prompting individuals to eat well and be more active

Giving children the best start in life

A range of services are provided to assist parents to give their child the best start in life. Some such as maternity services and health visiting are available to everyone. Others, such as children's centres or free child care, are focused on disadvantaged and / or vulnerable families. All should be the source of accurate bespoke advice to parents at this crucial time in their child's development.

- Midwives, health visitors and children's centre staff have a crucial role in identifying at risk children and offering effective support to their families.
- Maternal nutrition around the time of conception and during pregnancy can affect the physiology of the unborn child and increase the risk of childhood obesity.
- Pregnant women are advised that they only need consume 10 per cent more energy than average and then only in the last trimester of their pregnancy – and definitely not to 'eat for two'.
- Breastfed babies are less likely to become obese; but a quarter of babies born in Havering are not breastfed at all, and 6 out of 10 are bottle fed by 6-8 weeks.
- Delaying weaning until at least six months also reduces the likelihood of obesity.
- Providing selected parents with the knowledge and skills necessary to cook healthily may also help.
- In "Childhood Obesity: A Plan for Action", the Government recommits to the Healthy Start scheme which provides families on low incomes with vouchers for fruit, vegetables, milk and vitamins.

Voluntary sector support for breastfeeding in Havering is very strong. Successful funding applications by the National Childbirth Trust has enabled a group of eleven volunteers to be trained as peer supporters.

The Council's Early Help Service staff have also been trained and accredited as Breastfeeding Supporters.

Together, volunteers and staff provide invaluable support and information for mothers at four Infant Feeding Cafés each week, held at children's centres and other community venues throughout the borough.

We are looking into how we can both encourage more local retailers to accept Healthy Start Vouchers, for example using opportunities presented by the regeneration of Romford Market for traders to accept them, and increase uptake by eligible residents , by promoting the vouchers across more health and community settings.

Prompting individuals to eat well and be more active

Parents should consider the quality of the food provided by nurseries and childminders and the Council should work with care providers to assist them to identify and comply with appropriate food and nutrient-based standards.

Promoting self help

Health promotion campaigns have progressed beyond a simple call to action to offer on-going encouragement to the individual to initiate and maintain healthier behaviours in the form of smart phone apps. A bewildering number are available, many of them with little evidence base. Local residents are encouraged to use those recommended on the **NHS Choices tools library**.

The Havering Council website provides information to residents on achieving and maintaining a healthy weight.

This includes how to check if you are a healthy weight, advice on eating healthily and being active, and where to find support to lose weight.

www.havering.gov.uk/Achievingahealthyweight

Weight management services

Thus far, all of the opportunities discussed have focused on the environment or settings with the potential to the benefit large groups children if not the whole population.

This is very deliberate. In certain circumstances, weight management services may assist an individual to reduce their risk of ill health or disease progression.

However, they are not a practical or affordable means of reducing the prevalence of obesity in the population as a whole. Therefore whereas the Council and Clinical Commission Group will need to put in place effective care pathways for children whose obesity is such that it is the cause of significant ill health in childhood; weight management services do not form a significant part of our obesity prevention strategy.

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