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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD
AGENDA

1.00 pm	Wednesday, 15 March 2017	Committee Room 3B - Town Hall

Members: 16, Quorum: 9

BOARD MEMBERS:

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

Councillor Brice-Thompson 13:00

2. APOLOGIES FOR ABSENCE

(If any) – receive. Councillor Brice-Thompson.

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 AND MATTERS ARISING (NOT ON ACTION LOG OR AGENDA) (Pages 1 - 28)

To approve as a correct record the minutes of the Committee held on 18 January 2017 (attached) and to authorise the Chairman to sign them.

Councillor Brice-Thompson 13:05

5. ACTION LOG (Pages 29 - 30)

Action log attached for review by the Board.

Councillor Brice-Thompson 13.10

6. UPDATE ON REFERRAL TO TREATMENT DELAYS (Pages 31 - 36)

Sarah Tedford/Louise Mitchell 13:15

Report attached.

7. HEALTH PROTECTION FORUM REPORT (Pages 37 - 72)

Elaine Greenway 13:30

Report attached.

8. HAVERING CCG 17/18 OPERATING PLAN (Pages 73 - 78)

Alan Steward 13:45

Report attached.

9. PRESENTATION OF RECENT AREA INSPECTION OF SEND JOINT SELF-EVALUATION (Pages 79 - 88)

Tim Aldridge 14:00

Covering report and presentation attached.

10. OBESITY STRATEGY UPDATE (Pages 89 - 114)

Claire Alp 14:10

Report and action plan progress log attached.

11. UPDATE ON SUSTAINABILITY AND TRANSFORMATION PLAN (STP) (Pages 115 - 174)

Cover report and STP narrative attached.

Ian Tompkins 14:25

12. BETTER CARE FUND REPORT (Pages 175 - 182)

Caroline May 14:40

Report attached.

13. FORWARD PLAN (Pages 183 - 184)

Susan Milner 14:55

Attached.

14. DATE OF NEXT MEETING

Date of next meeting -10th May 2017 (1 pm).

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MINUTES OF A MEETING OF THE
HEALTH & WELLBEING BOARD
Committee Room 3B - Town Hall
18 January 2017 (1.00 - 3.00 pm)

Board Members Present:

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

Andrew Blake-Herbert, Chief Executive

Dr Susan Milner, Interim Director of Public Health

Tim Aldridge, Director of Children's Services

Barbara Nicholls, Director of Adult Services

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

Dr Gurdev Saini, Board Member, Havering CCG

Alan Steward, Chief Operating Officer, Havering CCG

Anne-Marie Dean, Chair, Healthwatch Havering

Piers Young, Deputy Chief Executive, Barking, Havering and Redbridge University Hospitals' NHS Trust (BHRUT) (substituting for Matthew Hopkins)

Carol White, North East London NHS Foundation Trust (NELFT) (substituting for Jacqui van Rossum).

Also present:

Ian Tompkins and Samantha Campbell, STP Communications
Dr Russell Razzaque, Associate Medical Director, NELFT
Oge Chesa, Deputy Chief Pharmacist Barking and Dagenham, Havering & Redbridge CCG
Mark Ansell, Public Health
Gloria Okewale, Public Health

All decisions were taken with no votes against.

1 CHAIRMAN'S ANNOUNCEMENTS

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

2 APOLOGIES FOR ABSENCE

Apologies for absence were received from Matthew Hopkins, BHRUT (Piers Young substituting) Jacqui van Rossum. NELFT (Carol White substituting) and from Conor Burke, BHR CCGs.

Apologies were also received from Philippa Brent-Isherwood, London Borough of Havering.

3 DISCLOSURE OF INTERESTS

Councillor Gillian Ford disclosed a personal interest in item 17 (update on integrated care partnership (previously ACO) locality boundaries and STP) due to a family relationship with a presenter of the item.

4 MINUTES

The notes of the inquorate meeting of the Board held on 10 November 2016 were agreed as a correct record.

5 DRAFT HEALTH AND WELLBEING STRATEGY

Note: Due to the previous meeting of the Board held on 16 November 2016, being inquorate, agenda items 5-13 were resubmitted in order to take any comments in addition to those shown in the notes of the meeting. The notes of the inquorate meeting are appended to these minutes for information.

The Board made no further comments on the draft Health and Wellbeing Strategy as this was being considered later in the agenda.

6 LOCAL SAFEGUARDING CHILDREN AND SAFEGUARDING ADULTS BOARD REPORTS

The Board made no further comments on this issue other than those shown in the notes of the previous meeting.

7 SINGLE INSPECTION FRAMEWORK UPDATE (VERBAL)

The Board made no further comments on this issue other than those shown in the notes of the previous meeting.

8 LOOKED AFTER CHILDREN - HEALTH CHECK UPDATE (VERBAL)

The Board made no further comments on this issue other than those shown in the notes of the previous meeting.

9 ADULT SOCIAL CARE LOCAL ACCOUNTS FOR 2015/16

The Board made no further comments on this issue other than those shown in the notes of the previous meeting.

10 REFERRAL TO TREATMENT DELAYS IN BHRUT UPDATE

The Board made no further comments on this issue other than those shown in the notes of the previous meeting.

11 HOUSING DEVELOPMENT

The Board made no further comments on this issue other than those shown in the notes of the previous meeting.

12 BHR CCGS' LOCAL DIGITAL ROADMAP

The Board made no further comments on this issue other than those shown in the notes of the previous meeting.

13 TERMS OF REFERENCE

The Board considered a report which recommended a slight amendment to the Board's terms of reference in order that named substitutes for Board members be allowed at Board meetings. Named substitutes would also have voting rights.

The report was agreed without division and it was resolved:

1. That the Health and Wellbeing Board agree that named substitutes be permitted for members in the event members are unable to attend meetings of the Board. These substitute members to have voting rights on issues where a vote is required.

2. That the following wording is added to the 'Reporting and Governance' section of the Board's Terms of Reference:

    - Named substitutes for Health and Wellbeing Board Members are permitted if advised prior to the start of a meeting. Named substitute members will have voting rights.

14 COMMUNITY PHARMACY (FOR INFORMATION)

A representative of Barking & Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHR CCGs) advised the Board that a Pharmacy Intervention Fund had been announced by NHS England in October 2016. This would allow NHS 111 to contract pharmacists to whom people could be referred for the administration of urgent repeat prescriptions. This would run

on a pilot basis until April 2018. Pharmacists would also be trained to carry out enhanced services within care homes.

There were no pilots running currently in Havering and so there were unlikely to be any changes to local pharmacy services until 2018. More details on the care home elements were expected to be released later in 2017. A written summary of which Havering pharmacists could currently take referrals from NHS 111 could be provided to the Board.

Officers from Havering CCG added that a new NHS 111 service was in the process of being procured and this would divert people to pharmacists if they simply required a repeat prescription. A small number of local GP practices already employed pharmacists and the CCG also ran a programme to train pharmacists in chronic disease management such as Chronic Obstructive Pulmonary Disease.

The Board noted the position.

15 REFRESHED HEALTH AND WELLBEING STRATEGY FOR APPROVAL

The Interim Director of Public Health advised that feedback from the Board had been taken into account in the mid-period refresh of the strategy. Members of the Board were invited to select performance indicators that could be put into a dashboard that would be brought regularly to the Board. It was planned to bring a dashboard to the Board in May 2017. The redraft of the strategy for the next period would commence in autumn 2017.

It would also be necessary to consider the governance structure of the Board and how this related to developments across North East London. Board members were therefore invited to submit any comments on the Board's governance and which other groups reported into the Board. It was confirmed that the Chairs of local Health and Wellbeing Boards did meet as part of a wider group but it had been decided not to formally combine local Health and Wellbeing Boards.

The Board approved the refreshed Health and Wellbeing Strategy.

16 UPDATE ON INTEGRATED CARE PARTNERSHIP (PREVIOUSLY ACO) LOCALITY BOUNDARIES AND STP

A representative of the Sustainability and Transformation Plan (STP) team confirmed that a more simple and transparent narrative explaining the proposals was in the process of being developed. A meeting of communications leads from all organisations involved with the STP (including the Council) had been arranged for 26 January. A memorandum of understanding re STP governance had also been circulated. The STP had started working on establishing a community council and had also

developed linkages with the Healthwatch organisations. A political leadership group was also being considered.

The Director of Communications and Engagement indicated he would like to attend the Board regularly and was also happy for his contact details to be circulated to the Board.

It was hoped that governance arrangements for the STP would be confirmed by April 2017 and that the focus would be on partnership working and local control from partner bodies. The STP was linked to the procurement of NHS 111 services across North East London and work was also in progress with the London Ambulance Service.

Councillor Ramsey felt that there may not be enough governance involvement from Councils with for example only one Local Authority representative on the STP Board. A Leader's Committee had been suggested but Councillor Ramsey felt that there was less understanding of the STP amongst Leaders of Boroughs not involved in the Integrated Care Partnership (ICP) work. The STP representative noted these concerns.

It was accepted that more detail was needed in the STP documents of work in the non-ICP areas covered by the plans. The Council Chief Executive felt there were some common themes across all the ICP boroughs but that Havering was further ahead in a number of areas. A report on STP governance would be brought to the next meeting of the Board.

The Healthwatch Chair added that local residents wished to be certain that people running services would still be in control of these under the STP. It was also felt that changes of names such as the ICP were confusing for members of the public. It was also accepted that the branding of the STP needed more work and that stronger linkages should be established with areas such as Essex, Epping Forest and the City of London.

The Board of the Integrated Care Partnership was chaired by the Cabinet Member for Health in Barking & Dagenham. Councillor Brice-Thompson also attended these meetings and a representative of Healthwatch was also present. The locality boundaries had been drafted and the Health and Wellbeing Board would be invited to agree these at a future meeting. Priorities for the locality areas included children's health & social care and urgent & emergency care. The benefits and challenges of each locality area were currently being investigated and it was hoped challenges could be solved at the locality level where possible. Progress in Havering would be reported on at the next ICP board meeting.

An Integrated Commissioning Board had been established and the Transforming Care Partnership Board could be used to test out joint commissioning across the pathway. It was agreed that housing, jobs etc were critical to prevention of health problems and the self-care of residents. Links had recently been established between housing officers and NELFT's talking therapies teams.

The Director of Public Health added that, with reduced budgets, it was difficult to focus on prevention but existing contacts could be used to improve this. Public health worked closely with BHRUT and the local CCGs on selected clinical pathways.

Councillor Ford felt that wellbeing was key and that areas such as children's centres and healthy eating should be considered as part of a focus on the wider determinants of health. The CCG chief operating officer agreed, feeling that it was important to use existing resources in a more effective way.

It was also felt that there should be more of a focus on prevention in the STP in order that the public health message could be spread more widely. The Marmot Report also focussed on giving children the best start in life and there was a need to focus more on tackling health inequalities which were likely to rise in Havering.

The Board noted the update.

17 **OPEN DIALOGUE - PRESENTATION FROM NELFT (FOR INFORMATION)**

The Associate Medical Director of NELFT explained that the Open Dialogue method of mental health care saw service users with their network of family or friends rather than just individually. The technique had originated in Finland and had resulted in a 72% discharge rate from mental health services after two years and good outcomes had also been seen when the technique was introduced in the USA.

NELFT had organised the first training in the UK for Open Dialogue and it was aimed to launch a pilot of the treatment in late 2017. An academic board had been formed with University College London and Kings College and a bid had been submitted for £2.4 million of funding for a trial of Open Dialogue. It was hoped to announce in March if this funding had been received. Trial areas for the technique would be in Havering and Waltham Forest.

The Open Dialogue model could be used to deliver other types of care such as Cognitive Behavioural Therapy. The trial of the service would focus on adults in the 18-65 age range although it was possible Open Dialogue could be applied to mental health services for younger people in the future.

The technique was patient centred and no negative feedback had been received from service users. It was accepted that there was a link between Open Dialogue and physical healthcare and that this area needed to be explored more in the future. It was noted that there were also linkages between Open Dialogue and the training in systemic family therapy that the Council's social workers were currently undertaking.

18 **UPDATE ON SEXUAL HEALTH SERVICES (FOR INFORMATION)**

The Board was advised that Havering performed at an average or better level for most sexual health services although abortion rates were relatively high. HIV rates for Havering had also increased slightly.

The redesign of Havering's sexual health services was now live and the London e-Service would start in May 2017. This would allow residents to order self-sampling kits to their homes. Inner North East London boroughs were looking to procure a new site for their services in the Stratford area which was likely to be more accessible for some Havering residents.

The ICP approach could lead to a change in the family planning pathway at locality level and it was planned to procure new contracts for the BHR area for sexual health by October 2018.

. There were no figures available for abortion rates at borough level and this would need to be looked at on a wider level. All abortions were carried out, by law, on health grounds so it was not possible to produce information on more detailed reasons for abortions. Sexual health services were also provided anonymously so there was no data on for example what proportion of Looked After Children were accessing services.

It was confirmed that Havering's family planning spokes had closed last year following a consultation. Family planning services were however still available at Queen's Hospital or via GPs. The GUM service had moved from Queen's to Barking Hospital. The morning after pill and long acting reversible contraception was still commissioned from GPs. It was confirmed that all existing clients had been advised where new services would be provided from and the e-service would offer a further option, once this commenced.

Pharmacists were not able to prescribe the contraceptive pill in Havering and the Director of Public Health added that 80% of Havering women accessed contraception via their GP. The Havering CCG Chair added however that there were capacity issues re this as there may not be not enough GPs to provide contraceptive services. It was felt that this was an issue that the ICP could look at.

The Board noted the report.

19 **UPDATE ON REFERRAL TO TREATMENT (VERBAL)**

The Deputy Chief Operating Officer of BHRUT reminded the Board that the Trust had suspended reporting figures on referral to treatment waits in September 2014. Havering CCG had supported BHRUT in its recovery of the long waiting times for patients to receive treatment. BHRUT had also worked closely with the local CCGs on validation of data around this issue.

Nineteen new consultant posts had been funded, with most now filled, which would increase BHRUT's capacity to treat patients. In addition, some 17,500 patients had been diverted for treatment elsewhere as part of a wider demand management scheme. Reviews were also carried out on patients who had been waiting a long time for treatment.

Some 76.3% of BHRUT patients were now being treated within 18 weeks. This was below the target of 92% but ahead of the Trust's trajectory at this point. Referral to treatment was now subject to a robust governance framework with regular meetings between BHRUT and the local CCGs. It was felt that the Trust had made significant steps forward towards delivering a consistent standard for patients on this issue.

The Chair of Healthwatch Havering congratulated BHRUT on the progress it had made and valued the Trust's openness on this matter.

20 **LETTER FROM HOME OFFICE: POLICE, CRIME COMMISSIONERS AND HEALTH AND WELLBEING BOARDS (FOR INFORMATION)**

The Board noted the contents of a letter received from the Home Office concerning the benefits to be realised through closer collaboration between policing and health partners.

21 **LETTER FROM DAVID MOWAT MP: (GENERAL PRACTICE FORWARD VIEW: PRIMARY CARE: HEALTH AND WELLBEING (FOR INFORMATION)**

The Board noted the contents of a letter from the Department of Health concerning the General Practice Forward View and the relationship that primary care had with the delivery of local health and wellbeing strategies.

22 **FORWARD PLAN**

It was noted that dates for meetings of the Board in the next municipal year were hoped to be announced in March 2017 and efforts would be made to avoid clashes with other meetings, as far as these were known.

It was agreed that the item on the Transforming Care Partnership would be moved to the May 2017 meeting of the Board, It was also suggested that a discussion on financial recovery and budget issues should be held, in private session, at the May meeting.

The Board noted with concern that Havering was not getting any extra funding under the needs assessment, despite the population of Havering being expected to rise to 270,000 by 2026. The Leader of the Council felt it was essential that health provision was factored into population growth.

The Forward Plan for the Board is attached to the minutes for information.

23 DATE OF NEXT MEETING

The next meeting of the Board would be held on 15 March 2017 at 1 pm at Havering Town Hall.

Chairman

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NOTES OF A MEETING OF THE HEALTH & WELLBEING BOARD
Committee Room 3A – Town Hall
16 November 2016 (1.00 – 3.10pm)

Board Members present:

Councillors Wendy Brice-Thompson (Chairman), Roger Ramsey and Robert Benham
Dr Susan Milner, Interim Director of Public Health, LBH (SM)
Tim Aldridge, Director of Children's Services, LBH (TA)
Anne-Marie Dean, Healthwatch Havering, LBH, (AMD)**Also present:**

Dr Russell Razzaque, Associate Medical Director, NELFT (RR)
Brian Boxall, Independent Chair for SAB and LSCB (BB)
Caroline May, Head of Business Management LBH (CA)
Rob Meaker, Director of Innovation, BHR CCGs (RM)
Simrath Bhandal, Project Manager BHR CCGs (SB)
Louise Mitchell, Chief Operating Officer CCG (LM)
Sarah Tedford, Chief Operating Officer BHRUT (ST)
Carol White, Integrated Care Director NELFT (CW)
Neil Stubbings, Interim Director of Housing Services, LBH (NS)
Elaine Greenway, Acting Public Health Consultant, LBH (EG)
Gloria Okewale, Public Health Support Officer, LBH (GO)
Richard Cursons, Democratic Services Officer, LBH (RC)

1 **WELCOME AND INTRODUCTIONS**

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

2 **APOLOGIES FOR ABSENCE**

Apologies were received from Andrew Blake-Herbert, Chief Executive, Barbara Nicholls, Director of Adult Services LBH, Connor Burke, Accountable Officer BHR CCGS, Alan Steward, Chief Operating Officer Havering CCG, Dr Atul Aggarwal, Chairman Havering CCG, Gurdev Saini, Havering CCG, Ceri Jacob NHS England, Jacqui Van Rossum, NELFT, Councillor Gillian Ford, Phillipa Brent-Isherwood, Head of Business & Performance.

It has been noted that board members should provide details of senior representatives if they are unable to attend the meeting.

3 **DISCLOSURE OF INTERESTS**

There were no disclosures of interest.

4 **MINUTES**

As the meeting was inquorate the minutes could not be agreed or signed by the Chairman, however the points raised previously were noted.

5 **ACTION LOG**

It was noted that the draft refreshed Joint Health and Wellbeing Strategy was circulated to board members as agreed.

The SEND JSNA executive summary was revised and circulated to board members. This included information on exclusions from maintained schools as well as free schools and academies.

Finalised Joint Health and Wellbeing Strategy to be circulated to board members.

SM to identify the organiser of the Havering governing body to ensure future dates doesn't clash with the HWB meeting.

6 **REFRESH OF HAVERING'S JOINT HEALTH AND WELLBEING STRATEGY**

SM advised that the current Joint Health and Wellbeing Strategy (2015–2018) had been signed off by the Havering Health and wellbeing Board in April 2015. It had been reviewed and refreshed in line with recent developments within the local health and social care economy to ensure it remained fit for purpose. The Board agreed the reframed themes and priorities for the strategy in May 2016. These had been reflected in the refreshed strategy document 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 were contained within a number of other key strategic documents and actions plans. To avoid duplication of effort it had identified, for each priority, the key document(s) which set out the agreed actions to deliver on that priority and who was responsible for ensuring those actions take place. In addition leads had been to identify the key performance indicators to include in the HWB performance dashboard for the strategy. This would provide the Board with

assurance that the actions required to deliver the Joint Health and Wellbeing Strategy were being carried out and were leading to the specified outcomes.

Members were invited to provide feedback by email so that the final document could be brought back to the next meeting.

Members agreed that it would be helpful if the areas that had changed could be highlighted.

BB advised that it would be useful if the Local Safeguarding Children Board (LSCB) could look over the document and email any suggested changes.

AMD asked if going forward the Health & Wellbeing function would remain Havering specific or become tri-borough. RR advised that at present it was planned to keep Health & Wellbeing functions borough specific.

7 HAVERING SAFEGUARDING CHILDREN BOARD AND HAVERING SAFEGUARDING ADULT BOARD 2015/16 ANNUAL REPORTS

The report provided the HWB with both the Havering Children and Adult Safeguarding Boards annual reports for 2015-2016.

BB gave a brief update on the highlights of both reports.

Members noted that since the reports had been written there had been a change in the process with a more face to face approach being introduced.

Ofsted had recently inspected the Board and the draft response was awaited.

The police re-structuring was imminent and more details would be known shortly.

The Children's report highlighted the work that had taken place and BB wished to acknowledge the support that was received from all members on the Board at all levels. The Board was of a very good level due to the amount of multi-agency workers working together.

The Multi Agency Sharing Hub (MASH) was now well developed and contact to referral level had 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 was now evidence of early intervention with children and young people and families requiring support being signposted to the appropriate service.

The Child Protection conferences had seen a problem with the lack of attendance by the police and the pressures it placed on other officers.

Staff stability was key as it impacted on various areas of the service.

Despite many attempts private fostering was still an area that needed improvement.

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

Members also noted that there was now a high risk register in place.

In relation to the Adult's Board the past year was the first that the HSAB had been operating as statutory body following the introduction of the Care Act 2014. The HSAB has focused on ensuring that it was able to comply with the requirements of the Act.

Adult safeguarding activity had continued to increase over the year especially in respect of the number of contacts and referrals and conference activity. The major increase had been in respect of the application of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLs) assessments.

The safeguarding activity was being undertaken under continued financial constraints and the on-going restructuring of some organisations. This, and the demography of Havering which had the oldest population in London, will continue to pose significant challenges to the local agencies and the HSAB.

Awareness had been raised in the areas of self neglect, modern slavery and domestic violence.

One of the biggest areas of work was around the transition between children's and adults and how users were prepared for the move between the two.

Current risks were:

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 was high.

Mental capacity - there was still a need to continuously brief staff in their responsibility to undertake MCA assessments.

RR advised that a first meeting had taken place between local authorities and the police to discuss Havering's involvement in a unified borough command with Barking & Dagenham and Redbridge. There had been a focus on child protection and domestic violence and although there would be the same amount of officers the plan was to de-centralise some of the specialist teams so the borough would have access to more specialist officers. RR also confirmed that the project was a pilot and was reversible if needed. It was also noted that Havering's current Borough Commander Jason Gwillim would oversee the tri-borough pilot.

8 SINGLE INSPECTION FRAMEWORK UPDATE

TA gave an update on the recent Ofsted inspection. It was noted that this had involved 12 inspectors over a 4 week period, where they had looked at over 200 cases and met with staff, external partners and parents to gain a complete overview of the service.

The overall rating was "requiring improvement" which was what the service had expected. An action plan was being produced to deal with the areas that needed improvements. It was felt by the inspectors that the vision for the future was good, but improvements needed to be made on the day to day work. Safeguarding was also considered a strength as was CSE/ Missing Service, Early Help and Female Genital Mutilation. Weaknesses included workforce and commissioning of children's services which had been seen as too reactive.

The draft report should be received later this week and then the Council would give its response before the final report is issued in December.

9 LOOKED AFTER CHILDREN - HEALTH CHECK UPDATE

TA advised that health of Looked after Children (LAC) had been a risk area that had previously been flagged to the HWB and LSCB and had been an area that Ofsted had looked at recently.

This had become a key priority area during the last six to nine months and there had been some improvement and whilst the report was being compiled colleagues from the CCG and NELFT had been linked with. Works would continue on improving progress. One of the areas of concern had been the initial health assessment which was now at 96% but still needed improvement.

There was a LAC/Heath sub group that would be reviewing progress of measures which took place every six weeks. Improvements had also taken place in the performance of review assessments
Plans were also in place to ensure that all children in care were offered dental and optical checks on an annual basis. The aim is for all children to have those checks or to be offered those checks by March 2017.

There had been an improvement in children in care whose immunisations were up to date.

A strengths and difficulties questionnaire, which was a CAMS tool, was given to service users each year to complete so users could give an indication of where their mental health and emotional wellbeing was. Improved score were being seen and Havering's average was now below the national average.

Plans were in place for developing an in-house team of systemic family therapists who would be providing direct support to the users or carers.

WBT asked about childhood obesity and was advised that that would be tackled by universal and targeted children's services including school nursing.

10 ADULT SOCIAL CARE LOCAL ACCOUNTS FOR 2015/16

Local accounts were not mandatory but it was good practise to publish each year by local authorities who had responsibility for adult social care services. These accounts were designed to provide residents and service users with information on their Council's adult social care performance, activity and objectives. The Havering Local Account summarised adult social care and support achievements in 2015-16 and ambitions for the future.

CM highlighted several areas within the report including:

In 2014/15, the Council had 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 had 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 Council faced significant financial challenges due to funding reductions and increasing demand for services. Demand was increasing in terms of numbers of people who needed care and support, and also in terms of complexity.

The Council was actively developing savings plans to address budget shortfalls, in line with overall Council budget plans and considering how it would continue to provide Adult Social Care services. This may mean that it had to provide services in different and innovative ways in order to address the funding reductions that were being seen. 2015/16 savings were £5.2m against a budget of £52m (representing 10% of the service budget).

The Care Act imposed 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 was sometimes referred to as the "wellbeing principle" because it was a guiding principle that puts wellbeing at the heart of care and support system.

Much work had taken place to ensure that Havering was compliant with those aspects of the Care Act which came into force on 1 April 2015. This was a large and complex undertaking that had been delivered through a programmed management approach.

The report also detailed the challenges that lay ahead which included:

Even more Havering residents would be dependent on care and support services provided by the Council and its partners, the biggest challenge remained meeting the needs of a growing number of service users - particularly those aged over 65 - with the resources and funding available.

Whilst the need for services was continually increasing and would continue to rise, the financial challenges and the need to be creative in delivering services become more difficult. Havering had a growing population with a profile that was ageing, with need that were 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 would continue to manifest.

11 REFERRAL TO TREATMENT DELAYS IN BHRUT UPDATE

The report before Members detailed the progress of the local Hospitals' Trust (BHRUT) and clinical commissioning groups (BHR CCGs) work together to tackle unacceptably long waits for treatment for some patients across the area.

ST and LM briefed jointly on the report which highlighted how the long waits had come about and what measures had been put into place to deal with the issues.

The report detailed how arrangements had been put into place to improve care, the clinical harm programme that had been undertaken, demand management and also showed the drop in the number of patients who had been waiting for more than 52 weeks for treatment.

The demand management had taken into account the ongoing treatment needs and those patients within the backlog and this had lead to commissioning of additional providers offering patients alternative means of treatment.

Members noted that systems were already in place so that the same situation did not arise again and there would be an external check of waiting lists annually which would help act as an early warning system.

BHRUT and Havering CCG had had to submit a system wide action recovery plan to enable them to return to reporting and achieve a standard of 18 week treatment time. The plan had been submitted to NHSE Board which would

make a decision in December as to whether legal directions would remain in place.

Going forward it was planned that by September 2017 all patients would be seen within 18 weeks.

12 HOUSING DEVELOPMENT

The report provided the Board with an update on the housing development proposals approved by Council and associated regeneration implications and aspirations.

NS advised that the report attached that went before Cabinet on 12 October contained the latest information regarding the Council's house building programme, funded through the Housing Revenue Account (HRA) to provide affordable housing for local residents.

The Council had an ambition to deliver at least 2000 units of affordable housing through the programme. 1000 of those would replace those already in situ, but 1000 would 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 meant that current target for delivery of units was 2500 total with 1500 being new units of affordable housing.

Previously there had been an over-provision of sheltered housing but this was now being overtaken by the need for extra care sheltered accommodation. The proposals previously put forward included estate regeneration, community hubs and not just house building in its simplest form.

AMD enquired as to when the community hubs would be in place. In reply it was hoped that the hubs would be started in the next year.

RR raised a concern regarding extra housing provision and additional healthcare provision going forward. It was felt that discussions should be taking place with the CCG regarding the possible inclusion of healthcare facilities within large developments.

NS advised that discussions were being had with the CCG over the One Public Estate Project where the CCG realised that there were key infrastructure issues that they needed to provide for Barking & Dagenham, Havering and Redbridge.

It was agreed that this should be taken forward to a future meeting.

13 BHR CCGs' LOCAL DIGITAL ROADMAP

The report updated the Board on the progress of the Local Digital Roadmap development.

RM advised that following the publication of the Five Year Forward View and Personalised Health and Care 2020, local health and care economies had 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 had undergone a review and were expected to be submitted for national publication by the end of October 2016**.**

Bids had been submitted for up to £40 million of funding although it was known that the final amounts awarded would be far lower than had been bid for.

In relation to GP clinical systems, meetings with the federations had taken place and an implementation date of April and June 2017 was hoped for. The estimated costs for the implementation of the system in Havering would be approximately £300,000. It was hoped that all GPs would sign up to one system making the implementation easier.

14 DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT (INFORMATION ONLY, NOT FOR DISCUSSION)

The Board noted the comments of the report.

15 FORWARD PLAN

Copies of the forward plan were distributed, it was noted that items had been raised at this particular plan needed to be added to the plan. Members were reminded that if they wished for items to be added to the plan then they should email SM and GO.

16 DATE OF NEXT MEETING

The next meeting of the Board would be on Wednesday 18 January 2017 at 1.00 pm at Havering Town Hall.

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Havering Health and Wellbeing Board - Forward Plan 2016/17

All meetings will start at 1pm (until 3pm) Rooms to be confirmed for each meeting.

HWB Meeting 15 March 2017. Deadline for papers **3 Mar 2017** To be held in room CR3B	
Transforming Care Partnership: Six Month Update	Barbara Nicholls
Obesity Strategy update	Mark Ansell
Health Protection Forum Report	Sue Milner
Report from End of Life Steering Group (tbc)	TBC
Presentation of Recent Area Inspection of SEND Joint Self-Evaluation (TBC)	Tim Aldridge
Drugs and Alcohol Strategy update	Sue Milner
Dementia Strategy- for sign off	CCG/ Public Health
Update on Referral to Treatment Delays	Sarah Tedford / Louise Mitchell
Combined Update on ACO/STP (Verbal)	Conor Burke/Alan Steward/Andrew Blake Herbert
Local Plan Development	Neil Stubbings
Forward Plan	

Havering Health and Wellbeing Board - Forward Plan 2016/17

HWB Meeting 10 May 2017. Deadline for papers **28 April 2017** To be held in room tbc	
Update on Referral to treatment delays	Sarah Tedford / Louise Mitchell
Combined update on ACO/STP	Conor Burke/Alan Steward/Andrew Blake Herbert
Forward Plan	

Havering Health and Wellbeing Board - Forward Plan 2016/17

Previous Board meetings and topics covered

HWB Meeting 20 July 2016. Deadline for papers **8 July 2016.** To be held in CR3B	
Strategic Outline Case for the ACO	Conor Burke /Andrew Blake Herbert
Delivering the NHS five year forward view: development of the North East London Sustainability and Transformation Plan (NEL STP)	Conor Burke
JSNA Programme Report	Sue Milner
Demand Management Strategy Case Study - Social Isolation	John Green
Launch of face to face intervention (working with children in social care)	Tim Aldridge
Forward Plan	Sue Milner
HWB Meeting 23 March 2016 – Room CR3b Deadline for paperwork **11 March 2016**	
Revised terms of reference for the HWB	Wendy Brice-Thompson
Confirmation of HWB priorities for 16/17 to inform refreshed JHWS	Wendy Brice-Thompson
Combined verbal update on ACO/UCC/STP	Cheryl Coppell/Conor Burke/ Alan Steward

Havering Health and Wellbeing Board - Forward Plan 2016/17

Market Position Statement – Commissioning in Adults Services	John Green
Transforming Care Partnership	John Green
BCF Plan for discussion	Caroline May
Havering Sexual Health Services Reconfiguration	Sue Milner
Drug and Alcohol Harm Reduction Strategy	Sue Milner
Obesity Strategy	Sue Milner
Forward Plan	Sue Milner
HWB Meeting 11 May 2016. Deadline for papers **29 April 2016** To be held in room CR3a	
Combined verbal update on ACO/UCC/STP	Conor Burke/Cheryl Coppell/Alan Steward
ToR for sign off	Wendy Brice Thompson
Outline draft of JHWS for discussion	Sue Milner
ASC Local Account	Barbara Nicholls
Place of Safety item	Barbara Nicholls
Clinical governance assurance report	Sue Milner
Primary Health Care Strategy consultation	Sarah See, BHRUT CCGs

Havering Health and Wellbeing Board - Forward Plan 2016/17

Forward Plan	Sue Milner
HWB Meeting 20 July 2016. Deadline for papers **8 July 2016.** To be held in CR3B	
Strategic Outline Case for the ACO	Conor Burke /Andrew Blake Herbert
Delivering the NHS five year forward view: development of the North East London Sustainability and Transformation Plan (NEL STP)	Conor Burke
JSNA Programme Report	Sue Milner
Demand Management Strategy Case Study - . Social Isolation	John Green
Launch of face to face intervention (working with children in social care)	Tim Aldridge
Forward Plan	Sue Milner
HWB Meeting 21 September 2016. Deadline for papers **9 Sept 2016** To be held in CR3B	
Combined update on ACO/STP	Conor Burke/Alan Steward/Andrew Blake Herbert
SEND Inspection and Needs Assessment	Mary Phillips/Mark Ansell
Transforming Care Partnership – for sign off	Barbara Nicholls
CCG Assurance Framework and rating	Conor Burke/Alan Steward

Havering Health and Wellbeing Board - Forward Plan 2016/17

Forward Plan	

HWB Meeting 16 November 2016. Deadline for papers **4 Nov 2016** To be held in CR3B	
LCSB/ASB reports	Brian Boxall
Draft Joint Health and Wellbeing Strategy	Sue Milner
DPH Annual Report (info only item)	
ASC Local Account for 2016	Caroline May/ Tina Nandra
Combined update on ACO/STP (Verbal)	Conor Burke/Alan Steward/Andrew Blake Herbert
Looked After Children update- Health check	Tim Aldridge, Alan Steward, Carol white
Housing Development	Neil Stubbings
BHR CCG's Local Digital Roadmap	Rob Meaker/ Simrath Bhandal
Single inspection framework update	Tim Aldridge
Update on Referral to treatment delays	Sarah Tedford / Louise Mitchell
Forward Plan	

Havering Health and Wellbeing Board - Forward Plan 2016/17

HWB Meeting 18 January 2017. Deadline for papers **6 Jan 2017** To be held in CR3B	
Agenda from HWB meeting (16 November 2016)	
Open Dialogue – presentation from NELFT	Carol White
Community Pharmacy	Oge Chesa
Update on Sexual Health Services	Mark Ansell
Refreshed Health and Wellbeing Board Strategy for approval	Susan Milner
Update on Integrated Care Partnership (previously ACO), locality boundaries and STP	Alan Steward / Barbara Nicholls /Ade Abitoye
Letter from Home Office: police, crime commissioners and health and wellbeing boards (information only item)	
Letter from David Mowat MP: General Practice Forward View: Primary Care: Health and Wellbeing Boards (information only item)	
Update on Referral to treatment delays	Piers Young
Forward Plan	

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Health and Wellbeing Board Action Log (following January 17 Board meeting)

No.	Date Raised	Board Member Action Owner	Non-Board Member Action Owner	Action	Date for completion	RAG rating	Comments
17.01	18 January 17	Susan Milner		SM to circulate to the board a summary of which Havering pharmacists can currently take referrals from NHS 111.	15th February		
17.02	18 January 17	Susan Milner		SM to produce governance diagram for circulation to HWB members.	3rd March		
17.03	18 January 17	Susan Milner		HWB strategy dashboard to be circulated via email in 4 weeks for comments to May Meeting.	14th February		
17.04	18 January 17	Susan Milner		SM to ensure that Ian Tompkins has a regular update slot on the HWB agenda in regards to the North East London Sustainability and Transformation Plan (STP).	3rd March		
17.05	18 January 17	Barbara Nicholls		Draft locality boundaries paper to come back to May HWB meeting	10th May		

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD, 15 March 2017

Subject Heading:	**Update on Referral to Treatment (RTT) Delays**
Board Lead:	**Alan Steward, Chief Operating Officer, Havering CCG**
Report Author and contact details:	**Sarah Tedford (PA LeeAnn Hamilton 01708 435039) and Louise Mitchell**

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

- ☐ Theme 1: Primary prevention to promote and protect the health of the community and reduce health inequalities
- ☒ 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: Quality of services and user experience

SUMMARY

Significant issues were identified with how Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) had historically reported Referral to Treatment (RTT). We suspended reporting of the RTT standard in 2014 so that we could fully investigate the issues and create a robust and comprehensive recovery plan. Since the RTT issues were identified in 2014 we have been working to recover our RTT position and implement our Recovery and Improvement Plan.

As of the end of January 2017, we were 7.3% ahead of our recovery trajectory to deliver the RTT national standard by the end of Sept 2017. We have treated 3,700 more patients than anticipated. In April 2014 we had just over 1,000 patients who had waited more than a year for their treatment. At the end of January 2017 we reported 17 patients had waited more than a year for their treatment, with a number of these patients choosing to wait longer following our offers to treat them sooner.

RECOMMENDATIONS

- To note progress of RTT activity and the reduction in long waiting patients
- To note progress with the clinical harm reviews of long waiting patients
- To note the work and support we have given with the development of a system-wide RTT recovery plan in response to the legal directions placed on NHS Havering Clinical Commissioning Group by NHS England which came into force on 20 June 2016.

REPORT DETAIL

In December 2013, the Trust migrated from Total Care Patient Administration System (PAS), to Medway PAS. This change in information system for the management of patient waiting lists, whilst large and complex, should not have affected performance. However, the migration exposed a discrepancy between current performance and historical performance and suggested that we were not compliant with Referral To Treatment (RTT) standards, as was previously thought. A reporting break was agreed in February 2014 to give us time to investigate.

In light of the issues identified, we undertook an investigation into the matter in August 2014, which concluded that there are five main reasons for the decline in performance following the deployment of Medway:

1. RTT performance was not calculated correctly
2. Our governance processes for reporting and oversight were weak
3. Demand and capacity were not aligned
4. Data quality was poor
5. Training and organisational awareness of RTT and its rules were limited.

Since the RTT issues were identified in 2014, we have been working to recover our RTT position as captured in this Recovery and Improvement Plan.

Current RTT Position

There is dedicated Project Management Office support for RTT across the whole health system and there are a number of work streams in motion to support the delivery of the recovery plan for RTT:

1. Operational management
2. Outsourcing
3. Demand and capacity analysis
4. RTT administration and governance
5. Validation and data quality
6. Theatre productivity
7. Clinical harm reviews
8. GP Referral demand management programme

Clinical Harm Reviews

A key element of the RTT Recovery Plan is the Clinical Harm Programme. The programme is designed to ensure risk to patients waiting longer than the NHS constitutional standards for their treatment are appropriately and efficiently managed. Patients are reviewed, and the findings reported weekly via Access Board and the Clinical Harm Review Panel.

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

Phase 3

- Commenced 1 October 2016
- Focused on patients who would have been waiting more than 52 weeks before 3 December 2016
- All 83 patients have been reviewed and no moderate or severe harm identified

Phase 4

- Commence 5 December 2016
- Focused on a random sample of 10% of undated patients with a 35 week breach date between 4 December and 13 March 2017
- 206 patients have been reviewed for risk of deterioration with no harm found.

GP referral demand management programme

The challenge of delivering the national standard for RTT has been prioritised by all three BHR Clinical Commissioning Groups (CCG). They have the responsibility to avert 24,000 GP outpatient referrals this year by sending patients to a range of alternative independent sector and community providers. At end Feb 2017, over 22,000 patients had been redirected by GPs.

Patients who have waited a long time for treatment (52 weeks plus)

We have a small number of patients who are now waiting over 52 weeks for treatment. These are patients who have;

- chosen to postpone their treatment for personal reasons having been offered reasonable choice
- not responded to three letters, contact via their GP asking them to arrange an appointment
- not attended two consecutive appointments are on a complex care pathway

We will continue to reduce waiting times to prevent this issue from arising again and in line with our commitment to deliver the RTT national standard by September 2017.

RTT recovery plan in response to legal directions

In response to the legal directions issued by NHS England in June 2016 to Havering CCG, (Lead CCG for BHRUT contract) we developed a robust and credible recovery plan, which will allow us to return to delivering the RTT standards. Based upon the modelling, the expectation is to deliver the national 92% RTT incomplete standard by the end of September 2017.

NHS England is now fully assured that all requirements, as set out in the original Directions, have been satisfied. This is the result of focused work to deliver our plan, plus subsequent system performance. The Legal Directions against Havering CCG concerning RTT have now been lifted (Feb 2017).

There is a significant challenge to return to meeting the RTT standards in a sustainable manner that has involved undertaking a significant amount of extra operations (5,000) and outpatient appointments (95,000) over a 12-month period, and we have worked hard with our system-wide partners on this challenge.

As of the end of January 2017, we were 7.3% ahead of our recovery trajectory to deliver the RTT national standard by the end of Sept 2017. We have treated 3,700 more patients than anticipated. In April 2014 we had just over 1,000 patients who

had waited more than a year for their treatment. At the end of January 2017 we reported 17 patients had waited more than a year for their treatment, with many choosing to wait longer following our offers to treat them sooner.

Return to Reporting RTT standards

Following extensive validation and improvements in data quality we have taken steps to assure a return to reporting for RTT performance. We returned to reporting with the October 2016 RTT position, which was reported at our December 2016 Board and nationally mid-December 2016. This was following a suspension of reporting since February 2014.

We constructed a detailed plan to support this work and sought external assurance as recommended by NHS England with this work. This was a big step for us as an organisation and has helped to increase our confidence with reducing waiting times and delivering the national RTT constitutional standards.

On-going assurance

A Governance and Assurance Framework has been developed with a clear reporting line and for governance. RTT assurance and governance will be managed through the RTT Programme Board. External assurance is also provided through weekly meetings with NHSE and NHSI. The Trust also has a weekly Access Board that feeds into the RTT Programme Board. This is chaired by the Deputy Chief Operating Officer. There is also an External Clinical Harm Panel chaired by NHS England.

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Health Protection Forum Annual Report 2016
Board Lead:	Dr. Susan Milner
Report Author and contact details:	Louise Dibsdall & Elaine Greenway Public Health Service

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

- ☒ Theme 1: Primary prevention to promote and protect the health of the community and reduce health inequalities
- ☒ 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: Quality of services and user experience

SUMMARY

The purpose of this report is to discharge the Director of Public Health's statutory duty to provide assurance and information on arrangements to protect the health of the population of Havering. It presents an overview of the key health protection functions of the Council and its partners and what actions are being taken.

The 2015 Health Protection report focused on the statutory changes that had taken place following the Health and Social Care Act 2012 and the roles and responsibilities of the agencies involved. This year's report provides a spotlight on seasonal influenza, including: an overview of the causes (aetiology) and spread (epidemiology) of the disease; an in-depth review of immunisation programmes for seasonal influenza; and actions being taken locally and nationally to improve uptake of flu vaccination.

Havering's Health Protection Forum provides surveillance of the respective components of the health protection system and challenges the system when risks are identified. The Forum meets quarterly and has received reports on various health protection topics over the past year, including: communication protocols for outbreaks/incidents; air quality; antenatal and newborn

screening programmes; antimicrobial resistance; infection control in acute hospital settings; and emergency planning.

Overall, health protection in Havering is effective and the established processes are performing as expected. There have been no major outbreaks or incidents outside of what would normally be expected when health protection processes are working well.

The main issues/highlights are:

- Uptake of seasonal flu vaccinations in Havering across all age groups in the 2015-16 flu season was broadly similar to the uptake for London, but worse than the overall uptake for England.
- Under 12 month, under 2 years and under 5 year old routine vaccinations are all either surpassing, close to the 95% uptake target or on a par with England.
- Although there is no national set target for Pertussis (whooping cough) vaccination for pregnant women, Havering is performing better than both London and England for uptake (latest available data for March 2016 was 70.1% compared to 49.8% in London and 60.7% in England).
- HIV infection in Havering is lowest out of all the London boroughs, but many cases are diagnosed late.
- The incidence of TB in Havering remains low at 10.9 per 100,000 and does not constitute a priority region. PHE have commenced a new universal BCG vaccination offer to all newborn babies, but until the global shortage of vaccine is rectified, available vaccines are still being prioritised to at risk individuals or priority regions with high incidence.
- There were 4 MRSA cases and 38 cases of *C.difficile* in BHRUT hospitals in 2015-16.

Key actions taken were:

- Havering Public Health Service maintains surveillance of the health protection system.
- PHE rolled out a national winter campaign, including Winter Readiness Packs for Care Homes and for Schools, together with the flu vaccination programme.
- NHSE recommissioned school vaccination service and require providers of the school childhood flu vaccinations programme to attain 100% of eligible children to be offered the immunisation, with a minimum 40% uptake rate to be achieved.
- NHSE have developed an immunisations improvement action plan in partnership with Havering CCG and the Council.
- GP practices have been reminded by NHSE to undertake call and recall for all immunisations cohorts (seasonal flu as well as routine vaccinations).
- NHSE have confirmed that vaccination for meningitis will continue to be provided as part of routine adolescent schools programme (school year 9 or 10), and will run a catch-up campaign for those students in years 10-12, and continue to offer immunisations to first time university entrants up to age 25.
- More people are being tested for HIV in A&E and through antenatal screening.
- Breast and cervical screening programmes in Havering are operating within normal parameters, and within 5% of the target uptake rate (75.1%) for cervical screening. However, Havering's bowel cancer screening programme has experienced some significant challenges. NHSE, as the commissioners of the bowel screening programme, made a decision to interrupt the screening programme at Queens to enable quality standards to be improved, but ensured all patients who were due for a screening test were called within nationally agreed timeframes.

- The Environmental Protection Team, plus partners from Smarter Travel and Public Health, have developed a bespoke Air Quality video, featuring Miles the Mole, which will be shown in primary schools throughout Havering. A 'stills' version is being developed for use in GP surgeries to advise patients on the impact of air quality on their health, what to do if they suffer from Asthma or COPD, and what they can do to reduce their exposure to air pollutants.
- LBH have commissioned a specialist Stop Smoking Service for pregnant women in Havering. Referrals can be made directly to the service by the BHRUT maternity team/midwives at any time during pregnancy, and will be offered by the maternity service at every contact, commencing from the time of booking for the first antenatal appointment.
- Following extensive and unprecedented flooding in the borough on 23rd June this year, the emergency planning team put on a special event to give information and advice to local residents on how to prepare for, and what to do in the event of flood. The emergency planners also highlighted to the CCG the need for GPs to have appropriate Business Continuity Plans.
- BHRUT have an Infection Prevention and Control (IPC) Annual Improvement Plan 2016-17 in place, which includes actions to reinforce standard infection control precautions to minimise the risk of hospital-acquired infections. The improvement plan is being implemented via a corporate strategy and monitored under the corporate umbrella by the Deputy Chief Nurse for Harm Free Care.

RECOMMENDATIONS

To note the contents of the report. No further action required.

REPORT DETAIL

Please see attached report.

IMPLICATIONS AND RISKS

Financial implications and risks: None
Legal implications and risks: None
Human Resources implications and risks: None
Equalities implications and risks: None

1.0 Background

1.1 Purpose

The purpose of this report is to provide assurance and information on arrangements to protect the health of the population of Havering. Following on from last year's report, which gave an overview of the new roles and responsibilities for health protection in the wake of the Health and Social Care Act, each year we will be focussing on one health protection topic in detail. This year's report provides an in-depth look at seasonal influenza – its causes (aetiology) and spread (epidemiology) and actions being taken by the council and its partners to minimise the risk of pandemic flu (including avian flu) (Appendix A). This report highlights key issues relating to health protection in Havering, including: routine childhood and adult immunisations as well as those specifically for at risk individuals; cancer and other screening programmes; infectious diseases; environmental health, including air quality and tobacco control; and health aspects of emergency planning. Where appropriate, the report also outlines what actions are being taken to strengthen local arrangements.

1.2 Havering Health Protection Forum

Havering's Health Protection Forum provides surveillance of the respective components of the local health protection system and challenges the system when risks are identified. The organisations represented on the Forum include:

- London Borough of Havering (Environmental Health; Public Health)
- Public Health England (PHE)
- NHS England (NHSE) (Cancer and non-cancer screening programmes; Immunisations)
- Havering Clinical Commissioning Group (HCCG)
- Havering Borough Resilience Forum (BRF)
- North East London Foundation Trust (NELFT)
- Barking, Havering and Redbridge University Hospitals Trust (BHRUT)

As a multi-agency partnership, the Forum receives quarterly updates from each of the partner agencies responsible for either commissioning or delivery of health protection functions. Surveillance of a set of key indicators - immunisations, screening and infections (MRSA, *C.Difficile*, and gastrointestinal infections) – are monitored via a Dashboard each quarter. In addition, an in-depth report is given on key health topics, and has included in the last year: an annual report of screening programmes (antenatal and newborn screening); infection prevention and control at BHRUT; Air Quality; PHE communications response to incidents/outbreaks; and emergency planning.

2.0 Health Protection Main Topics of Focus

Overall, health protection processes in Havering are performing as expected. There have been no major outbreaks or incidents outside of what would normally be expected when health protection processes are working well. The topics listed below represent the areas of most interest and/or concern to the Health Protection Forum and what is being done about these issues.

2.1 Immunisations

2.1.1 Spotlight on Seasonal Influenza

Influenza, or 'flu', occurs every year, with most cases during the winter months. A vaccination is available each season to protect against the three (trivalent) or four (quadrivalent) most common strains circulating that year. A quadrivalent vaccine has been authorised for use in the UK since 2013, and the Joint Committee on Vaccine and Immunisation (JCVI) has advised that, all things being equal, the quadrivalent vaccine is preferable to the trivalent vaccine[1]. NHS England (NHSE) commission a comprehensive programme of flu vaccinations for children aged 2,3, and 4 years old via their GP surgery, for children in school years 1-6 in Havering at school, for all adults aged 65 years or over via their GP or pharmacist, and for anyone under the age of 65 at clinical risk via their GP or pharmacist.

In the 2015/16 season, uptake of the flu vaccination in Havering was broadly similar to the uptake for London, but worse than the overall uptake for England (See Table 1 in Appendix A). Nationally, for all groups eligible for free vaccinations, uptake of flu vaccination was much lower than the ambition. NHSE have an action plan in place to improve performance in the 2016-17 season, supported by national campaigns to increase patient's response to taking up the vaccination. In addition, provision of school-aged vaccination has been recommissioned this year, with a new provider, Vaccination UK, now in place for Havering.

Cases of avian influenza (bird flu) are very rare, and the best way to prevent infection with avian Influenza A viruses is to avoid sources of exposure. PHE state that risks to public health are very low and avian flu does not pose a food safety risk for UK consumers. In order to prevent avian flu in the UK, on 6th December 2016, the Government Chief Vet declared a Prevention Zone introducing enhanced biosecurity requirements for poultry and captive birds, helping protect them from a strain of avian flu circulating in mainland Europe. This includes a ban on gatherings of poultry across the UK and issuing of advice to both commercial and domestic keepers of poultry on keeping them housed, separated from wild birds, and good biosecurity processes.

Please refer to Appendix A 'Spotlight on Flu' for a more detailed analysis of seasonal flu.

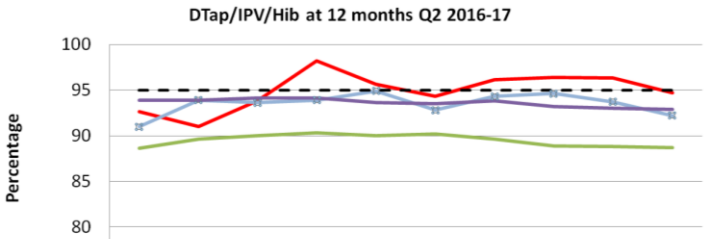
2.1.2 Routine Childhood Immunisations

NHS England commission the childhood immunisation programme, which sets out to provide protection against serious preventable infections[2]. Vaccinations are given locally by GPs, practice nurses, local immunisations teams, and pharmacists (flu only). Information about the delivery of the immunisation programme is collated by PHE and the DPH receives regular reports. The HPF receives a quarterly report on vaccination uptake and interrogates the data, posing questions back to both commissioners and providers where relevant. (Appendix B outlines the full vaccination schedule, dated summer 2016[3]).

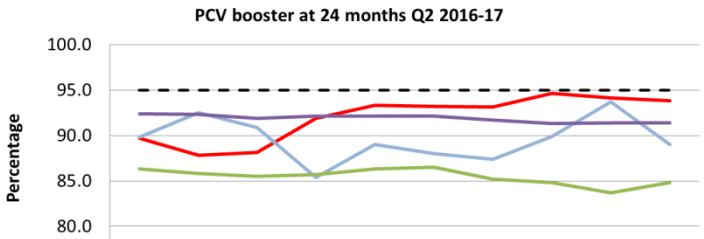
Over the past year, uptake of routine childhood immunisations has remained on a par with or above the England and London uptake levels, and above or close to the target of 95% uptake (Fig. 1). Where the uptake falls short of the 95% target, such as for MMR2 uptake by 5 years of age, Havering is still performing better than London and England. NHSE has developed an immunisations action plan jointly with the Council and Havering CCG to take action to improve immunisation uptake.

Human Papilloma virus (HPV) vaccine is offered to girls aged 12-13 years. The vaccine protects against cervical cancer. Whilst Havering is below the 90% target for uptake (currently at 86.3% for 2014/15), performance is better than London. Havering increased uptake in 2014/15 by 1.5% compared to 2013/14.

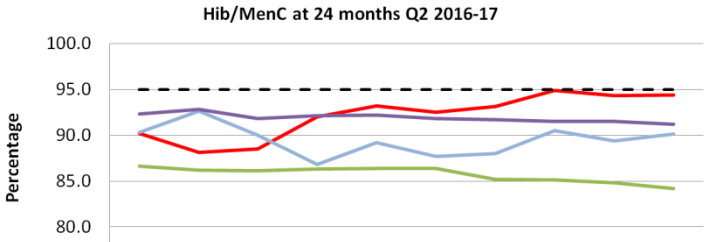
Figure 1. Childhood Immunisation Uptake by Quarter During Period Q1 2014/15 to Q2 2016/17 According to COVER Data



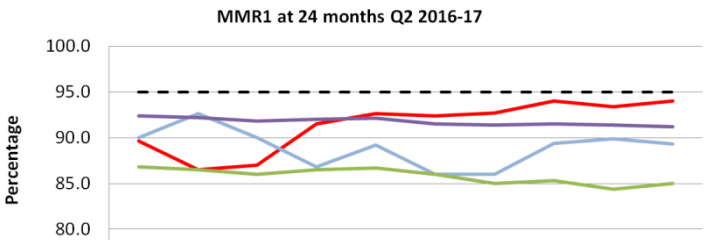
	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17
Havering	92.6	91.0	93.8	98.2	95.6	94.3	96.1	96.4	96.3	94.7
Bexley	91.0	93.9	93.6	93.9	94.9	92.8	94.3	94.6	93.7	92.2
London	88.6	89.6	90.0	90.3	90.0	90.2	89.6	88.9	88.8	88.7
England	93.9	93.9	94.1	94.1	93.6	93.5	93.8	93.2	93.0	92.9
Target	95	95	95	95	95	95	95	95	95	95



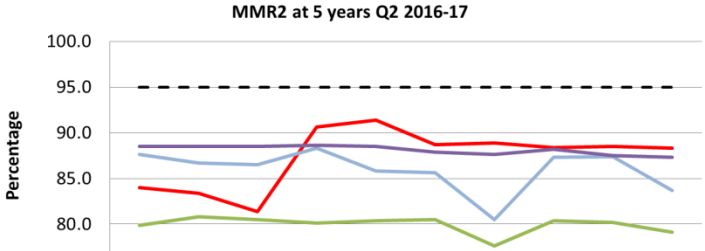
	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17
Havering	89.7	87.8	88.1	91.9	93.3	93.2	93.1	94.6	94.1	93.8
Bexley	89.8	92.5	90.9	85.4	89.0	88.0	87.4	89.9	93.7	89.0
London	86.3	85.8	85.5	85.7	86.3	86.5	85.2	84.8	83.7	84.8
England	92.4	92.3	91.9	92.1	92.1	92.1	91.7	91.3	91.4	91.4
Target	95	95	95	95	95	95	95	95	95	95



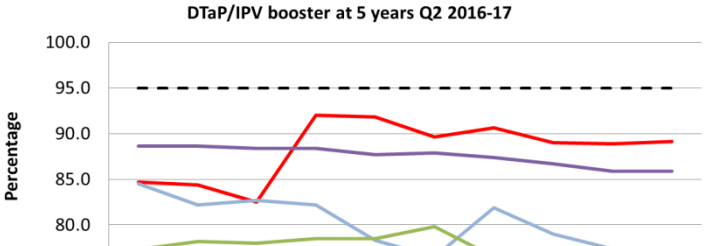
	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17
Havering	90.2	88.1	88.5	92	93.2	92.5	93.1	94.9	94.3	94.4
Bexley	90.3	92.6	90	86.8	89.2	87.7	88	90.5	89.4	90.1
London	86.6	86.2	86.1	86.3	86.4	86.4	85.2	85.1	84.8	84.2
England	92.3	92.8	91.8	92.1	92.2	91.8	91.7	91.5	91.5	91.2
Target	95	95	95	95	95	95	95	95	95	95



	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17
Havering	89.6	86.5	87.0	91.5	92.6	92.4	92.7	94.0	93.4	94.0
Bexley	90.0	92.6	90.0	86.8	89.2	86.0	86.0	89.4	89.9	89.3
London	86.8	86.5	86.0	86.5	86.7	86.0	85.0	85.3	84.4	85.0
England	92.4	92.2	91.8	92.0	92.1	91.5	91.4	91.5	91.4	91.2
Target	95	95	95	95	95	95	95	95	95	95



	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17
Havering	84.0	83.4	81.4	90.6	91.4	88.7	88.9	88.4	88.5	88.3
Bexley	87.6	86.7	86.5	88.3	85.8	85.6	80.5	87.3	87.4	83.7
London	79.9	80.8	80.5	80.1	80.4	80.5	77.6	80.4	80.2	79.1
England	88.5	88.5	88.5	88.6	88.5	87.9	87.6	88.2	87.5	87.3
Target	95	95	95	95	95	95	95	95	95	95



	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17
Havering	84.7	84.4	82.5	92.0	91.8	89.6	90.6	89.0	88.9	89.1
Bexley	84.5	82.2	82.7	82.2	78.3	76.5	81.9	79.0	77.4	74.7
London	77.3	78.2	78.0	78.5	78.5	79.8	76.5	77.4	77.0	76.8
England	88.6	88.6	88.4	88.4	87.7	87.9	87.4	86.7	85.9	85.9
Target	95	95	95	95	95	95	95	95	95	95

Notable actions being taken by NHSE include:

- MenACWY (meningitis) vaccine will continue to be provided as part of routine adolescent schools programme (school year 9 or 10). NHSE will run a catch up campaign for years 10-12, and continue to offer immunisations to first time university entrants up to age 25

- Ensuring MMR immunisation, through new patient GP registrations, as well as NHSE's local work with boroughs to implement plans to improve uptake
- Visits to GP practices by NHSE immunisations leads to support practices:
    - in ensuring they have processes in place to undertake effective call and recall processes for children who require immunisation;
    - ensure practices are using appropriate Read codes for immunisation data entry.
    - promote access to IT support for implementing immunisations reports;
    - ensure failsafe systems are in place
- NHSE will develop a good practice guide and distribute to GP practices in London

2.1.3 Routine Adult Immunisations

Vaccinations for adults are given routinely to the following groups:

- Pertussis (whooping cough) vaccination to pregnant women between 20 and 38 weeks of pregnancy
- Flu vaccinations to all adults aged 65 and over, and those aged between 6 months and 65 years identified as being clinically at risk. This includes, for example, those people with a long term condition such as chronic renal disease, heart, respiratory, neurological or liver disease; diabetes, or immunosuppression, such as those undergoing chemotherapy treatment. Pregnant women are also routinely offered the flu vaccination as they are identified as at clinically higher risk of complications from flu.
- Pneumococcal vaccination to all adults at age 65 years
- Shingles (Zostavax) for adults aged 70 or 78

Highlights are:

- Although there is no national set target for Pertussis vaccination, Havering is performing better than both London and England for uptake (latest available data for March 2016 was 70.1% compared to 49.8% in London and 60.7% in England).
- Shingles vaccination is given to two age cohorts – those aged 70 and 78 years to reduce the incidence and severity of shingles. There is also a 'catch-up' programme for those aged 71, 72, 73 and 79 (as at 1 Sept 16). . Havering has increased uptake in 2014/15 compared to 2013/14 by 4.1% in the 70 year old cohort, 3.8% in the 78 year old cohort and 1.8% in the 79 year old cohort.

2.1.4 Protecting those 'At Risk'

The primary aim of vaccination is to protect the individual who receives the vaccine. Vaccinated individuals are also less likely to be a source of infection to others. This reduces the risk of unvaccinated individuals being exposed to infection. This means that individuals who cannot be vaccinated (such as those too young to be vaccinated, or undergoing chemotherapy, for example) will still benefit from the routine vaccination programme. This concept is called population (or 'herd') immunity[4]. However, herd immunity only works if sufficient numbers of people are vaccinated.

When vaccine coverage is high enough to induce high levels of population immunity, infections may even be eliminated from the country, e.g. diphtheria. But if high vaccination coverage were not maintained, it would be possible for the disease to return. Vaccination against smallpox enabled the infection to be declared eradicated from the world in 1980. The World Health Organization (WHO) is currently working towards the global eradication of poliomyelitis.

Some medical conditions also increase the risk of complications from infectious diseases - children and adults with such underlying health conditions should be immunised as a matter of priority[5]. These include people with diabetes, chronic kidney, heart, respiratory, liver, lung or neurological disease, and those with dysfunctional or no spleen.. These groups may also require additional vaccinations or additional doses of vaccines to provide adequate protection. Other groups may be classed as 'at risk' due to their family circumstances or lifestyle, or because of the job they do, including frontline healthcare workers, streetcare operatives, cleaners in healthcare settings, police or firefighters. Those working in these types of occupations should be vaccinated against hepatitis B.

Key actions currently being taken by NHSE for 'at risk' groups include:

- NHSE is supporting the PHE pilot of HPV vaccination programmes for men who have sex with men (MSM). Up to 40,000 vaccines will be offered to MSM and the outcomes of this pilot will be used to inform future commissioning decisions by NHSE
- Promoting the uptake of seasonal flu vaccination for frontline health and social care workers, those aged over 65 years and those aged under 65 with an underlying health condition

2.2 Screening

Population screening programmes identify apparently healthy people who may be at increased risk of a disease or condition, enabling earlier treatment and better informed decisions. The UK National Screening Committee (UK NSC) oversees screening policy in all four nations, and works with the different implementation bodies to support delivery. The NHS runs a comprehensive screening programme for a range of adult cancers, and adult non-cancer conditions, and antenatal and newborn screening (Appendix C outlines the full list of screening programmes). The Health Protection Forum receives a report from NHS England on all cancer and non-cancer screening programmes. Non-cancer screening programmes include antenatal, newborn, Abdominal Aortic Aneurism (AAA) and Diabetic Eye Screening Programme (DESP).

2.2.1 Cancer Screening Programmes

Breast, bowel and cervical cancer screening is delivered by the NHS and co-ordinated by the national office of the NHS Cancer Screening Programme, part of Public Health England (PHE)[6]. People who are eligible for screening for breast, bowel and cervical cancer receive routine invitations. Every aspect of screening is assessed against quality programme standards. Staff at regional Quality Assurance Reference Centres work with screening services to ensure the national screening standards are met, including undertaking quality assurance visits.

Prostate cancer screening is not part of the national cancer screening programme, as there is currently no reliable screening test for prostate cancer. However, the Prostate Cancer Risk Management Programme has been set up to ensure that men who are concerned about the risk of prostate cancer receive clear and balanced information about the advantages and disadvantages of the PSA test and treatment for prostate cancer. This will help men to decide whether they want to have the test[7].

Breast and cervical screening programmes in Havering are operating within normal parameters, and within 5% of the target uptake rate (75.1%) for cervical screening. Havering's bowel cancer screening programme experienced some significant challenges during 2016. NHSE, as the commissioners of the bowel screening programme, made a decision to interrupt the screening programme at Queens in order to focus on key actions to be taken.. . Although the local

programme was interrupted, Havering's eligible population have still been called for their screen within the nationally set timeframes.

The National Screening Committee (NSC) has recommended the introduction of Faecal Immunochemical Testing (FIT) testing to replace the current Faecal Occult Blood Test (FOBt) used in bowel screening. The main reasons given by the NSC for its introduction are:

- FIT is subject to less analytical interference and can be measured more reliably using an automated analyser.
- FIT is sensitive to much lower concentrations of blood than FOBt and therefore can detect cancers more reliably and at an earlier stage. The increased sensitivity enables FIT to detect more pre-cancer lesions (advanced adenomas)
- FIT requires a single faecal sample and is more acceptable to invited subjects which markedly increases participation rates.
- FIT is a cost effective alternative to FOBt

An announcement was made by the Minister for Public Health on 6 June 2016 confirming the roll-out of the new test. NHSE will be working with PHE and other relevant agencies during 17/18 to develop implementation plans.

2.2.2 Ante-natal and Newborn Screening and adult non-cancer screening

The ante-natal and newborn screening programme aims to identify those at risk of particular health problems. Ante-natal and newborn screening programme relies on a range of organisations and health professionals to deliver the full programme and all agencies, from sample takers, to laboratory testing, to notification of results must meet nationally agreed standards.

The antenatal and newborn screening programme programme includes testing for:

- HIV
- Hepatitis B
- Down's Syndrome
- Antenatal Sickle Cell and Thalassaemia
- Newborn hearing
- Newborn and infant physical examination
- Newborn blood spot

Screening for Abdominal Aortic Aneurism (AAA) and Diabetic Retinopathy are specifically targeted to people who may be at higher risk of such conditions. All people aged 12 years and above who have been diagnosed with Type 1 or Type 2 Diabetes are eligible for diabetic retinopathy screening, whilst all men aged 65 years and over are eligible for AAA screening.

Available data show that screening rates for AAA, retinopathy, newborn hearing, newborn blood spot and antenatal HIV meet the required quality standards and targets and in many cases surpass the targets.

Key actions being taken by NHSE in respect of all screening programmes include:

- Primary HPV Screening will be introduced into the NHS Cervical Screening Programme during 2017/18, with full roll-out by April 2019, following an announcement by the Minister for Public Health on 4th July 2016.
- NHSE will be working with PHE and Sustainability Transformation Plan (STP) teams during 2017/18 to develop implementation plans and to scope and procure the future footprint of cytology laboratory services in London.

2.3 Infectious Diseases

Surveillance and response systems are in place to ensure that the infectious diseases of most concern are monitored and appropriate actions taken. Under the Health Protection Regulations 2010, medically qualified practitioners are required by law to report a range of infectious diseases to the "proper officer", which for Havering is Public Health England (PHE) (Appendix D gives the full list of notifiable diseases). Environmental Health Officers also report incidents to PHE, including food poisoning, water or airborne and environmental hazards.

PHE monitor and investigate outbreaks of infection, and provide advice on the control and prevention of infections. PHE provides a weekly report to Directors of Public Health (DsPH) on cases of infectious diseases, which supports the discharge of the surveillance function of DsPH. The DPH and team maintain a surveillance of such reports and provide advice, challenge and advocacy appropriately.

During the period of this report, the notifications and response mechanism is working well, as illustrated by the PHE response to finding legionnella as part of routine testing at a swimming pool local school – see below for further detail.

This report contains a description below of the infections that are of greatest concern:

2.3.1 HIV

The latest prevalence rate of diagnosed HIV in Havering is 2.09 per 1,000 (data to the end of 2015)[8]. This is the lowest rate out of all the London Boroughs, the highest being Lambeth (14.6 per 1,000). In Havering, the more important issue is late diagnosis, with 37.5% of new cases of HIV diagnosed late in the period 2013-2015[9]. This is higher than London average (33.5%) and 19th highest of the 31 London boroughs; however this is a significant improvement from 2011 data when 50% of new cases of HIV were diagnosed late[10].

Late diagnosis of HIV infection is associated with increased morbidity and mortality, increased costs to healthcare services and a reduced response to anti-retroviral treatment. An earlier diagnosis can decrease onward transmission of HIV as an individual's knowledge of their HIV status has also been found to reduce their risk behaviour and it is therefore important to continue to promote acceptability of testing for HIV. Local sexual health services are recommended to focus on raising awareness of early testing of HIV particularly for at risk heterosexual groups.

The antenatal and newborn screening programme makes a vital contribution to identifying women with HIV who are unaware that they were infected. National uptake of antenatal screening for hepatitis B, HIV, syphilis and rubella susceptibility ranged between 97.54% and 97.79% in 2013, with less than 0.16% positivity rate for new diagnoses in these conditions[11]. If identified as HIV positive during pregnancy, then interventions can reduce the risk of a mother passing on HIV to her baby from 25% (1 in 4) to less than 1% (1 in 100), as well as protecting the mother's own health[12].

2.3.2 Tuberculosis (TB)

Havering continues to have very low rates of TB (10.9 per 100,000 compared with 41.9 per 100,000 for London)[13]. The local TB service continues to treat individuals and trace close contacts of infected individuals to assess whether treatment is required. At present, NICE recommends vaccinating newborn babies who are born in an area of high TB incidence, have one or more parent or grandparent born in a high-incidence country, or have a family history of TB in the last 5 years[14]. However, the London Immunisations Board endorsed a universal (100%) offer of BCG

vaccine to all babies up to the age of one year across London, including areas where prevalence is less than 40/100,000. This offer is commissioned to be given in all maternity units in London with a community offer for those parents who missed out on the vaccine in maternity hospitals or who have recently moved into London.

Due to the global shortage of BCG vaccine, the rollout of the BCG Universal programme has only recently commenced. However, until the shortage is fully rectified, there continues to be prioritisation of available vaccine in some areas to babies born in priority regions where incidence is >40 per 100,000 population, or in households where a parent comes from a country with a high incidence rate of TB. The incidence of TB in Havering is 10.9 per 100,000 and therefore does not constitute a priority region.

A new pathway for the universal delivery of BCG vaccination was commenced on 1st October 2016, with the following elements:

- The pathway affects babies **born on the 1st September 2016 onwards.**
- For babies born before 1st September 2016, the previous optimisation plan remained. (Under this optimisation plan, the focus was on infants up to the age of 3 months.)
- The pathway consists of two offers:
    - All London maternity units will offer BCG vaccination to neonates.
    - For infants who fall into one of the PHE priority groups A or B[1] who have missed the vaccination in maternity, have moved into the borough or were born in a maternity unit outside London, they are eligible to be referred to a community BCG clinic up to the age of 12 months.

The TB service also works closely with the HIV service, due to the risk of co-infection with HIV in some communities. As is also the case with HIV, as a result of anticipated changes in the Havering population, the DPH and Health Protection Forum is keeping a watching brief on the incidence and prevalence of both HIV and TB.

2.3.3 Health Care Associated Infections (HCAI)

Healthcare-associated infections (HCAIs) can develop either as a direct result of interventions such as medical or surgical treatment, or from being in contact with the infection in a healthcare setting. The term HCAI covers a wide range of infections. The infections that are of most concern are methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* (*C. difficile*). HCAIs pose a serious risk to patients, staff and visitors. They can incur significant costs for the NHS and cause significant morbidity to those infected. As a result, infection prevention and control is a key priority for the NHS.

The Infection Prevention and Control (IPC) team at BHRUT cover a range of areas designed to protect the health of patients and staff alike. The team monitor cleanliness of wards, staff hygiene practices, safe cleaning of medical equipment, antimicrobial stewardship, and hospital acquired infections.

[1] Groups eligible for vaccination:

Group A. All infants (aged 0 to 12 months) with a parent or grandparent who was born in a country where the annual incidence of TB is 40/100,000 or greater.

Group B. All infants (aged 0 to 12 months) living in areas of the UK where the annual incidence of TB is 40/100,000 or greater.

PHE provides a quarterly report to the Health Protection Forum, which includes data on MRSA cases and *C.difficile*. In addition, the membership of the HPF includes representation from infection control teams at Barking, Havering and Redbridge University Hospital Trust (BHRUT) and North East London Foundation Trust (NELFT). The CCG, as commissioner of healthcare, is also a member of the HPF.

The Department of Health sets a zero tolerance target for Acute Trusts for MRSA and less than 30 cases of *C.difficile*; published figures for BHRUT showed a total of 4 MRSA cases and 38 cases of *C.difficile* for 2015-16. Latest available data from PHE show that for this year to date (from April 2016 to October 2016) BHRUT has had 8 cases of MRSA and 56 cases of *C.difficile.*

Key actions being undertaken by BHRUT in their Annual Improvement Plan 2016-17 are:

- Increasing the visibility of the Infection Prevention and Control (IPC) team
- Streamlining the IPC Governance and Assurance processes and ensuring corporate support. The IPC Annual Improvement Plan 2016-17 is being implemented via a corporate strategy and being monitored by the Deputy Chief Nurse for Harm Free Care
- Creating more opportunities for closer alignment between IPCT/Sepsis Lead/Antimicrobial Pharmacist
- Developing and implementing current urinary catheter audit in line with care pathway; implementing catheter policy, care plan and passport.
- Improvements in cleaning and storage in Dirty Utility Rooms, toilets, etc.
- 3-yearly Antimicrobial Stewardship mandatory E-learning training for all junior doctors. Yearly face to face Antimicrobial Stewardship session for junior doctors (see also section 2.3.3 below).
- Ensuring systems are in place to manage and monitor the use of antimicrobials to ensure inappropriate and harmful use is minimised and patients with severe infections such as sepsis are treated promptly with the correct antibiotic
- Quality Improvement Programme in collaboration with NHS Improvement to increase compliance with hand hygiene, including advice to patients/visitors.
- Ensuring compliance with MRSA decolonisation regimen for new and known colonised patients

2.3.4 Antimicrobial Resistance

Antibiotic resistance is one of the most significant threats to patients' safety in Europe. It is driven by overuse, inappropriate prescribing and non-adherence to the prescription regimen (how to take the medicine, when, and completing the entire course). The response to this issue is being led globally by the World Health Organization, with individual nations responding with their own plans.

The UK Government published its Five-year Anti-Microbial Resistance (AMR) strategy in September 2013, led by Department of Health (DoH), Department for Environment Food and Rural Affairs (DEFRA), and Public Health England (PHE). PHE has also set up an AMR Strategy Programme Coordination Group to bring together delivery partners from across the health and social care sector. This group will coordinate the implementation of the human health aspects of four (out of seven) important areas of the AMR strategy for England. PHE's Antibiotic Guardian campaign (www.antibioticguardian.com) supports the AMR strategy.

The Barking and Dagenham, Havering and Redbridge Area Prescribing sub-Committee approved the formation of a North East London Antimicrobial Resistance Strategy Group (AMRSG) on 7th

May 2015, to provide clinical leadership and improve collaboration for antimicrobial stewardship. Havering Public Health Service contributes to this group. In May, the membership was extended to Waltham Forest, Newham and Tower Hamlets CCGs with the support of the relevant medicines decision making groups. City and Hackney CCG, Homerton University Hospital Foundation Trust and East London Foundation Trust joined in November 2016.

The Group is responsible for ensuring the implementation of a co-ordinated North East London wide response to the DoH and DEFRA UK Five-year Antimicrobial Resistance (AMR) strategy 2013-2018 and any associated guidelines. It supports the delivery of the main three strategic aims:
1. **Improve the knowledge and understanding of Antimicrobial Resistance (AMR)** through better information, intelligence, supporting data and developing more effective early warning systems to improve health security.
2. **Conserve and steward the effectiveness of existing treatments** through improving infection prevention and control and development of resources to facilitate optimal use of antibiotics in both humans and animals,
3. **Stimulate the development of new antibiotics, diagnostics and novel therapies** by promoting innovation and investment in the development of new drugs and ensuring that new therapeutics reach the market quickly.

Key actions being undertaken by the AMRSG include:

- BHR CCGs are co-ordinating a cycle of providing education and training to health and social care practitioners about antimicrobial stewardship and antimicrobial resistance with Health and Social Care teams
- conducting a prescribing review audit (ePACT, Define, pre-registration pharmacists/FY1 doctors) to capture non-formulary, cost and treatment length of antibiotics
- developing local systems and processes for peer review of prescribing.
- building a cycle of audit in primary care capturing the impact of discharge and follow up to avoid issuing repeat prescriptions for antimicrobial antibiotics, unless needed for a particular clinical condition or indication.
- Ensuring antimicrobial stewardship operates across all care settings, for example by increasing public awareness of antimicrobial resistance through local support of the Antibiotic Guardian campaign.

2.3.5 Routine Testing for Legionella

Legionnaires' disease was first recognised in 1976 and the bacterium later isolated and named *Legionella pneumophila*[15]. Since then, over 45 other species of *Legionella* have been described of which at least 18 have been associated with disease in humans. These organisms are widespread in the natural aquatic environment and in artificial water systems. The organism is an opportunistic human pathogen and infection is more often associated with artificial water systems. The disease is not known to be transmissible via person-to-person contact. As a result, the way to prevent or control outbreaks of Legionnaires' disease is to inhibit or limit the growth of these organisms in water. In the UK, the control of legionellae (bacteria of the genus *Legionella*) is prescribed in legislation[16] and associated regulations[17]. A code of practice and associated guidance were first published as separate documents and were revised and combined into one document in 2000[18]. In 1992, a British Standard[19] on *Legionella* sampling was published, and in 1998, an international standard[20] (which is currently under revision) for the detection and enumeration of legionellae by culture was published.

In September 2016 routine water testing identified low levels of legionella bacteria, i.e. at levels that are highly unlikely to cause infection, in a hydrotherapy pool at a senior school in Havering. This is exactly what routine testing is expected to identify and demonstrates the health protection system works well, identifying the presence of the bacteria before they reach a point that could cause a problem. The school carries out water testing routinely as a precaution and, as per standard procedures, use of the pool was immediately suspended until the legionella bacteria were removed. Public Health England worked closely with the school and sent out a letter and factsheet to all parents explaining how Legionnaire's is caught, and what are the early symptoms.These include a 'flu-like' illness with muscle aches, tiredness, headaches, dry cough and fever. Abdominal pain and diarrhoea are also common. These symptoms may lead on to pneumonia.

A further communication was sent to local GPs to advise them of the incident and what signs/symptoms to look out for if a child presented from that particular school. The Health Protection Team at PHE dealt with all necessary communication and provided the relevant scientific advice and actions.

Removal of the bacterium was actioned quickly and efficiently, with appropriate infection control measures in place to prevent infection.

2.4 Environmental Health

2.4.1 Air Quality

In Havering the main source of air pollution is road traffic vehicle emissions. Significant amounts also come from residential and commercial gas use, industry, construction sites and emissions from outside London. In 2006 Havering borough was declared an Air Quality Management Area (AQMA) by the Council. The declaration of Havering as an AQMA was considered the most appropriate action as a report indicated that the health related Air Quality Objectives for Nitrogen Dioxide (NO_2) and Airborne Particulate Matter (PM_{10}) at some locations would not be met by the relevant target date.

Although Havering has better Air Quality than most other London Boroughs, initiatives such as the Havering Air Quality Action Plan 2016-19 aims to continue the work already carried out to improve air quality and support the ambition to provide a cleaner environment in which to live.

In order to improve the air quality in the Borough this Council has delivered, or is currently working on, several initiatives;

- The Public Health and Environmental Protection team have collaboratively produced a Factsheet on Air Quality to advise the public on the impacts of air pollution on health and wellbeing, and what people can do to reduce their exposure. It directs people to sign up to the AirText alert system, which is designed to alert uses to when air pollution levels are elevated so that they can take simple measures to help reduce the likelihood of impacts. When air pollution levels are predicted to reach moderate or higher levels users will receive an SMS message, a voicemail or an email to warn theme that pollution may be elevated the following day. It is available to download on: www.airtext.info/signup
- Significant improvements are being made to Havering Council's Fleet Vehicles (around 210 diesel/bio mix and 5 electric utility vehicles), including fitting Nitrogen-filled tyres for greater efficiency and safety; and training for Fleet drivers on Eco-driving and urban driving.

- The 'Target Your Trip' webpage is located on the Council's website and aims to provide residents and businesses with sustainable travel information and the options available for them to use. It contains information on Cycling, Walking, Public Rights of Way, School Travel Plans, Taking Steps Magazine, Public Transport in Havering, Travel Advice for Business, Car Share Scheme and the links to the Freedom Pass available for older and disabled residents. The 'Target Your Trip' webpage can be found at: https://www.havering.gov.uk/Pages/Category/Target-your-trip.aspx
- As part of the Mayor's Air Quality Fund (MAQF) successful bid, a bespoke video has been created by the Environmental Protection team, in partnership with the Smarter Travel and Public Health teams, to advise on the causes and impacts of air pollution and what we can do to reduce our exposure to it. Two versions, featuring a character designed specifically for Havering, Miles the Mole, have been developed for use:
    - In primary schools, with narration provided by an age-appropriate actor
    - In GP surgeries, featuring stills clips from the original video with the key messages, particularly targeting those with underlying health conditions such as COPD or asthma, who may benefit from reducing their exposure to pollutants.

  The videos will be supported by a campaign featuring Miles the Mole including posters, banners, bus and petrol pump nozzle advertisements, and a bespoke play created to be shown in 10 primary schools in Havering supported by appropriate lesson plans and curriculum materials.

The Health Protection Forum receives an annual report on air quality from the Air Quality Working Group, which has a comprehensive action plan to locally address the air quality issues.

2.4.2 Tobacco Harm Reduction

The Tobacco Harm Reduction Partnership was set up in September 2016, with the aim of providing leadership in the reduction of harm caused by tobacco in the local population, and to facilitate achievement of the vision of a tobacco-free generation in Havering by 2025 (please refer to Appendix E for full Terms of Reference). Meetings are held quarterly, with a special topic of focus: to date, the topics chosen have included the latest evidence on the harms caused by Tobacco and the Public Health Outcomes Framework (PHOF) profiles; and the evidence on use of e-cigarettes/vaping in public places and workplaces.

Quarterly reports on tobacco control initiatives, including actions to tackle underage sales and prosecutions, are received by the Health Protection Forum.

In November 2016 a free specialist Stop Smoking Service was commissioned and is now available for all pregnant women living in the borough. Referrals can be made directly to the service by the BHRUT maternity team/midwives at any time during pregnancy, and will be offered by the maternity service at every contact, commencing from the time of booking for the first antenatal appointment. Women can be referred to the service from the time of a first positive pregnancy test, by contacting the Stop Smoking Service for Pregnant Women directly. In order to further reduce potential harm to the unborn child, the service will also be available to partners/family members who normally reside in the same household as the pregnant woman. The Stop Smoking Clinics for pregnant women are available in a range of locations, including the Ingrebourne Children's Centre .

The specialist stop smoking service for pregnant women is supported by the BabyClear programme, which is a systematic approach to reducing the harms of tobacco smoke to the unborn baby. It aims to ensure every woman smoking during pregnancy is given factual information from a trained health professional about the harmful effects of Carbon Monoxide (CO) and encouraged to quit.

2.5 Emergency Planning

Local resilience forums are multi-agency partnerships of local public services that plan for and respond to large scale localised incidents; identifying potential risks and emergency plans to either prevent or mitigate the impact of any incidence on their local communities. The Chairperson of the Havering Borough Resilience Forum is a member of the HPF. Activities/issues this year included:

- Participation by BRF members in relevant emergency preparedness training exercises, including, e.g.: Exercise Cygnus – an NHSE-led exercise to test response to pandemic influenza; Operation Blackstart – a tabletop exercise to test the Council's preparedness and response to complete loss of power across the UK; and Exercise Unified Response – a multi-agency, multinational emergency response exercise to a major rail catastrophe.
- Appropriate preparedness across both health and social service sector staff to the Junior Doctors strikes
- More stringent controls on aviation events in Havering (particularly at Damyns Hall Aerodrome) following the Civil Aviation Authority's new rules for air shows in the wake of the A27 air show crash.
- Following extensive and unprecedented flooding in the borough on 23rd June, which the emergency services and Council responded to with speed and effectiveness, NHSE (through the BRF) are offering support to GPs to ensure they have up to date and appropriate Business Continuity Plans in place.
- In the light of the floods, the Council's Emergency Planning team put on a special event to give advice to local residents on how to prepare for, and what to do in the event of experiencing a flood. Support included advice from local insurance agencies to ensure local residents have the right level of protection and knew how to contact their insurers.

3.0 Continuing to Protect the Health of Havering

The Health Protection Forum will continue to undertake surveillance of health protection in Havering through challenge and monitoring of health protection programmes and services. It will do this by continuing to receive a dashboard of key indicators that health protection arrangements are working well, and receiving reports on the main issues of concern.

Appendix A – Spotlight on Influenza

1.0 Background

Flu was chosen as the 'spotlight' topic for this year's report for a number of reasons:

i) NHSE recommissioned the school age vaccinations programme across London, with contracts that commenced in July 2016. Vaccination UK now delivers all of the relevant school-based immunisations in Havering. Nationally, flu vaccination is now offered to all primary school children in years 1-3. It was originally delivered just in year 1 children and is increasing by one school year each year. However, Havering was one of the original pilot sites for vaccination amongst primary school-aged children, and was the representative for the London region, covering children in years 1-6. Vaccination UK therefore continues to deliver flu vaccinations to children in years 1-6 locally. We are therefore in a privileged position to get ahead of the other boroughs in trialling and improving our uptake in children in years 4, 5 and 6.

ii) Concerns raised by a local resident with Healthwatch Havering regarding confusion over eligibility criteria for receipt of a free flu vaccination and who is responsible for delivery of a vaccination to a child with an underlying health condition. The matter was taken up and resolved by the commissioners, NHSE.

iii) A new vaccine, a Live Attenuated Influenza Vaccine (LAIV) was newly licensed and rolled out for the first time during the 2015-16 season. Therefore, this will be the first year that uptake of the new vaccine will be able to be compared.

iv) Vaccine Effectiveness (VE) is the ability of a vaccine to prevent cases of flu circulating that season. However, there are many strains of flu circulating at any one time, and each one can mutate (known as antigenic drift (this is further explained below). If the circulating strain matches any of the 3 strains used in the vaccine, it will likely be more effective at preventing flu. The estimated VE was particularly low for the 2014-15 season, due to likely antigenic drift, at around 3%. News reports at the time suggested that the vaccination was "Flu jab given to millions is 'useless'"[2]. Such reporting may have significantly damaged people's views about the need for vaccination and prevented them from taking up the opportunity. PHE and NHSE have run media and educational campaigns to highlight the benefits of having a flu jab, and the need to have one annually, as it is tailored to the predominant strain(s) circulating each year. However, the VE for 2015-16 was 52.4%, showing that the vaccination was much more compatible with the circulating strains[3].

[2] Daily Telegraph 5th February 2015. http://www.telegraph.co.uk/news/health/news/11393560/Flu-jab-given-to-millions-is-useless.html

[3] Public Health England (PHE) (2016). Influenza vaccine effectiveness: 2015 to 2016 estimates. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/530756/Influenza_vaccine_effectiveness_in_primary_care_in_children.pdf

2.0 An Introduction to Influenza

According to the World Health Organization (WHO), annual epidemics of influenza result in three to five million cases of severe illness, and approximately 250,000 to 500,000 deaths[4]. Influenza is a concern to public health, to the economy as a result of worker absenteeism, and to health infrastructure, by contributing to winter pressures.

2.1 What is Influenza (Flu)?

Influenza is an acute viral infection of the respiratory tract, with a usual incubation period of one to three days. The flu virus is contained in the millions of tiny droplets that come out of the nose and mouth when someone who is infected coughs or sneezes. These droplets typically spread about one metre. They hang suspended in the air for a while before landing on surfaces, where the virus can survive for up to 24 hours[5].

Anyone who breathes in the droplets can catch flu. The virus can also be transmitted by touching the surfaces that the droplets have landed on and then touching the nose or mouth. Everyday items at home and in public places can easily become contaminated with the flu virus, including food, door handles, remote controls, handrails, telephone handsets and computer keyboards. Hand hygiene and cleaning surfaces frequently both help to reduce the likelihood of infection.

For healthy individuals, influenza is an unpleasant but usually self-limiting disease with recovery usually within two to seven days. Symptoms include:

- a high temperature (fever) of 38C (100.4F) or above
- tiredness and weakness
- a headache
- general aches and pains
- a dry, chesty cough

2.2 Who is most at risk?

The risk of serious illness from influenza is higher amongst the more vulnerable population:

- children under six months of age
- older people aged 65 or over
- pregnant women
- those with underlying health conditions including[6]
    - heart disease
    - lung disease
    - diabetes
    - chronic kidney disease
    - chronic neurological conditions
- those with a weakened immune system e.g. from chemotherapy or have HIV

[4] World Health Organization (2009) *Influenza (Seasonal) Factsheet no. 211* [Online] *World Health Organization* http://www.who.int/mediacentre/factsheets/fs211/en/index.html

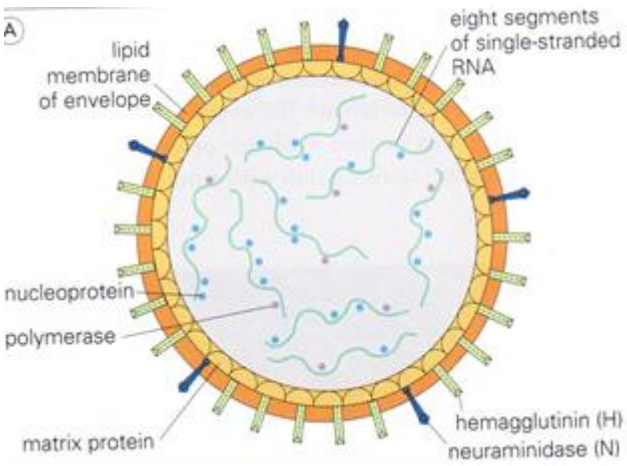
[5] NHS Choices (2015). *Flu*. http://www.nhs.uk/conditions/flu/Pages/Introduction.aspx

[6] Public Health England (2015). Influenza: Green Book, chapter 19. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/456568/2904394_Green_Book_Chapter_19_v10_0.pdf

Influenza during pregnancy may also be associated with perinatal mortality, prematurity, smaller neonatal size and lower birth weight.

2.3 What causes flu?

There are three types of influenza virus: A, B and C. Influenza A and influenza B are responsible for most clinical illness, with Influenza C occurring in only very few sporadic cases[7].



- **type A flu virus** – this is usually the more serious type. The virus is most likely to mutate into a new version that people are not resistant to. The H1N1 (swine flu) strain is a type A virus, and flu pandemics in the past were type A viruses.
- **type B flu virus** – this generally causes a less severe illness and is responsible for smaller outbreaks. It mainly affects young children.
- **type C flu virus** – this usually causes a mild illness similar to the common cold.

The influenza virus is constantly evolving as a way to ensure it continues to replicate itself inside its host. By changing the structure of the proteins on its cell surface (antigens), the virus fools its host that it is a new virus. Minor changes to these surface antigens (hemagglutinin and neuraminidase) occur continuously, resulting in the circulation of new strains during each influenza "season" (antigenic drift). Influenza A and B viruses alter gradually (antigenic drift) leading to significant epidemics every few years. Occasionally a major change to the virus occurs, resulting in a new subtype (antigenic shift), which can lead to major pandemics that the existing population have little immunity to. The last major pandemic was in 2009 when the Influenza A virus underwent antigenic shift[8]. Flu can be caught multiple times, because flu viruses change regularly and the body won't have natural resistance to the new versions[3].

2.4 Why is it called 'Seasonal Flu'?

Although flu can actually be caught at any time over the year, most cases of flu in the UK tend to occur during an eight- to ten-week period during the winter. The timing, extent and severity of this 'seasonal' influenza can all vary. Influenza A viruses cause outbreaks most years and it is these viruses that are the usual cause of epidemics. Large epidemics occur intermittently. Influenza B tends to cause less severe disease and smaller outbreaks overall. The burden of influenza B disease is mostly in children when the severity of illness can be similar to that associated with influenza A.

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[7] Public Health England (2013). *Immunisation Against Infectious Diseases: The Green Book; Chapter 19- Influenza.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/456568/2904394_Green_Book_Chapter_19_v10_0.pdf

[8] World Health Organisation (2010). *What is the pandemic (H1N1) 2009 virus?* http://www.who.int/csr/disease/swineflu/frequently_asked_questions/about_disease/en/

2.5 Complications

Complications of flu mostly affect people in high-risk groups, such as the elderly, pregnant women and those who have a long-term medical condition or weakened immune system. The most common complication is a bacterial chest infection, such as bronchitis. Occasionally, this can become more serious and develop into primary influenza pneumonia. Although primary influenza pneumonia is a rare complication that may occur at any age and carries a high case fatality rate, it was seen more frequently during the 2009 pandemic and the following influenza season.

Amongst people who suffer from a long term condition, such as asthma, or Chronic Obstructive Pulmonary Disease (COPD), their condition can be worsened by getting flu. In people with diabetes, flu can affect blood sugar levels, potentially causing hyperglycaemia (high blood sugar) or, in people with type 1 diabetes, diabetic ketoacidosis (a dangerous condition caused by a lack of insulin in the body). Less common complications of flu include:

- tonsillitis – inflammation of the tonsils
- otitis media – an infection of the middle ear
- sinusitis – inflammation of the lining of the sinuses (small, air-filled cavities behind your cheekbones and forehead)
- febrile seizures (convulsions) – a fit that can happen when a child has a fever
- meningitis – infection in the brain and spinal cord
- encephalitis – inflammation of the brain

3.0 Protecting Against Flu

Strategies for protecting against flu are conducting good surveillance, vaccination, good hygiene (including handwashing and cleaning), and antiviral medication, which are detailed below.

3.1 Surveillance

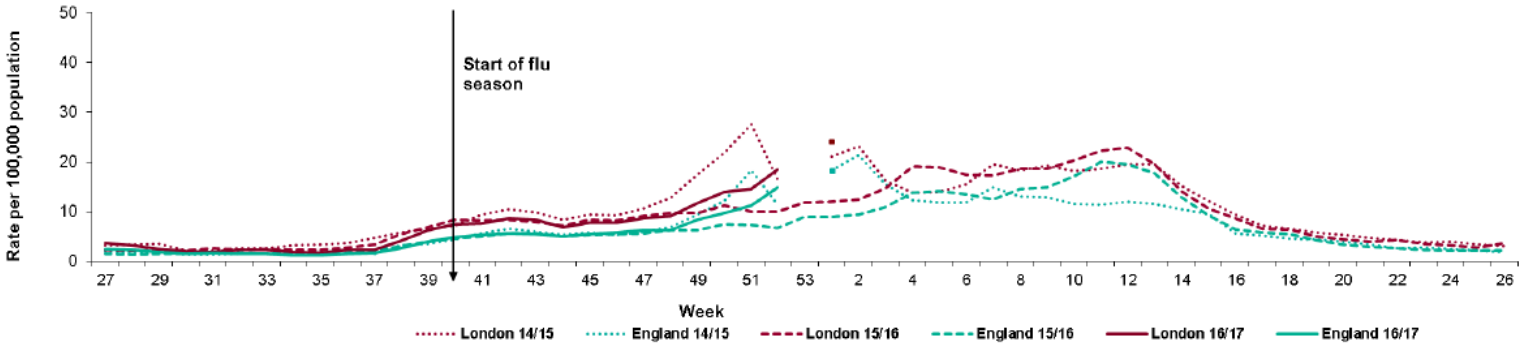
It is important to keep track of the incidence and prevalence of flu in the population, both globally and locally, to detect and respond to epidemics or pandemics as they start to occur.) WHO plays an important role in surveillance of the global trends in flu outbreaks. The WHO's Global Influenza Programme (GIP) provides global standards for influenza surveillance. In addition GIP collects and analyses virological and epidemiological influenza surveillance data from around the world. The regular sharing of quality influenza surveillance and monitoring data by countries allows WHO to:

- provide countries, areas and territories with information about influenza transmission in other parts of the world to allow national policy makers to better prepare for upcoming seasons;
- describe critical features of influenza epidemiology including risk groups, transmission characteristics, and impact;
- monitor global trends in influenza transmission; and
- support the selection of influenza strains for vaccine production.

In the UK, Public Health England is responsible for monitoring trends in presentations of influenza-like illness (ILI) at GP surgeries (Fig. 1). Those GPs who do report presentations of

ILI do so voluntarily, which provides a valuable estimate of the spread of flu cases, but not all GPs choose to take part. Confirmed cases of flu are verified biochemically by teams at PHE.

Figure 1. Historical Trends in Influenza-Like-Illness (ILI) GP Consultation Rates in London[9]



3.2 Vaccination

3.2.1 How Vaccinations Work

Vaccines work by introducing our bodies to a safe form of a disease without actually infecting us with that disease. Vaccination prompts the immune system to recognise a foreign agent (pathogen), and produce antibodies to fight that infectious agent. If the live virus attacks the body at some future point, the antibodies created from contact with the vaccine then prevent infection.

Three types of influenza vaccine are available in the UK:

- 'Split virion inactivated' or 'disrupted virus' – the whole virus is treated so they cannot cause infection – it is inactivated by exposing it to organic solvents or detergents in a lab environment.
- 'Surface antigen, inactivitated' – containing the surface material from disrupted virus particles (*i.e.* hemagglutinin)
- A live attenuated vaccine – made 'weaker' in the laboratory. The vaccine currently given in the UK is Fluenz®, which is preferred for children aged 2-18 years because it provides a higher level of protection. This is delivered as a nasal spray, rather than as an injection

There is no difference between the first two types of vaccines in efficacy or adverse reactions. Being inactivated, they do not cause the diseases against which they protect. Fluenz® should not be given to pregnant women. The live attenuated vaccine has been shown to have increased efficacy in children aged 2-18 years.

After vaccination, antibody levels can take up to 14 days to reach the level required for protection. It is important that vaccination takes place each year to protect against the emergent viruses.

No vaccine is 100% effective, including the flu vaccine. However, the vaccine usually prevents about half of all flu cases. Even if someone does get flu after being vaccinated, the disease is often less severe than it would have been. It is important to remember that the flu vaccine only protects against flu, but there are other illnesses which have flu-like symptoms which can still be caught after getting the flu vaccine. It takes up to two weeks for the

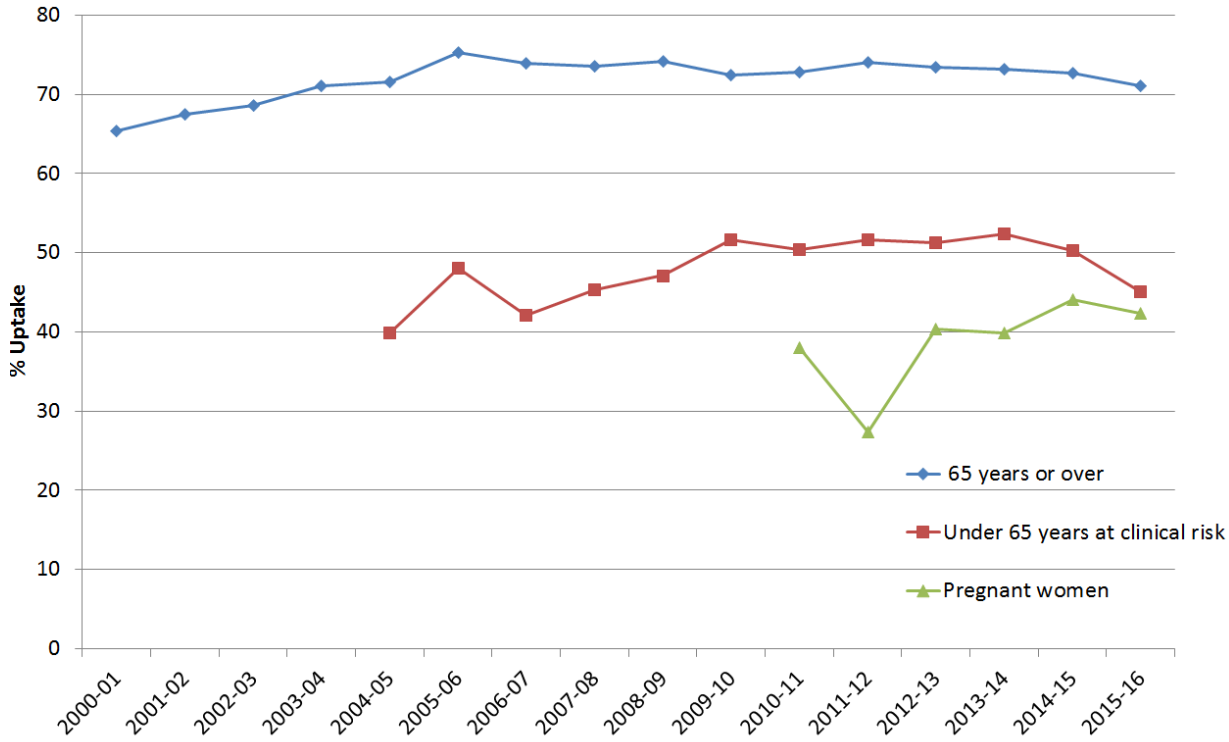
[9] Data Source: Public Health England (2016) Field Epidemiology Service, SEaL

vaccine to take effect, so flu may still be caught if a person is exposed to the virus during this time. Getting vaccinated as early as possible in the season can help to prevent this.

3.2.2 Vaccination Uptake

Vaccinations are offered by GPs, Pharmacists, and in schools by an NHS vaccination service for children in years 1-4 (or 1-6 in Havering, as it is a pilot site for children's flu vaccinations). Uptake has increased since it was introduced in 2000, but there is still a way to go to meet the ambition of 75% uptake by all eligible groups, particularly among pregnant women (Fig. 2).

Figure 2. Uptake of Flu Vaccination Amongst Eligible Groups in England 2000-2015



In Havering, uptake for the 2015-16 season was lower than that for England, but on a par with London (Table 1).

Table 1. Percentage (%) uptake of seasonal flu vaccination by eligible groups for the 2015-16 flu season for Havering compared with London and England[10]

% Vaccination Uptake 2015/16 Season	Havering	London	England
Children Aged 2 years & NOT in a clinical risk group	24.9	26.3	35.0
Children Aged 3 years & NOT in a clinical risk group	26.1	28.3	37.0
Children Aged 4 years & NOT in a clinical risk group	21.2	21.0	29.1
Children in school years 1-6 (pilot areas only)	52.1	52.1*	57.9
People between 6 months and 65 years in a Clinical Risk Group	38.9	43.7	45.1
Pregnant Women	34.2	38.6	42.3
65 years and Over	66.4	66.4	71.0

* The Pilot area in London was Havering, so this figure is actually Havering.

3.3 Good Hygiene

Simple measures such as adopting good hygiene can be one of the most effective ways of preventing flu (as well as several other common illnesses such as Norovirus). To reduce the risk of getting flu or spreading it to other people, care should be taken to always:

- wash hands regularly with soap and warm water
- clean surfaces such as computer keyboards, telephones and door handles regularly to get rid of germs
- use tissues to cover the mouth and nose when coughing or sneezing
- put used tissues in a bin as soon as possible , following the 'Catch it, Kill it, Bin it' routine.

3.4 Antiviral Medication

Antiviral drugs are prescription medicines that help fight the virus in the body once infected. In terms of flu, the main benefit of an antiviral is that they can lessen the symptoms by 1-2 days, thereby reducing the burden on the body, and the likelihood of serious flu complications such as pneumonia. Taking the antiviral medicines oseltamivir (Tamiflu) or zanamivir (Relenza) is recommended if all of the following apply:

- when the rate of reported Influenza-Like-Illness (ILI) rises above the baseline thresholds set for that particular time of year. These thresholds are calculated using the "Moving Epidemic Method" (MEM), which takes into account the rates of ILI that would be expected for seasonal variation in flu cases. MEM is used as a standard methodology for setting influenza surveillance thresholds across Europe

[10] Public Health England (2016). *National Childhood Influenza Vaccination Programme 2015 to 2016. Seasonal influenza vaccine uptake for children of primary school age Final data for 1 Sep 2015 to 31 Jan2016*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/544542/Childhood_Influenza_Vaccination_Programme_Report_2015_2016.pdf

- someone is over 65, pregnant, or has a medical condition that puts them at risk of complications of flu, such as diabetes, heart disease, lung disease, kidney disease or a neurological disease
- the individual has been in contact with someone with a flu-like illness they can start antiviral treatment within 36-48 hours
- not had the flu vaccination

If there is an outbreak of flu in a residential or nursing home – where the flu virus can often spread very quickly – antiviral medication may be offered to people if they have been in contact with someone with confirmed flu.

4.0 Annual Flu Plan 2016-17 Governance

4.1 Responsibilities

The arrangements for flu prevention extends across a range of organisations, and relies on systems to work together seamlessly.

The **Department of Health** (DH) is responsible for:

- policy decisions on the response to the flu season
- holding NHS England and PHE to account through their respective framework agreements, the Mandate, and the Section 7A agreements
- oversight of the supply of antiviral medicines and authorisation of their use
- authorising campaigns such as 'Catch it, Kill it, Bin it'

NHS England is responsible for:

- commissioning the flu vaccination programme under the terms of the Section 7A agreements
- assuring that the NHS is prepared for the forthcoming flu season
- monitoring the services that GP practices and community pharmacies provide for flu vaccination to ensure that services comply with the specifications
- building close working relationships with Directors of Public Health (DsPH) to ensure that local population needs are understood and addressed by providers of flu vaccination services

Public Health England is responsible for:

- planning and implementation of the national approach
- monitoring and reporting of key indicators related to flu, including flu activity and vaccine uptake
- procurement and distribution of flu vaccine for children
- oversight of central vaccine supply
- advising NHS England on the commissioning of the flu vaccination programme
- managing and co-ordinating the response to local incidents and outbreaks of flu
- public communications to promote uptake of flu vaccination and other aspects of combating flu such as hand hygiene
- supporting DsPH in local authorities in their role as local leaders of health and ensuring that they have all relevant expert input, surveillance and population data needed to carry out this role effectively

Local authorities, through their DsPH, have responsibility for:

- providing appropriate advocacy with key stakeholders and challenge to local arrangements to ensure access to flu vaccination and to improve its uptake by eligible populations
- providing leadership, together with local resilience partners to respond appropriately to local incidents and outbreaks of flu infection

Clinical commissioning groups (CCGs) are responsible for:

- quality assurance and improvement which extends to primary medical care services delivered by GP practices including flu vaccination and antiviral medicines

GP practices, community pharmacists and other providers are responsible for:

- educating patients, particularly those in at-risk groups, about the appropriate response to the occurrence of flu-like illness and other illness that might be precipitated by flu
- ordering the correct amount and type of vaccine for their eligible patients, taking into account new groups identified for vaccination and the ambition for uptake, to ensure that vaccine wastage is minimised
- storing vaccines in accordance with national guidance
- ensuring that all those eligible for the flu vaccine are invited personally to receive their vaccine
- ensuring vaccination is delivered by suitably trained, competent healthcare professionals who participate in recognised on-going training and development in line with national standards
- maintaining regular and accurate data collection using appropriate returns
- encouraging and facilitating flu vaccination of their own staff
- ensuring that antiviral medicines are prescribed for appropriate patients, once the CMO/CPhO letter has been distributed alerting them that antiviral medicines can be prescribed

Schools can assist by:

- supporting the local vaccinations provider to deliver the LAIV nasal spray to pupils in their school
- ensuring parents receive information about the importance of the flu vaccination
- incorporating flu information in PSHE curriculum talks

Local authorities can also assist by:

- promoting uptake of flu vaccination among eligible groups, for example older people in residential or nursing care, either directly or through local providers
- promoting uptake of flu vaccination among those staff providing care for people in residential or nursing care, either directly or through local providers

All employers of individuals working as providers of frontline health and social care services are responsible for:

- management and oversight of the flu vaccination campaign or alternative infection control measures for their frontline staff
- support to providers to ensure access to flu vaccination and to maximise uptake among those eligible to receive it

4.2 Actions being Taken

The following actions were outlined by NHS England (NHSE) in its Annual Flu Letter for the 2016/17 flu season:

- there should be a 100% active offer of immunisation to eligible children. Providers and commissioners will be required, if asked, to demonstrate that such an offer has been made. A minimum uptake of 40% has been shown to be achievable in both primary care and school based programmes and some have achieved much higher rates. As a minimum, we would expect vaccine uptake rates of between 40-65% to be attained by every provider. Uptake levels should be consistent across all localities and sectors of the population. A limited number of sessions for children who missed out on vaccination during the first routine planned session should be considered towards the end of the season. Such arrangements would be subject to local commissioning agreement."The childhood fly vaccination programme has now been extended to children in year 3 nationally, but as Havering is already a pilot site, it already covers children in years 1-6.
- NHSE has an uptake ambition for all eligible groups (Table 2).
- NHS England is incentivising the uptake of flu vaccinations for frontline clinical staff through the CQUIN scheme for 2016/17. Providers commissioned under the NHS Standard Contract will be eligible for CQUIN payments, e.g. acute, mental health, community and ambulance trusts. Providers will be rewarded based on the percentage of staff vaccinated. Only those providers that achieve 75% or above will be eligible for the full payment associated with this indicator. It is expected that primary care providers aim to achieve this ambition as well.
- The WHO target for flu vaccination uptake in the 65 years and over age group is 75%. Over the last ten years NHSE have been close to this in England and will continue to aim for the WHO target. Whilst the principal focus of the national programme in England is the extension of the programme to children, it is essential to work hard to achieve the WHO ambition this year.

Table 2. Uptake Ambitions for Seasonal Flu Vaccination amongst eligible groups for 2016/17

Target group	Uptake ambition for 2016/17
Aged under 65 'at risk'	55%
Pregnant women	55%
Eligible children aged 2 years to school year 3 age	40-65%
Aged 65 years and over	75%
Healthcare workers*	75%

* This is an NHSE Trust-level ambition to reach a minimum of 75% uptake amongst healthcare workers and an improvement in every Trust

Appendix B – Routine Immunisation Schedule from Summer 2016

The routine immunisation schedule from Summer 2016

Age due	Diseases protected against	Vaccine given and trade name		Usual site[1]
Eight weeks old	Diphtheria, tetanus, pertussis (whooping cough), polio and *Haemophilus influenzae* type b (Hib)	DTaP/IPV/Hib	Pediacel or Infanrix IPV Hib	Thigh
	Pneumococcal (13 serotypes)	Pneumococcal conjugate vaccine (PCV)	Prevenar 13	Thigh
	Meningococcal group B (MenB)[2]	MenB[2]	Bexsero	Left thigh
	Rotavirus gastroenteritis	Rotavirus	Rotarix	By mouth
Twelve weeks	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib	Pediacel or Infanrix IPV Hib	Thigh
	Rotavirus	Rotavirus	Rotarix	By mouth
Sixteen weeks old	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib	Pediacel or Infanrix IPV Hib	Thigh
	MenB[2]	MenB[2]	Bexsero	Left thigh
	Pneumococcal (13 serotypes)	PCV	Prevenar 13	Thigh
One year old	Hib and MenC	Hib/MenC booster	Menitorix	Upper arm/thigh
	Pneumococcal (13 serotypes)	PCV booster	Prevenar 13	Upper arm/thigh
	Measles, mumps and rubella (German measles)	MMR	MMR VaxPRO[3] or Priorix	Upper arm/thigh
	MenB[2]	MenB booster[2]	Bexsero	Left thigh
Two to seven years old (including children in school years 1, 2 and 3)[5]	Influenza (each year from September)	Live attenuated influenza vaccine LAIV[4]	Fluenz Tetra[3]	Both nostrils
Three years four months old	Diphtheria, tetanus, pertussis and polio	DTaP/IPV	Infanrix IPV or Repevax	Upper arm
	Measles, mumps and rubella	MMR (check first dose given)	MMR VaxPRO[3] or Priorix	Upper arm
Girls aged 12 to 13 years	Cervical cancer caused by human papillomavirus (HPV) types 16 and 18 (and genital warts caused by types 6 and 11)	HPV (two doses 6-24 months apart)	Gardasil	Upper arm
Fourteen years old (school year 9)	Tetanus, diphtheria and polio	Td/IPV (check MMR status)	Revaxis	Upper arm
	Meningococcal groups A, C, W and Y disease	MenACWY	Nimenrix or Menveo	Upper arm
65 years old	Pneumococcal (23 serotypes)	Pneumococcal polysaccharide vaccine (PPV)	Pneumococcal polysaccharide vaccine	Upper arm
65 years of age and older	Influenza (each year from September)	Inactivated influenza vaccine	Multiple	Upper arm
70 years old	Shingles	Shingles	Zostavax[3]	Upper arm[6]

[1] Where two or more injections are required at once, these should ideally be given in different limbs. Where this is not possible, injections in the same limb should be given 2.5cm apart. For more details see Chapters 4 and 11 in the Green Book. All injected vaccines are given intramuscularly unless stated otherwise.
[2] Only for infants born on or after 1 May 2015
[3] Contains porcine gelatine
[4] If LAIV (live attenuated influenza vaccine) is contraindicated and child is in a clinical risk group, use inactivated flu vaccine
[5] Age on 31 August 2016
[6] This can be administered subcutaneously but intramuscular is preferred.

All vaccines can be ordered from www.immform.dh.gov.uk free of charge except influenza for adults and Pneumococcal polysaccharide vaccine.

Immunisation
The safest way to protect children and adults

NHS

Selective immunisation programmes

Target group	Age and schedule	Disease	Vaccines required
Babies born to hepatitis B infected mothers	At birth, four weeks, eight weeks and at one year[1]	Hepatitis B	Hepatitis B vaccine (Engerix B / HBvaxPRO)
Infants in areas of the country with TB incidence >= 40/100,000	At birth	Tuberculosis	BCG
Infants with a parent or grandparent born in a high incidence country[2]	At birth	Tuberculosis	BCG
Pregnant women	During flu season At any stage of pregnancy	Influenza	Inactivated flu vaccine
Pregnant women	From 20 weeks gestation[3]	Pertussis	dTaP/IPV (Boostrix-IPV or Repevax)

[1] Take blood for HBsAg to exclude infection
[2] Where the annual incidence of TB is >= 40/100,000
www.gov.uk/government/uploads/system/uploads/attachment_data/file/393840/Worldwide_TB_Surveillance_2013_Data_High_and_Low_Incidence_Tables_____2_.pdf
[3] Can be given from 16 weeks but usually offered after the anomaly scan

Additional vaccines for individuals with underlying medical conditions

Medical condition	Diseases protected against	Vaccines required[1]
Asplenia or splenic dysfunction (including sickle cell and coeliac disease)[2]	Meningococcal groups A, B, C, W and Y Pneumococcal Haemophilus influenzae type b (Hib) Influenza	Hib/MenC MenACWY MenB PCV13 (up to five years of age) PPV (from two years of age) Annual flu vaccine
Cochlear implants	Pneumococcal	PCV13 (up to five years of age) PPV (from two years of age)
Chronic respiratory and heart conditions[2] (such as severe asthma, chronic pulmonary disease, and heart failure)	Pneumococcal Influenza	PCV13 (up to five years of age) PPV (from two years of age) Annual flu vaccine
Chronic neurological conditions[2] (such as Parkinson's or motor neurone disease, or learning disability)	Pneumococcal Influenza	PCV13 (up to five years of age) PPV (from two years of age) Annual flu vaccine
Diabetes[2]	Pneumococcal Influenza	PCV13 (up to five years of age) PPV (from two years of age) Annual flu vaccine
Chronic kidney disease (CKD)[2] (including haemodialysis)	Pneumococcal (stage 4 and 5 CKD) Influenza (stage 3, 4 and 5 CKD) Hepatitis B (stage 4 and 5 CKD)	PCV13 (up to five years of age) PPV (from two years of age) Annual flu vaccine Hepatitis B
Chronic liver conditions[2]	Pneumococcal Influenza Hepatitis A Hepatitis B	PCV13 (up to five years of age) PPV (from two years of age) Annual flu vaccine Hepatitis A Hepatitis B
Haemophilia	Hepatitis A Hepatitis B	Hepatitis A Hepatitis B
Immunosuppression due to disease or treatment[2]	Pneumococcal Influenza	PCV13 (up to five years of age)[2] PPV (from two years of age) Annual flu vaccine
Complement disorders[2] (including those receiving complement inhibitor therapy)	Meningococcal groups A, B, C, W and Y Pneumococcal Haemophilus influenzae type b (Hib) Influenza	Hib/MenC MenACWY MenB PCV13 (to any age) PPV (from two years of age) Annual flu vaccine

[1] Check relevant chapter of green book for specific schedule
[2] To any age in severe immunosuppression
[3] Consider annual influenza vaccination for household members and those who care for people with these conditions

Appendix C – National Screening Programmes[11]

- NHS abdominal aortic aneurysm (AAA) programme : The NHS abdominal aortic aneurysm (AAA) screening programme is available for all men aged 65 and over in England. The programme aims to reduce AAA related mortality among men aged 65 to 74. A simple ultrasound test is performed to detect AAA. The scan itself is quick, painless and non-invasive and the results are provided straight away. A result letter is also sent to all patients' GPs.
- NHS diabetic eye screening (DES) programme: Evidence shows that early identification and treatment of diabetic eye disease could reduce sight loss. The eligible population for DES is all people with type 1 and type 2 diabetes aged 12 or over. Screening gives people with diabetes and their primary diabetes care providers information about very early changes in their eyes. The main treatment for diabetic retinopathy is laser surgery. People already under the care of an ophthalmology specialist for the condition are not invited for screening. The programme also offers pregnant women with type 1 or type 2 diabetes additional tests because of the risk of developing retinopathy.
- NHS fetal anomaly screening programme (FASP) : The NHS fetal anomaly screening programme (FASP) is one of the antenatal and newborn NHS population screening programmes. FASP offers screening for pregnant women to check the baby for Down's syndrome and other fetal anomalies, including:
    - Anencephaly
    - open spina bifida
    - cleft lip
    - diaphragamtaic hernia
    - gastrochisis
    - exomphalos
    - serious cardiac abnormalities
    - bilateral renal agenesis
    - lethal skeletal dysplasia
    - Edwards' syndrome (T18)
    - Patau's syndrome (T13)

- NHS infectious diseases in pregnancy screening (IDPS) programme: The IDPS programme currently screens for HIV, Hepatits B, Syphilis and Rubella susceptibility. Midwives and healthcare professionals should offer and recommend testing to all pregnant women as part of their antenatal care. The woman's decision to accept or decline testing should be noted in the woman's health records.
- NHS newborn and infant physical examination (NIPE) screening programme: NIPE screens newborn babies within 72 hours of birth, and then once again between 6 to 8 weeks for conditions relating to their:
    - Heart – congenital heart disease
    - Hips – developmental dysplasia of the hip
    - Eyes – congenital cataracts
    - Testes – cryptorchidism (undescended testes)

  The 6 to 8 week screen is necessary as some conditions appear later in a child's development.
- NHS newborn blood spot (NBS) screening programme: The NHS newborn blood spot (NBS) screening programme aims to identify rare but serious conditions. Midwives carry out heel prick tests (taking blood from a baby's heel) when babies are 5 days old (the first day of life being day 0) and sends the samples off for testing. Babies who are new to the country or are yet to have a heel prick test are eligible for testing up to a year old. This excludes the cystic fibrosis screening test, which is not reliable after 8 weeks of age.
- NHS sickle cell and thalassaemia (SCT) screening programme: The NHS Sickle Cell and Thalassaemia (SCT) screening programme is a genetic screening programme. This means that it also identifies people who are genetic carriers for sickle cell, thalassaemia and

[11] HM Government, NHS Screening Programmes. Available on: https://www.gov.uk/topic/population-screening-programmes

other haemoglobin disorders. If 2 people who are carriers have a baby together, there is an increased risk that their baby could inherit a haemoglobin disorder. It screens for:
    - genetic carriers for sickle cell, thalassaemia and other haemoglobin disorders
    - sickle cell disease
    - thalassaemia
    - haemoglobin disorders

  It offers screening to:
    - all pregnant women
    - fathers-to-be, where antenatal screening shows the mother is a genetic carrier
    - all newborn babies, as part of the newborn blood spot screening programme
- NHS newborn hearing screening programme (NHSP): Early identification of hearing impairment gives children a better chance of developing speech and language skills, and of making the most of social and emotional interaction from an early age. The parents of all babies born or resident in England should be offered hearing screening for their baby within 4 to 5 weeks of birth. Babies that miss screening should receive it as soon as possible, but not after 3 months of age. Some babies are not eligible for screening; this may be because the babies have an already-known risk of hearing impairment or deafness, from another condition. Healthcare staff can refer these babies for full audiological assessment without requiring a routine hearing screen. The programme offers 2 types of test:
    - automated otoacoustic emission (AOAE): usually the default test for well babies.
    - automated auditory brainstem response (AABR): test performed on both ears when there was no clear AOAE response.
- Screening and quality assurance (all programmes): All screening programmes are audited and quality assured to minimise the risk of harm to patients. Screening processes are not perfect, and in every screen there are a number of false positives and false negatives. Utilisation of failsafe procedures, programme standards and quality assurance by regional quality teams aims to make the screening process as rigorous and effective as possible

Appendix D – Notifiable Diseases

Diseases notifiable to local authority proper officers under the Health Protection (Notification) Regulations 2010:

- Acute encephalitis
- Acute infectious hepatitis
- Acute meningitis
- Acute poliomyelitis
- Anthrax
- Botulism
- Brucellosis
- Cholera
- Diphtheria
- Enteric fever (typhoid or paratyphoid fever)
- Food poisoning
- Haemolytic uraemic syndrome (HUS)
- Infectious bloody diarrhoea
- Invasive group A streptococcal disease
- Legionnaires' disease
- Leprosy
- Malaria
- Measles
- Meningococcal septicaemia
- Mumps
- Plague
- Rabies
- Rubella
- Severe Acute Respiratory Syndrome (SARS)
- Scarlet fever
- Smallpox
- Tetanus
- Tuberculosis
- Typhus
- Viral haemorrhagic fever (VHF)
- Whooping cough
- Yellow fever

Report other diseases that may present significant risk to human health under the category 'other significant disease'

Havering Tobacco Harm Reduction Partnership Board

Terms of Reference v1.0

1. Introduction

Smoking is the largest single preventable cause of morbidity, mortality and inequalities in health in Britain and accounts for about half of the difference in life expectancy between the lowest and the highest income groups[12]. Tobacco is responsible for causing approximately 80,000 premature deaths each year in England and kills half of life-long users, causing harm not only to smokers but also to the people around them. Deaths from smoking are more numerous than the next six most common causes of preventable death combined (i.e. drug use, road accidents, other accidents and falls, preventable diabetes, suicide and alcohol abuse).[13]

Smoking and the harm it causes are not evenly distributed. People in disadvantaged areas are more likely to smoke and less likely to quit. Men and women from the most deprived groups have more than double the death rate from lung cancer compared with those from the least deprived. Smoking is twice as common among people with longstanding mental health problems.[14] Smoking in pregnancy increases the risks of miscarriage, stillbirth or having a sick baby, and is a major cause of child health inequalities. Two-thirds of smokers start smoking before the age of 18, and the reasons they start are complex, ranging from peer pressure to behavioural problems.

Since the publication of the Government's 2011 Tobacco Control Plan, there has been a strengthening of smoke-free legislation, and more is known about the factors that prompt and sustain tobacco use. For example:

- There is greater knowledge and focus on the influence of social networks and settings, including the role of employers and workplace health
- There is greater availability and use of self-help aids for all types of health improvement including for smoking cessation, such as smartphone apps and other online products, and fitness products
- Many people are now choosing to use electronic cigarettes to help them to quit
- There is greater knowledge about the factors that contribute to children taking up smoking, including the part played by the availability of illicit tobacco and under-age sales

[12] Public Health England (2015): *Smoking Cessation in Secure Mental Health Settings – Guidance for Commissioners,* avail: https://www.gov.uk/government/publications/smoking-cessation-in-secondary-care-mental-health-settings

[13] Department of Health (2011): *Healthy Lives, Healthy People: a tobacco control plan for England',* avail: https://www.gov.uk/government/publications/the-tobacco-control-plan-for-england

[14] Public Health England (2015) *Health matters: smoking and quitting in England* avail https://www.gov.uk/government/publications/health-matters-smoking-and-quitting-in-england/smoking-and-quitting-in-england

Public Health England describes a vision for a tobacco-free generation by 2025. A multi-agency Havering Tobacco Harm Reduction Partnership Board has been established to provide strategic leadership for this vision locally, taking into account new knowledge and evidence about the impact and use of tobacco products.

2. Aims of the Tobacco Harm Reduction Partnership Board

To provide leadership in the reduction of harm caused by tobacco in the local population, and to facilitate achievement of the vision of a tobacco-free generation in Havering by 2025.

3. Objectives of the Tobacco Harm Reduction Partnership Board

- Understand the use of tobacco in Havering and the harm caused
- Take stock of existing tobacco harm reduction measures
- Provide strategic leadership in the prevention of smoking in children and young people, promotion of smoking cessation in all age groups, and promote smoke free environments
- Take account of national policy guidance and evidence of best practice to develop an action plan setting out key priorities to be taken forward locally.
- To review progress regularly by developing and monitoring a set of indicators that links clearly to agreed outcomes.

4. Governance Arrangements

The Board is responsible to the Health Protection Forum, and will provide annual reports to the Forum. The Board may wish to set up task and finish groups to take forward specific initiatives.

5. Secretariat

The Board will be supported by the Council's Public Health Team. Papers will be circulated by email one week before the meeting.

6. Regularity of Meetings

The Board will meet every six weeks in the initial period followed by quarterly meetings The group will determine the need for working groups and annual workshops with wider stakeholders.

7. Review of Terms of Reference

Terms of Reference will be reviewed annually and may be subject to review more frequently if requested by a member of the Board, and seconded by another member.

8. Membership:

Director of Public Health, LBH (Chair)
Consultant in Public Health, LBH (Vice Chair)
Public Health Specialist, LBH
Environmental Health, LBH
Trading Standards, LBH

Enforcement/Underage Sales, LBH
BHRUT representative
Healthy Schools Co-ordinator, LBH
Education Strategic Partnership Rep
CCG Commissioner (Mental Health Services)
NELFT Mental Health Service representative
GP/Practice Nurse representative
Pharmacy representative
Communications, LBH
Healthy Workplace Lead, LBH

Other services and organisations will be co-opted on to the Board as necessary.

Terms of Reference agreed on …….. (date)

Signed …… (Chair)

Appendix F – Glossary of Terms

- Antigenic Drift - small changes in the genes of influenza viruses that happen continually over time as the virus replicates. These small genetic changes usually produce viruses that are pretty closely related to one another, usually share the same antigenic properties and an immune system exposed to an similar virus will usually recognize it and respond. (This is sometimes called cross-protection.) But these small genetic changes can accumulate over time and result in viruses that are antigenically different. When this happens, the body's immune system may not recognize those viruses. This process works as follows: a person infected with a particular flu virus develops antibody against that virus. As antigenic changes accumulate, the antibodies created against the older viruses no longer recognize the "newer" virus, and the person can get sick again. Genetic changes that result in a virus with different antigenic properties is the main reason why people can get the flu more than one time. This is also why the flu vaccine composition must be reviewed each year, and updated as needed to keep up with evolving viruses.
- Antigenic Shift - is an abrupt, major change in the influenza A viruses, resulting in new hemagglutinin and/or new hemagglutinin and neuraminidase proteins in influenza viruses that infect humans. Shift results in a new influenza A subtype or a virus with a hemagglutinin or a hemagglutinin and neuraminidase combination that has emerged from an animal population that is so different from the same subtype in humans that most people do not have immunity to the new (e.g. novel) virus. Such a "shift" occurred in the spring of 2009, when an H1N1 virus with a new combination of genes emerged to infect people and quickly spread, causing a pandemic. When shift happens, most people have little or no protection against the new virus. While influenza viruses are changing by antigenic drift all the time, antigenic shift happens only occasionally. Type A viruses undergo both kinds of changes; influenza type B viruses change only by the more gradual process of antigenic drift.
- CQUIN - The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. The payments exist to encourage NHS organisations to sharpen their focus on quality by making a proportion of income conditional on quality and innovation. Since its introduction in 2010/11, CQUIN has increased in importance for providers — increasing from 0.5 to 2.5 per cent of contract income in 2012/13. With the average acute trust earning around £230m a year, nationally the CQUIN pot amounts to over £700m. For individual trusts, it can be millions of pounds.
- COVER – The Cover of Vaccination Evaluated Rapidly programme (COVER) evaluates childhood immunisation in England, collating data for children aged 1, 2 and 5. Quarterly data tables are provisional and give an indication of current coverage. Data is collected by financial year.
- Failsafe Systems - Failsafe is a back-up mechanism, in addition to usual care, which ensures if something goes wrong in a healthcare pathway, such as for screening or immunisations, processes are in place to (i) identify what is going wrong and (ii) what action follows to ensure a safe outcome.
- Read Codes - are the standard clinical terminology system used in General Practice in the UK. It supports detailed clinical encoding of multiple patient phenomena including: occupation; social circumstances; ethnicity and religion; clinical signs, symptoms and observations; laboratory tests and results; diagnoses; diagnostic, therapeutic or surgical procedures performed; and a variety of administrative items (e.g. whether a screening recall has been sent and by what communication modality, or whether an item of service fee has been claimed). It therefore includes but goes significantly beyond the expressivity of a diagnosis coding system.

References

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[3] https://www.gov.uk/government/publications/the-complete-routine-immunisation-schedule

[4] PHE (2013). *Immunity and how vaccines work: Green Book, Chapter 1.* *https://www.gov.uk/government/publications/immunity-and-how-vaccines-work-the-green-book-chapter-1*

[5] NHS (2016) Green Book: Chapter 7: Immunisation of individuals with underlying medical conditions. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/566853/Green_Book_Chapter7.pdf

[6] http://www.cancerscreening.nhs.uk/

[7] NHS Cancer Screening Programmes (2015). Prostate Cancer Risk Management http://www.cancerscreening.nhs.uk/prostate/index.html

[8] PHE (2016). *HIV Annual Data Tables.* *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/557561/LA_UTLA_Prevalence_Tables.xlsx*

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[14] National Institute for Health and Care Excellence (NICE) (2011). Preventing the Spread of Tuberculosis by BCG Vaccination. http://pathways.nice.org.uk/pathways/tuberculosis/preventing-the-spread-of-tuberculosis-by-bcg-vaccination#content=view-node%3Anodes-neonates

[15] Legionnaires' disease: isolation of a bacterium and demonstration of its role in respiratory disease, J E McDade *et al*, *New England Journal of Medicine*, 1977, 297,pp1197-1203.

[16] Health and Safety at Work etc Act 1974.

[17] Control of Substances Hazardous to health regulations 2002, Statutory Instrument 2002/2677.

[18] Approved code of practice and guidance, "Legionnaires' disease: the control of legionella bacteria in water systems", HSC, London, 2000.

[19] BS 1992:7592 - Sampling for *Legionella* organisms in water and related materials.

[20] ISO 1998:11731 - Water Quality - Detection and enumeration of *Legionella*.

HEALTH & WELLBEING BOARD

Subject Heading:	**Havering Clinical Commissioning Group: 17/18 Operating Plan**
Board Lead:	**Conor Burke, Accountable Officer, BHR CCGs**
Report Author and contact details:	**Alan Steward, Havering CCG Chief Operating Officer, 0203 182 3403, alansteward@nhs.net**

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

- ☒ Theme 1: Primary prevention to promote and protect the health of the community and reduce health inequalities
- ☒ 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: Quality of services and user experience

SUMMARY

This paper sets out the annual Operating Plan requirements for Havering Clinical Commissioning Group (CCG). It sets out the financial, quality and performance standards that the CCG must deliver – working with partners and providers – for 17/18 and 18/19. The Better Care Fund requirements and plan is set out in a separate committee report.

RECOMMENDATIONS

The Board is recommended to:

- Review and note the content of this report

REPORT DETAIL

1. Background and Introduction

1.1. NHS England and NHS Improvement published the NHS operating and contracting planning guidance in September 2016, which for the first time covered two financial years. The planning guidance set out the national priorities for 2017/18 and 2018/19.

1.2. The NHS operational planning process has developed to support the new Sustainability and Transformation Plans (STP) which are the route map for delivering the Five Year Forward View and maintaining financial balance. To enable NHS organisations to focus more on transformation and less time on transactional relationships, the contracting round was brought forward by 3 months. The BHR CCGs agreed two year contracts (April 2017 to March 2019) with their main providers – BHRUT and NELFT on 23 December 2016.

1.3. The planning guidance sets out nine 'must do' priorities for 2017-2019 related to the delivery of financial control totals and the delivery of the Five Year Forward view priorities. These are to be delivered alongside other local priorities.

2. CCG Financial position

2.1. The CCGs' November 2017/18 draft Operating plan submissions assumed an in-year breakeven position, but required a very significant savings plan (QIPP) ask of the CCG. The QIPP target included both the full year effect of 2016/17 efficiency schemes and new 2017/18 schemes. The majority of the QIPP plan was focused on reducing costs associated with the largest providers: BHRUT, Barts Health and NELFT.

2.2. A number of additional pressures, mainly driven by pricing issues, arose as a result of the CCGs/BHRUT contract mediation process. These totalled £12m across the BHR CCGs, increasing the BHR QIPP savings plan for 2017/18 to £55m (circa £22.0m for Havering CCG). £35M of the £55M relates to activity in the BHRUT contract.

2.3. The BHRUT contract mediation panel made up of NHS regulators directed BHRUT and BHR CCGs to establish a joint programme board (on which they wish to sit) to agree by 28 February 2017 how the £35m of the required savings are to be delivered by the system in year. NELFT and BHR CCGs have similarly agreed the need for such a board.

2.4 The Integrated Care Partnership Board (ICPB) agreed to establish a System Delivery and Partnership Board (SDPB) in 2016 to lead on BHR system level delivery planning and implementation. It is proposed that the ICPB agree that this will now be established and take on the requirements as directed by regulators. The Board will include primary care and local authority providers along with other stakeholders critical to the delivery of the plan.

2.5 The SDPB was charged with delivering an initial System Delivery Plan, including a financial plan, by 28 February 2017. Whilst the performance responsibilities of the Board remain critical, the initial emphasis is on agreeing savings plans on an open book basis and developing system wide clinical change capabilities and support to ensure plans are implemented.

2.6 A concerted six week system wide effort is required by all partners to plan how the system will return to financial balance. If regulators conclude the Board will not achieve its stated aim by 28 February, intervention by London's Regional Directors will be triggered. An update on this will be provided at the 15 March HWB meeting.

3.0 Operating Plan Priorities

3.1 The 2017 to 2019 operating plan, which is aligned to delivery of the North East London STP, sets out the standards that the CCGs are planning to achieve over a 2 year period. These reflect the national 'must dos' as set out below.

a) Primary care commitments

- To ensure the sustainability of general practice by implementing the General Practice Forward View
- To ensure local investment meets or exceeds minimum required levels.
- To tackle workforce and workload issues
- To extend and improve access in line with requirements for new national funding by March 2019
- To support general practice at scale

b) Urgent and emergency care commitments

- To deliver the four hour A&E standard, and standards for ambulance response times including implementing the five elements of the national A&E Improvement Plan.
- By November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services.
- To implement the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each STP footprint, including a clinical hub that supports NHS 111, 999 and out-of-hours calls.

- To deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an A&E department.
- To initiate cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis.

c) Referral to treatment times and elective care commitments

- To deliver the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT).
- To deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018 in line with the 2017/18 CQUIN and payment changes from October 2018.
- To streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups.
- To implement the national maternity services review - Better Births - through local maternity systems.

d) Cancer

- Working through Cancer Alliances and the National Cancer Vanguard, implement the cancer taskforce report.
- Deliver the NHS Constitution 62 day cancer standard, including by securing adequate diagnostic capacity, and the other NHS Constitution cancer standards.
- Make progress in improving one-year survival rates by delivering a year- on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.
- Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types.
- Ensure all elements of the Recovery Package are commissioned

e) Mental health commitments

- To increase access to psychological therapies so that at least 19% of people with anxiety and depression access treatment by 2019 from 2016/17 target of 15%, whilst maintaining recovery rate and waiting time standards
- To expand capacity so that more than 53% people experiencing a first episode pf psychosis begin treatment with a recommended package of care within two weeks of referral;

- To ensure that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of Children and Young People Improving Access to Psychological Therapies (CYP IAPT) by 2018;
- To increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline;
- To commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases; and
- To reduce suicide rates by 10% against the 2016/17 baseline.
- To ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals.
- To increase baseline spend on mental health to deliver the Mental Health Investment Standard.
- To maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support.
- To eliminate out of area placements for non-specialist acute care by 2020/21.

f) Learning disabilities Commitments

- To deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism.
- To reduce inpatient bed capacity by March 2019 to 10-15 in CCG- commissioned beds per million population, and 20-25 in NHS England- commissioned beds per million population.
- To improve access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check.
- To reduce premature mortality by improving access to health services, education and training of staff and by making necessary reasonable adjustments for people with a learning disability and/or autism.

4. Recommendations for the Board

4.1 The Board is recommended to review and note the content of this report

Havering
LONDON BOROUGH

IMPLICATIONS AND RISKS

5.1 Financial implications

Havering CCG is required to deliver a minimum of a £22.0M QIPP in 2017/18, contributing to a BHR system QIPP of £55M. A BHR System Delivery and Performance Board (SDPB) has been established to lead on the identification and delivery of schemes for 2017/18.

The on-going financial pressures across health and social care represent significant challenges for both commissioners and providers and this will need to be taken into account when future service delivery plans are considered.

5.2 Legal implications

Joint commissioning of services and for learning disabilities will be formalised through Section 75 agreements in 17/18.

5.3 Risk Management

CCG risks are managed through the Governing Body Assurance Framework. System Delivery Plan risks are managed through the Integrated Care Partnership.

5.4 Patient/Service User Impact

The overall impact of the CCG's Operating Plan will be measured through nationally mandated and locally selected indicators. Public engagement is planned as part of the delivery of the System Delivery Plan.

BACKGROUND PAPERS

None.

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD, 15 March 2017

Subject Heading:	**SEND programme update**
Board Lead:	Sue Elliott, CCG Tim Aldridge, LA Director of Children's Services
Report Author and contact details:	Caroline Penfold, Head of Children's and Adults Disability Service

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

- ☐ Theme 1: Primary prevention to promote and protect the health of the community and reduce health inequalities
- ☒ 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: Quality of services and user experience

SUMMARY

The Board will be provided with a presentation update on SEND developments and improvements, following the previous update to the Board in September 2016.

The Borough and CCG anticipate a joint inspection of services to children and young people with Special Educational Needs and Disabilities (SEND), by Ofsted and Care Quality Commission. Inspection will assess how we have implemented reforms for children and young people, moving from 'statements' of SEN to child-centred Education, Health and Care plans. The inspection is 'short notice' and all areas in England will be covered in a programme which began in June 2016.

Havering
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RECOMMENDATIONS

The Board is invited to receive a presentation at the meeting, which outlines the progress made since the previous update to the Board in September 2016 and note areas for action over the coming months.

REPORT DETAIL

A presentation will update the Health and Wellbeing Board covering:

- the form and purpose of the joint CQC/OFSTED Area Inspection of services to support children and young people aged 0-25 with special educational needs and disabilities (SEND);
- work undertaken to date by Council and CCG officers in preparation for future inspection;
- work underway to address known risks; and
- priorities for further action.

IMPLICATIONS AND RISKS

The implications of a negative inspection, particularly one that results in a ‘written statement of action’ will be significant for the CCG and Council and regular monitoring by regulators would follow to check improvement has taken place. Risks have been identified and plans have been made to improve known areas of vulnerability, ahead of unannounced inspection.

BACKGROUND PAPERS

None

Update of services to support children with **Special Educational Needs and Disabilities (SEND)**

Tim Aldridge (LA)

Sue Elliott(CCG)

Overview

- Update provided to Sept 2016 HWBB
- Children and Families Act reforms (2014)
- Child-centred approach to SEND
- Improve ***outcomes*** for children with SEND
- Move from 'statements' to Education, Health, Care Plans (EHCP)
- Joined up approach across health, schools, colleges and council
- Preference for needs to be met in school settings

Joint regulation: Ofsted and CQC

- Inspection how the ***local area*** is working together to:
- improve the outcomes for children and young people with SEND (0-25)
- know and understand fully the needs in the area
- create a Local Offer which sets out the support available by all organisations
- undertake joint assessments to produce EHC Plans
- commission jointly, across the CCG/LA to meet the needs identified and improve outcomes
- involve children and young people and parents/carers

Progress since previous HWBB update (1)

- Single inspection – positive feedback on children with disability services
- Improved education provision (ARPs, Corbets Tey @ The Avelon)
- JSNA Deep Dive on SEND complete
- Local Offer reviewed (with parents) and to be relaunched
- Parental engagement continues (regular forums)
- SEND2 survey returned to DfES (snapshot evidence base, used during inspection and to compare areas)
- Timeliness of EHC plans improved (80% within 20 weeks)
- Additional resource to improve conversion rate in place (of previous statements to EHC plans)

Progress since previous HWBB update (2)

Self-evaluation process leading to agreed areas to improve:

- Joint Commissioning priorities agreed between council and CCG
- Decision-making panels (for children with EHC plans and complex health needs) reviewed and improved
- Plans to implement holistic child records (improving efficiency for parents and carers) currently being implemented
- Short Breaks service - out to tender for new provision
- High Needs review to begin mid 2017

- Exploring joint work across LBBD and Redbridge (to replicate the CCG area)

Ofsted / CQC inspections to date

17 area reports to date; 4 formal “statements of action”

Recurring themes:

- Limited involvement of parents and carers
- Timeliness of agreeing EHC plans
- High number of exclusions, weak educational outcomes
- Long wait times for speech and language therapy, paediatrics, audiology and occupational therapy
- Inefficient management and coordination of area information
- Leaders too slow to set up joint commissioning between education, health and care
- Use of personal budgets limited

Risks identified / being mitigated

- Managing increasing demand (cost, numbers and complexity)
- Continual engagement with parents / carers
- Use of personal budgets across LA and Health
- Wait times for (some) therapies
- Timeliness of EHC plans agreed for children with complex needs
- Smooth transition processes into adulthood
- ***Limited evidence*** of joint commissioning improving outcomes for children and young people
- Tracking of children through health identification from pre-birth
- Integrated early years checks – e.g. health visiting and early years settings

Implementation and Review

- Programme of improvements (across LA and CCG) agreed
- Action plan in place to monitor
- Local Offer reviewed (established group in place)
- Executive Board established to oversee joint improvements – expanding to include parent(s) and schools
- Regular update from Executive Board to HWBB

Havering
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HEALTH & WELLBEING BOARD

Subject Heading:	Havering Obesity Prevention Strategy – Annual Update
Board Lead:	Sue Milner, Interim Director of Public Health
Report Author and contact details:	Claire Alp, Senior Public Health Specialist Claire.Alp@havering.gov.uk 01708 431818

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

- ☒ Theme 1: Primary prevention to promote and protect the health of the community and reduce health inequalities
- ☒ 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: Quality of services and user experience

SUMMARY

Havering's Prevention of Obesity Strategy 2016-19 and associated action plan was published in April 2016.

The strategy set out our approach to preventing obesity in Havering, and encouraging our local population to be more active and eat more healthily. This was presented as three interlinked work streams to: -

- Shape the environment to promote healthy eating and physical activity;
- Support a culture that sees physical activity and healthy eating as the norm;
- Prompt individuals to change, primarily through self-help.

The action plan detailed how we would use existing assets and new opportunities to progress these work streams, and the Health and Wellbeing Board agreed that an Obesity Prevention Working Group should be formed to periodically refresh and oversee delivery of this rolling annual action plan.

The purpose of this paper is to:-

- Update the Health and Wellbeing Board on progress made with implementation of the 2016/17 action plan. Notable successes during 2016/17 include;
    - Gathering residents' views through the Great Weight Debate
    - Local amplification of national campaigns – Change4Life 'Be Food Smart'
    - Positive impact of multiple transport and travel initiatives
    - Junior Citizen Event Healthy Eating session successfully transitioned to delivery by student volunteers
    - Healthy Workplace steering group established and action plan in progress
- Inform the Health and Wellbeing Board of local trends in levels of obesity, physical activity and healthy eating. Headline information includes:
    - Excess weight remains broadly stable amongst 4-5 year olds and adults but continues to increase amongst 10-11 year olds.
    - 55.4% of adults in Havering achieve the recommended levels of physical activity.
    - Half of young people aged 15 (49.2%) and adults (42.1%) in Havering eat 5 portions of fruit and vegetables per day.
- Highlight new regional and national publications or campaigns launched in the past year that support or guide our local efforts to prevent obesity;
- Request the board's approval of the rolling action plan, refreshed for 2017/18.

RECOMMENDATIONS

The Board is asked to: -

- Review progress made with the action plan during 2016-17;
- Discuss the refreshed action plan for 2017-18 and suggest any amendments and additions;
- Pay particular attention to proposed action 2.3 in the action plan and associated information provided in section 4.2 in this paper, and give approval for the Obesity Prevention Working Group to pursue cross-Council commitment to the Local Government Declaration on Sugar Reduction and Healthier Food;
- Subject to there being general agreement with the approach taken to date, and that any changes suggested by members are made, agree that the Chair of the Health and Wellbeing Board can approve the 2017-18 action plan without further reference to the Board;
- Agree that the next update should be provided at the May 2018 meeting of the Health and Wellbeing Board. The slightly later date will allow for year-end data to be collected and reported.

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REPORT DETAIL

1.0 Update on progress made with implementation of the action plan and future planning

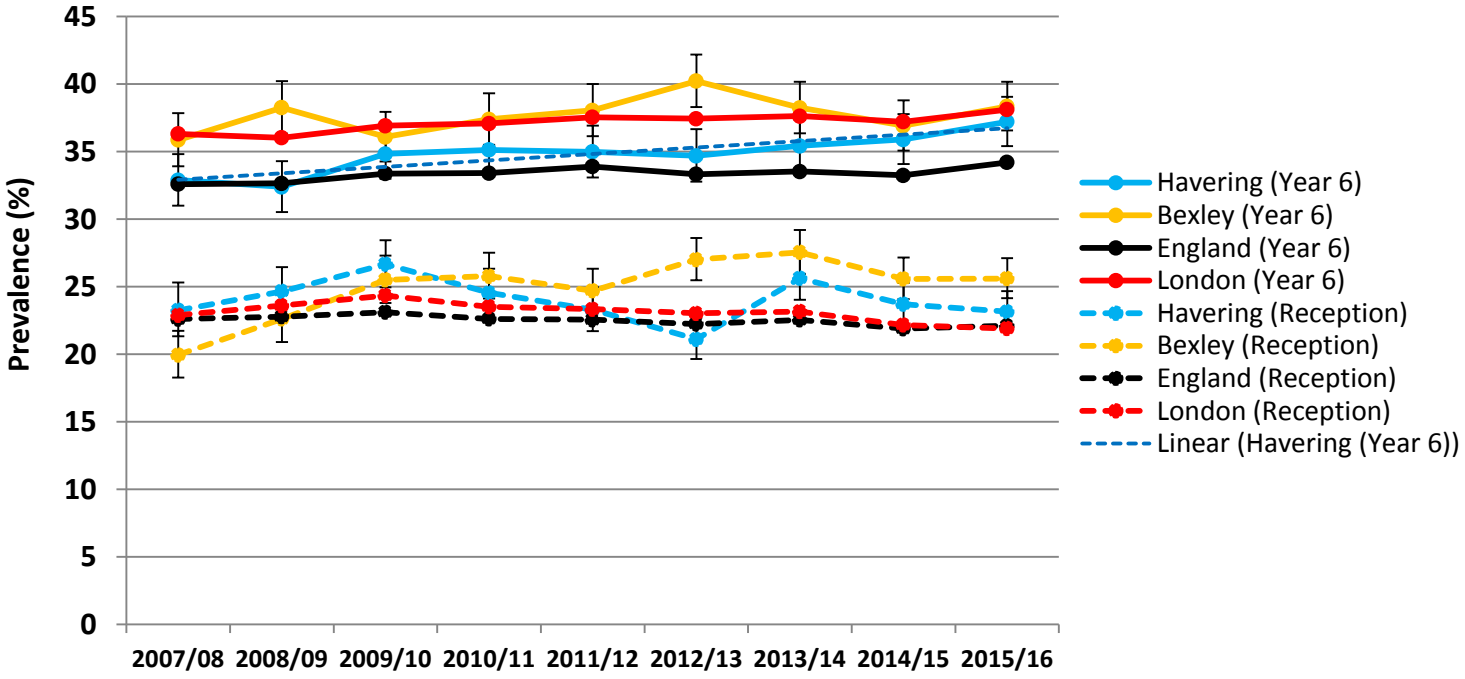
The task and finish group that was established to inform development of the strategy has evolved into an Obesity Prevention Working Group. Led by the LBH Public Health Service, internal and external stakeholders meet quarterly and take responsibility for delivery of the action plan.

The action plan is provided as Appendix 1. RAG ratings and progress notes have been provided against 2016-17 actions, whilst new actions to be progressed during 2017-18 are indicated in blue in the RAG column.

2.0 Update on local trends in levels of obesity, physical activity and healthy eating

2.1 The prevalence of obesity in Havering

Figure 1. Prevalence of Excess Weight (Overweight and Obesity) Time Trend



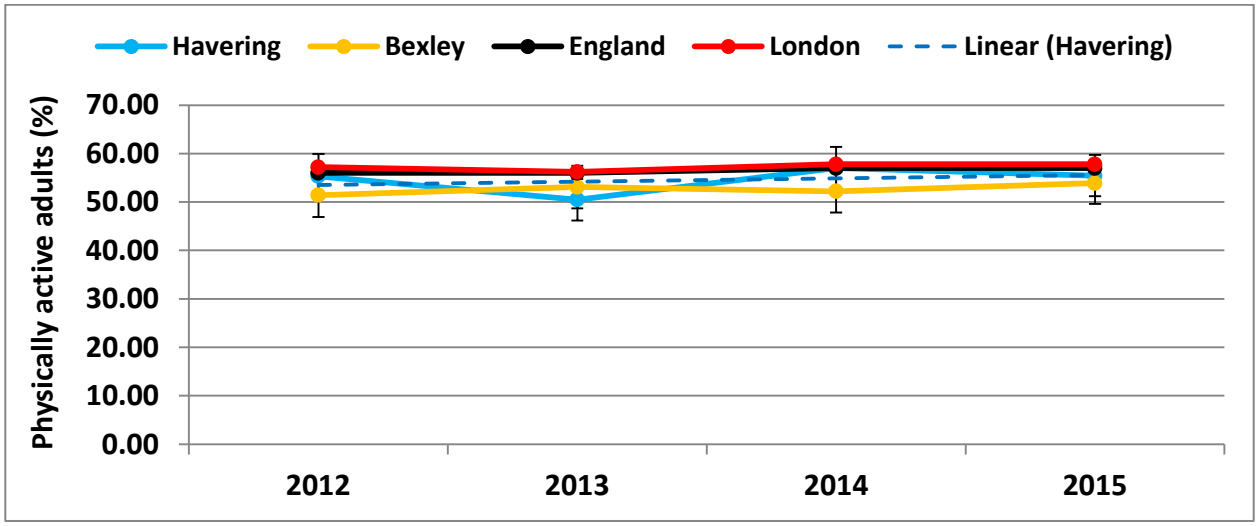
- National Child Measurement Programme (NCMP) data shows that in 2015/16 prevalence of excess weight (overweight and obesity combined) amongst Reception children (4-5 year olds) in Havering was 23.1%. Trend data shows

that prevalence has remained broadly stable since 2008/09. In 2015/16, Havering was similar to England (22.1%) and London (22.0%).

- NCMP data shows that in 2015/16 prevalence of excess weight amongst Year 6 children (10-11 year olds) in Havering was 37.2%. There has been an overall increase in excess weight in this age group since 2008/09, in line with the national trend. In 2015/16, prevalence in Havering was significantly worse than the England average (34.2%) but similar to the London average (38.1%).
- Prevalence of excess weight amongst adults in Havering, drawn from self-reported height and weight measurements in the Sport England 'Active People Survey' is 66.1% in 2015. This has remained broadly stable since 2012 and remains similar to the England average (64.8%). It is significantly higher than the London average of 58.8%.

2.2 Physical activity amongst adults and children in Havering

Figure 2. % of Physically Active Adults Time Trend



- Data on physical activity levels amongst children at Local Authority level is not available.
- In Havering in 2015, 55.4% of adults self-reported that they achieve the recommended levels of physical activity (150 minutes per week according to the Chief Medical Officer's guidance). This data has been collected since 2012 and there are currently not enough data points to calculate reliable trend information. In terms of comparison to regional and national averages in 2015, it is similar to London (57.8%) and England (57.0%).

2.3 Healthy eating amongst adults and children in Havering

- In Havering in 2015, 49.2% of young people (aged 15) surveyed in the What About Youth survey self-reported that they achieve the recommended consumption of fruit and vegetables (5 portions). This is significantly lower than the London (56.2%) and England (52.4%) averages. This data was collected for the first time in 2015 so no trend data is available yet.
- In Havering in 2015, 42.1% of adults surveyed in the Sport England Active People Survey self-reported that they achieve the recommended consumption of fruit and vegetables (5 portions) on a 'usual day'. This is significantly worse than the London (49.4%) and England (52.3%) averages. This data was collected for the first time in 2014 so no trend data is available yet.

3.0 Highlights of 2016-17 work to prevent obesity

Addressing obesity has gathered pace in the past year with the launch of the cross-Government plan for action and a number of new local and regional campaigns that aim to galvanise a whole system approach. Those described below highlight the successes achieved and challenges faced in our efforts to tackle obesity locally.

3.1 Childhood Obesity: A plan for action (HM Government, August 2016)

Since we developed our local strategy, the national childhood obesity prevention plan 'Childhood Obesity: A plan for action' has been published. The plan outlines 14 actions. Those that can be strengthened by local input or action are indicated in *italics*. These have been incorporated into our Havering action plan for 2017-18.

1. Soft drinks industry levy
2. Taking out 20% of sugar in products, achieving salt targets
3. Supporting innovation to help businesses to make their products healthier
4. Updating the nutrient profile model
5. *Making healthy options available in the public sector*
6. *Continuing to provide support with the cost of healthy food for those who need it most*
7. *Helping all children to enjoy an hour of physical activity every day*
8. *Improving the co-ordination of quality sport and physical activity programmes for schools*
9. *Creating a new healthy rating scheme for primary schools*
10. *Making school food healthier*
11. Clearer food labelling
12. *Supporting early years settings*
13. Harnessing the best new technology
14. *Enabling health professionals to support families*

3.2 Successful actions completed during 2016/17

Highlights from actions carried out in the past year include:

3.2.1 Gathering residents' views through the Great Weight Debate

The Healthy London Partnership's 'Great Weight Debate' took place during 2016. The aim of the campaign was to raise awareness of the obesity crisis and hear what changes residents believe could be made in London to help young people lead healthier lives. Opportunities to join the debate included a pan-London online survey and a variety of borough level events. The debate was promoted locally through a number of channels including a direct link to the online survey on the Council's Public Health webpage.

The online survey was completed by 220 Havering residents. Awareness of obesity across the borough was fairly high and residents felt strongly that tackling obesity should be a London priority. However, residents felt that fast food shops and concerns about children's safety made it difficult for them to live healthy lives. They felt that children could lead healthier lifestyles if parents were supported to make healthy meals for their families, schools had more physical education resources, healthy foods and drinks were made cheaper, and families were educated on healthy eating by health professionals.

Respondents to the survey were predominantly female (171 of the 214 who declared their gender) and aged 35-64 (145 of the 216 who declared their age). In order to engage more young people, the Public Health team facilitated a face-to-face debate with Havering's Youth Council to raise awareness of the obesity crisis and discuss what changes could be made in the borough to help young people lead healthier lives. Members of the Youth Council felt that the higher cost of healthy food is sometimes a barrier to them purchasing it and that the types of food shops located near to their schools and homes make buying unhealthy food and drink much easier than healthy options. They also thought more healthy advertising would help boost healthy eating in the borough. They discussed how their social life plays a big role in their eating habits and expressed how difficult is it to be physically active everyday given homework deadlines and the availability, cost and safety aspects of different types of activities. The full report details responses across Barking and Dagenham, Havering and Redbridge and is available on request from the author, Miriam Fagbemi (Public Health Project Officer, Miriam.Fagbemi@havering.gov.uk).

Although the pan-London survey is no longer live online, the Public Health team has developed a local survey that builds on the conversation started by the Great Weight Debate and the topics raised by the Youth Council, and will continue to promote this to young people through schools in 2017/18.

3.2.2 Local amplification of national campaigns – Change4Life 'Be Food Smart'

Public Health England's flagship Change4Life brand is primarily promoted through two annual campaigns – healthy eating in January and physical activity in July. This year's January campaign was themed 'Be Food Smart', with the main focus being promotion of

a new smartphone app which enables people to scan the barcodes of food products to access a simple summary of the sugar, salt and saturated fat content.

Havering benefited from a visit by the 'Be Food Smart' roadshow which spent two days in the Brewery shopping centre. This event was promoted through local communication channels, including the Yellow Advertiser and Romford Recorder. Havering's Health Champions supported Change4Life staff at the event, demonstrating the app to passers by, offering to accompany them during the start of their supermarket shop, starting a conversation about healthy eating and signposting to further support.

3.2.3 Positive impact of multiple transport and travel initiatives

Work to improve the transport and travel environment successfully continues to contribute to the obesity prevention agenda. Sustained investment across multiple initiatives has seen the following successes to date in 2016/17:

- 2286 children participated in Bikeability cycle training
- 183 adults participated in adult cycle training
- Station and public realm improvements continue throughout the borough as a result of Crossrail and TfL investment
- 292 HGV drivers completed Safer Urban Driver training
- 55 schools have an active School Travel Plan

Reach of this area of work is also extending throughout the borough as a result of the Council-developed Sustainable Travel pack for businesses. Two businesses have successfully applied for small grants to support staff to travel actively, and MyPlace, Hornchurch Leisure Centre and Queens Hospital are applying for cycle storage from the TfL Cycling Workplaces scheme.

3.2.4 Junior Citizen Event Healthy Eating session successfully transitioned to delivery by student volunteers

Since 2014, Public Health has supported Havering's Junior Citizen Event run by the Community Safety Team in partnership with the Metropolitan Police. The event for Year 6 pupils focuses on raising awareness and knowledge around staying safe in the community during the transition period from primary to secondary education. The Public Health session focuses on educating children about healthy eating, particularly in relation to food available from fast food outlets which become increasingly available to young people at this age when they begin to travel to school independently, and have more control over their spending and food choices.

Recent budget cuts meant delivery of the session could no longer be funded in 2016 but a successful relationship with London Metropolitan University through the Council hosting dietetic student placements was further developed and five student volunteers were recruited from Human Nutrition and Dietetics courses to deliver the Junior Citizen event healthy eating session. This was welcomed by the university and students as a valuable work experience opportunity.

Feedback from staff and pupils was positive, and we intend to repeat this in 2017 and incorporate monitoring and analysis of impact on pupil knowledge/ behavioural intention.

3.2.5 Healthy workplaces

Havering Council's efforts to create a healthy workplace continue to progress with a strategic workplace health forum now set up and chaired by Councillor Brice-Thompson (Cabinet Member for Adult Services and Health).

Representation and engagement from across Council departments is increasing and a draft Workplace Wellbeing Action Plan is due to be completed by April 2017.

4.0 Future Opportunities

4.1 London Borough of Havering vision

The new vision for the Council launched in January 2017 is themed under communities, places, opportunities and connections.

The action plan for 2017-18 is strongly aligned with these themes, and will continue to build on work commenced in the past year. Examples include:

- **Communities** - Empowering residents to make positive lifestyle choices through promoting healthy workplaces and working towards healthy food offers in Council-run public places. The action plan also focuses on ensuring a good start in life with an increased emphasis this year on opportunities to support early years settings to promote health and wellbeing and to increase access to healthy food for families on low incomes.
- **Places** - Ongoing improvements to parks and leisure facilities, continued work to make it easier and safer to walk and cycle in the borough, and development of thriving town centres provide opportunities for residents to enjoy physical activity and access healthy food**.**
- **Opportunities** – Close working between Economic Regeneration and Public Health to ensure the health impacts of new developments are taken into account.
- **Connections** - Transport Planning and Development continuing to develop public transport links and walking and cycling opportunities. Public Health England is developing online weight management tools that we will promote locally when they become available.

4.2 Local Government Declaration on Sugar Reduction and Healthier Food

The new Local Government Declaration on Sugar Reduction and Healthier Food aims to achieve a public commitment by Local Authorities to improve the availability of healthier food and to reduce the availability and promotion of unhealthier alternatives. It must be signed by the Leader of the Council, Lead Member for Health and the Director of Public Health.

To sign the declaration the Local Authority has to commit to take a minimum of one action from each of six key areas:

Area 1 Tackle advertising and sponsorship (e.g. advertising and sponsorship policies)
Area 2 Improve the food controlled or influenced by the council and support the public and voluntary sectors to improve their food offer (e.g. catering standards, tackle promotions, junk food near tills and queuing areas, vending)
Area 3 Reduce prominence of sugary drinks and actively promote free drinking water (e.g. promote water, voluntary sugar tax)
Area 4 Support businesses and organisations to improve their food offer (e.g. planning, licensing, favourable treatment of healthy businesses, healthier catering awards)
Area 5 Public events (e.g. healthy food at event stalls, welcoming breastfeeding)
Area 6 Raise public awareness (e.g. local or national campaigns, local champions, healthy eating programmes, training)

These commitments require the Council to take a strong lead in promoting healthy eating and physical activity and preventing obesity. The existing obesity prevention action plan includes actions relevant to 5 of the 6 priority areas. Further action would be needed to achieve compliance regarding the sponsorship and advertising commitment that asks the Council to either:

- Develop a coherent policy on future corporate partnerships or sponsorships that welcomes opportunities for investment in the borough and joint working, whilst avoiding those that promote unhealthy foods and drinks and undermine breastfeeding; or

- Develop coherent policy on future marketing/advertising that welcomes opportunities for investment in the borough and joint working, whilst avoiding those that promote unhealthy foods and drinks and undermine breastfeeding.

This can be integrated into existing policies where they exist, adding a clause that takes health into account when planning activities, forming partnerships or promoting businesses and products. Recent activity on the part of the Council that would be subjected to this additional consideration includes utilising a promotional campaign by a soft drinks company to boost footfall in Romford marketplace and taking young people to a fast food restaurant as a reward for public service. The policy would promote consideration of more health affirming options such as offering free leisure centre passes/ sessions as a reward to young people.

The Board is asked to consider whether pursuing commitment to this declaration should be included as an action in 2017/18 Obesity Prevention action plan. If agreed, proposed next steps would be for Public Health to lead on discussions regarding which actions are committed to, involving officers from other relevant teams (e.g. Communications), and submitting the proposed declaration to required signatories (in person or by email, as preferred) for discussion and agreement prior to signing.

4.3 The Mayor of London's 'Healthy Streets for London' vision and transport strategy

The Mayor of London, Sadiq Khan, and the new Walking and Cycling Commissioner, Will Norman, have launched 'Healthy Streets for London' their long-term vision to

encourage more Londoners to walk and cycle, by making London's streets healthier, safer and more welcoming.

This new vision for a healthy London will see increasing physical activity put at the centre of a wide range of GLA and TfL policy. This new approach will be embedded across the full range of Mayoral policy and strategy documents to ensure it is delivered effectively across the city, with the new London Plan, new Mayor's Transport Strategy and the Health Inequalities Strategy taking a leading role in this. A draft of the Mayor's Transport Strategy is expected to be published for consultation in the Spring.

In addition to the substantial physical health benefits, the Mayor's new approach will serve to reduce air and noise pollution, improve mental health, help combat social isolation, and bring economic benefits to local high streets across the Capital. It will also focus on minimising road danger, directly seeking to address the safety fears people have about cycling and walking more.

IMPLICATIONS AND RISKS

Financial implications and risks:

Any significant decisions arising from the ongoing implementation of this strategy action plan have or will be subject to normal governance processes within the relevant organisation.

Action 2.3 (outlined in Section 4.2 of this paper) will result in careful consideration of advertising and sponsorship opportunities associated with food brands, and decisions may increase in significance as the central Government grant continues to decrease and the Council becomes increasingly required to generate its own income.

There are no further significant implications arising from adoption of this action plan.

Legal implications and risks:

Any significant decisions arising from the ongoing implementation of this strategy action plan have or will be subject to normal governance processes within the relevant organisation.

Human Resources implications and risks:

Ditto

Equalities implications and risks:

Ditto

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BACKGROUND PAPERS

Prevention of Obesity Action Plan

Havering Prevention of Obesity Strategy 2016-19
Available at: www.havering.gov.uk/achievingahealthyweight

HM Government (2016) Childhood Obesity: A Plan for Action
Available at: https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action

Local Government Declaration on Sugar Reduction and Healthier Food
Briefing - Available at:
www.sustainweb.org/resources/files/reports/BoroughDeclaration_Briefing.pdf
Support Pack - Available at:
https://www.sustainweb.org/resources/files/reports/BoroughDeclaration_SupportPack.pdf

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Havering Prevention of Obesity Strategy - Action Plan 2016/17 and 2017/18

Contents

Key for RAG Rating columns

Action completed in 2016/17. Will not continue to be carried out/ monitored in 2017/18.
Action completed in 2016/17. Will continue to be carried out/ monitored in 2017/18.
Action in progress. Will continue to be carried out/ monitored in 2017/18.
Action halted or cancelled. Will not continue to be carried out/ monitored in 2017/18.
New action for 2017/18.

Key for other items

Brackets around officer names indicates officer is no longer responsible. New lead officer is named.

BHRUT	Barking, Havering and Redbridge University Hospital Trust
BPWG	Bedfords Park Walled Garden
C4L	Change4Life
CCG	Clinical Commissioning Group
CS	Children's Services
CSU	Commissioning Support Unit
CYP	Children and young people
DfT	Department for Transport
ED	Economic Development
FSM	Free School Meal
HAC	Havering Adult College
HCS	Havering Catering Services
HEYL	Healthy Early Years London
HIA	Health Impact Assessment
HSC	Havering Sports Collective
HV	Health Visitor
HWiSS	Health and Wellbeing in Schools Service
JCU	Joint Commissioning Unit
L&A	Learning and Achievement
LAC	Looked After Children
LBH	London Borough of Havering
LDP	Local Development Plan
LIP	Local Implementation Plan
MECC	Making Every Contact Count
NELFT	North East London Foundation Trust
NHS	National Health Service
PARS	Physical Activity Referral Scheme
PHS	Public Health Service
RS	Regulatory Services
STARS	Sustainable Travel: Active, Responsible, Safe
STP	Sustainability and Transformation Plan
SUD	Safer Urban Driving
TfL	Transport for London

Shaping the environment to promote healthy eating and physical activity									
Strategy objective *What we are trying to achieve*	**Action No.**	**Project/ Action** *What we will do to achieve it*	**Outcome** *How we will know we've achieved it*	**Resources** *What we need to be able to achieve it*	**Timescale**	**Lead officer**	**Impact on other services and organisations**	**Progress** *RAG*	*Notes*
Ensure strategic spatial plans are consistent with efforts to increase levels of healthy eating and physical activity	**1.1**	Health Impact Assessment of the LDP	HIA complete. Recommendations made as to how potential benefits might be maximised / harms mitigated.	Officer time	Commence March 2016	Elaine Greenway *Public Health Service* Lauren Miller *Planning, ED*			HIA has been undertaken and report is currently being written.
Continue programme of work to create healthy streets and places	**1.2**	Continue to improve the street scene and local High Street offer	Planned improvements in street scene and the local high street offer are completed. More people accessing local centres on foot or bike. (reliant on DfT/ TfL data for monitoring) Reduction in road accidents (reported annually)	LIP/ Major Scheme funding LBH capital budget contribution for regeneration works Staff time	LIP funding awarded annually following a three year delivery plan Major Scheme funding for 5 year plan from 2016/17 (2 years of design, 3 years of build)	Bob Flindall *ED* Chris Barter *Regeneration, ED* Chris Smart *Regeneration, ED*	Positive impact on local businesses Positive impact on transport network through new rail station		Currently on track towards end of year 1 according to TfL's gateway process. Aligning with Mayor's new Healthy Streets agenda.
	1.3	Continue to ensure that protection and safety of pedestrians and cyclists is a key factor in decisions regarding road design		Annual Casualty Reduction Programme – LIP funding	Annual Programme	Mark Philpotts *Street Care*	Casualty Reduction programme competing against other projects for LIP funding		In process of carrying out schemes that specifically help safe walking and cycling. This will continue under general work programme.
	1.4	Continue to deliver Safer Urban Driving (SUD) programme	Increased number of HGV drivers completing the training	TfL Borough Cycling Programme Funding	Training currently funded until April 2018	(John Lynn) Martin Day *Development & Transport Planning, RS*			Carried out in 2016/17 and continuing into 2017/18. 292 drivers trained between April 2016 and January 2017. Final numbers for 2016/17 will be available in April.
	1.5	Explore opportunities presented by Romford Market regeneration to increase access to healthy food	Healthy food offer, Health Impact Assessment integrated into market regeneration plans	LEP London Regeneration Fund LBH budget stream Officer time	Commence exploring opportunities April 2016	(Rebecca Davey) Lindsay Hondebrink *Regeneration, ED* Claire Alp/ Lindsey Sills *PHS*	Positive impact on market traders and potential opportunities for start-up food businesses		Romford Market and Town Centre regeneration is progressing. Public Health will be invited to input into future discussions with Market Traders Panel and other relevant colleagues/ forums. Scope opportunities to work with Market Traders to register to accept Healthy Start Vouchers.
Continue to improve the public transport offer	**1.6**	Public transport to improve as a result of Romford, Gidea Park and Harold Wood Stations Crossrail investment	Planned improvements in public transport infrastructure are completed.	TfL funding	Ongoing - Crossrail works in place by 2019	Bob Flindall Chris Smart	Positive impact on local businesses, commuters and environment		Works to Romford station commenced in Oct 2016, due to be complete August 2017. Works to Gidea Park and Harold Wood expected to commence in summer 2017 and are anticipated to complete in spring 2018.
	1.7	Exploit opportunities provided by the Rainham and Beam Park Housing Zone to improve transport accessibility	Active travel increases in line with increased use of public transport.	TfL funding	Ongoing as Housing Zone develops	Bob Flindall Chris Barter	London Riverside Opportunity Area		Council had mtg with Head of Network Development at London buses in Feb 2017 about aspirations for improved links. Hoping London Buses will be able to deliver new route between Harold Wood and Harold Hill in coming two years. Council is in process of commissioning feasibility study for new tram or light rail link between Romford and Rainham to support two emerging housing zones.

Shaping the environment to promote healthy eating and physical activity									
Strategy objective *What we are trying to achieve*	**Action No.**	**Project/ Action** *What we will do to achieve it*	**Outcome** *How we will know we've achieved it*	**Resources** *What we need to be able to achieve it*	**Timescale**	**Lead officer**	**Impact on other services and organisations**	**Progress** *RAG*	*Notes*
	1.8	Continue to lobby TfL tor improved north-south bus links and better links between hospitals	Improved bus access to Rainham to support Riverside development Increased bus capacity at Queens Hospital	TfL is responsible for bus routes	Ongoing as Housing Zone develops	Daniel Douglas	London Riverside Opportunity Area		
	1.9	Develop transport and smarter travel work in ine with the Mayor of London's new 'Healthy Streets' vision and Transport Strategy	Programmes align	TBC	TBC	Daniel Douglas *Development & Transport Planning, RS*			
	1.10	Improve public transport accessibility	95% of Havering bus stops reaching the Mayor's accessibility level.	TfL Bus Stop Accessibility Funding	By April 2017	Mark Philpotts			90% at 28/02/16, on track to achieve 95% by 31/03/17
Maintain and improve access to high quality green space	**1.11**	Install wayfinding and interpretation signage to strengthen linking of Lodge Farm Park, Raphael Park, Rise Park and Bedfords Park	More residents use the borough's green spaces for active leisure	Funding application in progress to be submitted to Veolia Environmental Trust	By April 2018	(Martin Stanton) James Rose *Parks & Open Spaces, C&L*	Increased footfall could have positive impact on trade in park cafés		No longer due to be grant-funded. Subject to Council approval will be carried out through capital funding in 2017/18.
	1.12	Explore funding opportunities to continue installing cycle parking in parks	Increased number of parking facilities in place	Reliant on funding opportunities from TfL	Report annually	(John Lynn) Martin Day			Borough Cycling Partnership funding ended in 2017. Will know in May 2017 whether funding will continue from an alternative source.
Improve the 'cyclability' of Havering	**1.13**	Explore opportunities to offer bike maintenance courses	Local residents attend bike maintenance courses	TfL Borough Cycling Programme Bid	By June 2017	(John Lynn) Martin Day			Four cycle hubs across borough will include maintenance courses. Operational from May 2017.
	1.14	Continue to promote British Cycling 'led' rides around the local area	Local residents attend SkyRide events	British Cycling (Sky Ride)	Report annually	(John Lynn) Martin Day			Let's Ride continues via British Cycling. Possibility for local led rides to be delivered through four cycling hubs in future.
	1.15	Cycle to Work scheme assists employees to purchase bikes to commute to work	Havering Council staff sign up to Cycle to Work scheme	Officer time	Report annually	(John Lynn) Martin Day			Was offered throughout 2016/17 and will continue into 2017/18.
Further improve schools as 'healthy' environments	**1.16**	Support schools to develop and update travel plans and continue to achieve STARS accreditation	Increased number of children, parents and staff travelling safely and actively. Monitoring integrated into programme including modal shift.	Officer time via TfL/ LIP funding	Report annually	Jay Amin *Development & Transport Planning, RS*			Continuing. 55 schools had active school travel plans in the 2015/16 school year.
	1.17	Continue to ensure meals meet school food standards in primary schools and work to implement standards in secondary schools	More CYP eating healthily, including disadvantaged CYP. Measure school meal take up in schools with menus that meet school food standards	Officer time HCS marketing	Report annually	Dennis Brewin *HCS, L&A* Claire Alp Tracey Wraight			Menus offered in primary schools continue to meet school food standards. Secondary school menus also meet the standards but a broader food offer (e.g. Grab & Go section) means students may not choose a balanced enough range of items for their meal to comply with the standards. Proposals are being developed for the HWiSS and HCS to further support schools around healthy eating promotion, provision and education.

Shaping the environment to promote healthy eating and physical activity									
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	1.18	Encourage secondary schools to adopt policies that require children to stay on site at lunchtimes	More schools adopt a stay-on-site policy. Monitor via Healthy Schools applications/ School Nursing Service 'Health Profile tool'.	Officer time School Nursing Service	Report annually	Tracey Wraight *HWiSS* (Natalia Clifford) Claire Alp *PHS* Breda Kavanagh *NELFT*			Scoping of 15 out of 18 secondary schools to date shows that: - 9 have a stay-on-site policy for all students - 3 allow only Year 11 students to leave the site as a daily or weekly priviledge - 3 allow only Years 12 and 13 students to leave the site. Information on other schools will continue to be gathered through the Healthy Schools programme and School Health Profiles. A session for school staff on how to develop a whole school food policy, which includes a recommendation to have a stay-on-site policy, but also covers wider issues around education etc will be delivered at the Healthy Schools Network meeting in March 2017.
	1.19	Work with schools to continue to improve playground physical activity environments	Monitor via Healthy Schools applications/ School Nursing Service 'Health Profile Tool'/ HSC. Training for playground supervisors offered by HSC/ HWiSS as required	PHS/ HSC Officer time School Nursing Service School buy-in (PE and Sport Premium/ other school funding)	Training offered 2017/18	Sharon Phillips *HSC* Claire Alp (Natalia Clifford) Breda Kavanagh			Integrated into School Health Profiles. HSC has run 19 sessions for midday supervisors/playleaders in positive play to date, with more to follow this school year.
	1.20	Promote regular runnning schemes in schools	Monitor via Smarter Travel, Healthy Schools and HSC data Add to School Health Profiles in Sept 2017.	Officer time School staff time	Update School Health Profile for September 2017. Report annually	Jay Amin Tracey Wraight Sharon Phillips			Encourage schools to integrate regular running/ walking initiatives into school day e.g. Havering Mile, Daily Mile, Schools Run, Golden Mile.
Ensure environment provided for clients / staff in public sector premises supports healthy choices	**1.21**	Develop, pilot and disseminate a practical tool to audit healthiness of public sector premises	Tool developed. Premises pilot tool to enable development of consistent healthy living ethos	Officer time	Tool developed and piloted by end March 2016	Lindsey Sills BHR NELFT CCG			Explored but focus is currently on the workplace health scheme rather than an additional tool.

Supporting a culture that sees healthy eating and physical activity as the norm									
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Ensure key decisions are consistent with healthy living ethos	**2.1**	Pilot a joint Equality Impact Assessment and Health Impact Assessment that promotes early consideration of equalities and health benefits (including physical activity and healthy eating)	Method agreed, piloted, evaluated and decision taken regarding wider roll out	Officer time	By end March 2017	(Savinder Bhamra) *Corporate Policy and Community* Elaine Greenway	Potential for other services/ organisations to utilise HIA after pilot		Currently under discussion and in progress.
	2.2	Commissioners/ procurement to explore whether wider health benefits can be considered as 'added value' when awarding contracts	More of the public sector's commissioning budget adds health value (not just the portion commissioning health and social care services)	Officer time	By December 2016	PH Commissioners			Incorporated into LAC placements contracts. Has become part of good practice and will continue in future.
	2.3	Explore cross-council commitment to Local Governmen Declaration on Healthier Food and Sugar Reduction	Declaration signed	Officer time	By July 2017	Claire Alp	Consider potential impact on other services during development		
Continue to ensure that schools support healthy choices and lifestyles	**2.4**	Encourage schools to integrate regular running/ walking initiatives into school day e.g. Havering Mile, Daily Mile, Schools Run, Golden Mile.	Monitor via Smarter Travel, Healthy Schools and HSC involvement in schools Add to School Health Profiles in Sept 2017.	Officer time School staff time	Report annually	Jay Amin Tracey Wraight Sharon Phillips			
	2.5	Research secondary school students' food choices on the way to and from school	Project carried out by dietetic students during September placement	BSc Dietetic/ Human Nutrition students	By October 2016	Claire Alp Tracey Wraight			
	2.6	Promote local Great Weight Debate survey to schools	Available on schools portal and used by schools developing healthy eating projects for HSL silver awards	Officer time	Ongoing	Miriam Fagbemi Tracey Wraight			
	2.7	Explore opportunities to offer Youth Health Champions programme to secondary schools	Decision made regarding introduction of programme	Officer time	December 2017	Tracey Wraight			
	2.8	Continue to develop HWiSS offer and bring into line with national Healthy Rating Scheme for schools	Programmes align	Officer time	National scheme due to be introduced in September 2017	Tracey Wraight			
	2.9	Develop stronger links between Healthy Workplace Charter and Staff Wellbeing section of Healthy Schools London awards	Programmes align	Officer time	By April 2018	Tracey Wraight Lindsey Sills			

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Continue to ensure that workplaces support healthy choices	**2.10**	Council and NHS organisations to actively participate in London Healthy Workplace Charter; share resources/ best practice	Up to date plan in place Evidence of on-going implementation Improvement against assessment criteria	Officer time	Ongoing	Lindsey Sills BHR			Havering Council had first strategic workplace health forum chaired by Cllr Brice-Thompson in January. Strategic direction agreed. Representatives from Havering Council attend BHRUT Workplace Wellbeing Steering Group at Queens Hospital
	2.11	Council to continue to run and promote workplace health activities at lunchtimes and after-work	Activities promoted and run Monitor attendance at events/ activities	Officer time Health and Sports Development budget for activities	Report annually	(Roxy Naz - on maternity leave) Maria Healy Lindsey Sills			As above - programme of activities run by Havering Council workplace wellbeing operational steering group (choir, yoga, book club, pilates)
	2.12	Council to consider using workplace health programme to promote walking meetings	Promotion of walking meetings via Yammer/ Global News "Walking" added to Outlook calendar locations	Officer time	By April 2018	(Mark Porter /Roxy Naz) Maria Healy Lindsey Sills			To be revisited in Workplace Wellbeing action plan (draft due to be ready April 2017)
	2.13	Explore opportunities to offer Pool Bike scheme to LBH staff (alternative to Pool Car scheme)	Scheme set up and available to staff	Reliant on TfL funding availability	By April 2018	(John Lynn) Martin Day			Continuing to explore. Intention is to commence in 2017/18 at Mercury House and Town Hall.
	2.14	Extend learning to private sector through Sustainable Travel pack	More businesses engage with sustainability agenda promoted via business pack	Officer time PH to offer input/ support	Ongoing	Martin Day	Positive impact on employee health in private sector		Began offering small grants to businesses in 2016/17 to support staff to travel actively. Two businesses have taken up this offer to date. Continuing into 2016/17.
	2.15	Promotion of TfL Cycling Workplaces scheme via Sustainable Travel pack/ other communications	More businesses utilise funding to install showers, bike parking etc	Officer time	Report annually	(John Lynn) Martin Day			Ongoing. MyPlace, Hornchurch Leisure Centre and Queens Hospital are also now applying under this scheme for cycle storage.
Continue to ensure the ethos of local education and community settings supports and encourages healthy choices		Explore opportunities to provide fresh fruit and vegetable snacks at Stay and Play sessions in Children's Centres.	Fruit and vegetable snacks provided.	Officer time Budget to buy/ regular donation of fruit and vegetables	By end of 2016/17	Helen Anfield *Early Help Service*			

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		Explore capacity to re-start Buggy Walks from Children's Centres and promote the Big Toddle	Buggy Walk Programme developed. Big Toddle promoted.	Officer time Volunteer time (to lead buggy walks)	By end of 2016/17	Helen Anfield *Early Help Service*			
	2.16	Transition support for Healthy Schools London awards to traded Health and Wellbeing in Schools Service	Support for healthy schools award is self-funding and hence sustainable in long term.	Officer time School buy-in	By end of 2016/17	Claire Alp	Competition for school budgets		Health and Wellbeing in Schools Service launched in April 2016. 16 schools have purchased the service to date Proposals are in development to further develop the HWiSS offer to provide additional teacher training. This will include support to improve healthy eating aspects of the curriculum and school environment and add value to the HSC's work to improve physical activity.
	2.17	HCS initiatives to increase uptake of school meals (L&A Service Plan) supported by HWiSS.	School meal uptake increases	Officer time HCS budget and officer time	Report annually	Dennis Brewin Claire Alp			01/02/17 This workstream is currently in development as part of the broader development of the HWiSS offer and Healthy Schools Officer role.
	2.18	Encourage FSM-eligible children to take up offer. - L&A/ Housing Benefits identify children eligible but not registered for FSM. Parents advised of eligibility on opt-out basis. Schools notified. - L&A FSM eligibility data cross-referenced with HCS take-up data. HCS and HWiSS encourage take-up.	Increased take-up of FSM by eligible pupils.	Officer time	Annual check carried out in December 2017	Dave Allen (L&A) Dennis Brewin Tracey Wraight	If additional children are identified through housing data as eligible for FSM, schools can also claim Pupil Premium funding.		Annual check carried out in December 2016. 280 additional pupils identified as eligible for free school meals but not currently taking this entitlement. These have been registered on an opt-out basis. Opt-out data to be obtained.
	2.19	Integrate PH messages into HCS communications	PH blog/ regular article on current topics e.g. Sugar Smart, School Food Plan & Ofsted, etc.	Officer Time	Termly article	Claire Alp Miriam Fagbemi Dennis McKenzie *HCS, L&A*			Two blogs provided by Public Health for HCS website. Further termly articles planned for the current school year.
	2.20	Ensure up-to-date, evidence-based nutrition advice provided in HCS menus and advertising	PH advises/ supports HCS as required	Officer Time	As required	Claire Alp Charlotte Newman *HCS, L&A*			Public Health passes information on new advice and guidance to HCS as it emerges and provides training where appropriate e.g. updating of Eatwell Plate to Eatwell Guide in April 2016
		Use HWiSS to support schools to increase healthiness of packed lunches	Schools publish robust School Food Policy and packed lunch guidance for parents on their websites.	Officer time	2017/18 school year	Tracey Wraight	Strict packed lunch policies can increase take up of school meals, increasing viability of		A session for school staff on how to develop a whole school food policy, which includes a recommendation to have a stay-on-site policy, will be delivered at the Healthy

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	2.21		HWiSS advises re. implementation to schools choosing to buy into service.	Template/ sample School Food Policy School staff time			school meal service		Schools Network meeting in March 2017. Plans are being developed to provide further training and support in the 2017/18 school year.
	2.22	Bikeability training and road safety support continues to be offered to schools	Bikeability courses delivered Road Safety and 'Safe Drive Stay Alive' roadshow delivered	TfL funding Officer time School buy-in	Report annually	(John Lynn) Martin Day Elaine Keeler *Development & Transport Planning, RS*			April 2016-Jan 2017 - 2286 children trained. Final 2016/17 figures will be available in April 2017. Year 11 students from all 18 Secondary Schools attended 'Safe Drive Stay Alive' in 2016/17 - a total of 3,200 students.
	2.23	Focus on adult cycle training	Adult cycle training courses delivered	TfL funding	By April 2018	Martin Day			(183 adults trained in 2016/17)
	2.24	Support schools to offer diverse programme of sport and health engaging whole school community	Monitored via Healthy Schools London bronze award/ HSC (No. of healthy lifestyle-related activities/ events for parents, no. of sports clubs coming into school etc) Support provided via HSC/ HWiSS where required	PHS/ HSC Officer time ?School Sport Premium/ other school funding School buy-in	2017/18 school year	Tracey Wraight Sharon Phillips			To date in Feb 2017, 31 schools have achieved Healthy Schools London awards. HSC supports 36 schools to run a Change4Life Sports Club, with up to 4 more expected to set up this school year. Most of these have 'C4L champions' and at least 10 schools have received training for this. HSC delivered 'Health Days' in 18 schools in 2015/16. A new model - 'Smart Days' is being delivered this year which has been piloted in 2 schools to date.
	2.25	Promote 'Parks Protection for Kids' Roadshow through HWiSS	Parks Protection assemblies listed on Bronze award guidance. Parks Protection assemblies session plan incorporates health messages	Officer time	Report annually	Claire Alp Stephen Rawlins *Parks Protection, C&L*			Parks Protection for Kids' assembly delivered to 6 schools in 2016/17. HWiSS will put offer on schools portal and support Parks Protection to increase uptake during 2017/18.
	2.26	Healthy eating session to be developed and delivered at Community Safety Junior Citizen Event (for Year 6 children)	Session plan developed Sessions delivered at annual two-week event	Officer time BSc Dietetic/ Human Nutrition students	Session plan updated by end May 2016 Annual event held in June/ July	Claire Alp Jane Eastaff *Community Safety, C&R*			July 2017 - 5 students were successfully recruited and were supported to develop a session plan. This was delivered over the 2 week period and positive feedback received. There is potential to repeat this model if the Junior Citizen event runs in 2017.
	2.27	Cooking in the Curriculum training to be delivered to teachers	School staff attend training	Officer time School buy-in	Report annually	Sharon Phillips Gill Mangham			Course scheduled to run at Redden Court School in March 2016. In the future, support will be offered in schools by the HSC instead of at a central venue by the HWiSS, in order to increase take-up and allow greater tailoring to schools' needs.
	2.28	Develop links between HSC health offer and HWiSS	HSC and HWiSS offers align/ complement each other	Officer time	By Sept 2016	Claire Alp			Continuing to work closely together and define service offers that align and complement each other.

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						Sharon Phillips			
	2.29	Develop links between Bedford's Park Walled Garden project and HWiSS	Food Growing training for teachers offered by BPWG as part of HWiSS Explore opportunities for BPWG Horticulture trainees to offer food-growing support to schools	- Officer time - Food Growing Schools: London resources - Grant funding (BPWG applying to City Bridge Trust) or schools fund	Course developed by Sept 2016	Claire Alp Kirsty McArdle *BPWG*	Food Growing Schools: London to support		BPWG has focused on offering support to schools close to Bedfords Park (Mead PS, Hilldene PS, Drapers Pyrgo Priory PS, St Ursulas JS, Drapers' Brookside JS and Harold Court PS) - contacts have been shared between HWiSS and BPWG. BPWG has also applied to be an Alternative Provision provider with Havering Education Services.
	2.30	Explore opportunities for healthy eating and physical activity training for PVI and nursery staff	Training courses organised and attended.	- External provider to deliver, funded by Early Years budget	Course dates agreed by Sept 2016 Training delivered 2016/17	(Susie Williams) Celia Freeth *Early Years QA, L&A*			This will be integrated into Healthy Early Years programme (see update below).
	2.31	Keep up-to-date with progress on Healthy Early Years London programme development	Viability of offering HEYL programme in Havering considered	Officer time	Determined by Greater London Authority	(Susie Williams) Celia Freeth Claire Alp Tracey Wraight			GLA is intending to pilot HEYL during Summer term 2017. We have expressed an interest in being a pilot borough.
	2.32	C&L Services facilities to continue to develop whole setting ethos that helps people to be healthy	PARS provided by leisure centre provider At least 50% of catering offer in leisure centres is healthy (including vending machines) Libraries, Fairkytes, MyPlace promote healthy eating and physical activity (including local clubs/ courses/ events)	Officer time Leisure provider Free PHE resources (e.g. Sugar Smart posters and packs)	Ongoing	Guy Selfe SLM *Leisure Centre Operator* *Jane Herbert MyPlace* *Nicky Dunne Libraries* *Lucy Shadwell Fairkytes*			Written into leisur provider contract. PARS Coordinator has TUPE'd across to SLM in order for this service to continue. SLM attends Obesity Prevention Working Group meetings and Public Health and Health and Sports Development teams will continue to support them with implementation of Sports & Activity Development plan and Community Health & Wellbeing Plan. This will include work on vending.
Coordinated programme of campaigns and marketing across partnership	**2.33**	Amplify national campaigns including Change4Life '10 Minute Shake Up', Change4Life 'Be Food Smart' and Sport England 'This Girl Can'	Increased awareness of campaign messages. Local press highlight support for campaign messages from Council / NHS partners	Staff time	In line with PHE marketing campaigns timeline	PH officers Comms officers *LBH and NHS*			Be Food Smart' campaign resources distributed to Council community facilities in January 2017. Good local press coverage. National Be Food Smart Roadshow in Romford for 2 days in February 2017.
	2.34	Consider capacity of Health Champions programme to roll out Great Weight Debate conversations	Great Weight Debate conversations carried out in community settings	Tapestry staff time Health Champion time	By April 2018	Claire Alp Lindsey Sills			Online Great Weight Debate survey promoted. Face-to-face debate held with Havering Youth Council. Youth Council pilot can be used to develop debates with other groups e.g. parents through Early Help, Health Champions
	2.35	Use opportunities presented by air quality	Short film/ animation made to promote smarter travel.	Mayor's Air Quality Fund	Film made by April 2016 Promoted during 2016/17	Martin Day Louise Dibsdall *PHS*			Miles the Mole animation completed. Communications plan to be delivered throughout 2017.

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						Louise Watkinson *EH*			
	2.36	NHS and LBH to sign up to high profile voluntary campaigns e.g. Children's Health Fund sugar levy	LBH sign-up to sugar levy explored by PH and HCS BHR sign-up to sugar levy explored via catering contractor representation on workplace health group LBH and BHR signed up to campaigns	Staff time	Report annually	Claire Alp Dennis Brewin Lindsey Sills			Since this action was planned, the new Sugar Smart Borough resource has been developed and will be promoted to hospitals plus other organisations during 2017/18 to improve healthiness of food offer in public and private sectors. https://www.sugarsmartuk.org/get_involved/#act
	2.37	Encourage independent restaurants and other organisations to sign up to high profile voluntary campaigns	Independent restaurants and cafes signed up to campaigns	Staff time Business web portal and e-newsletter	Report annually	Claire Alp Miriam Fagbemi Jolly Choudhury Business Development, ED	Positive press coverage for restaurants and cafes signing up		Since this action was planned, the new Sugar Smart Borough resource has been developed and will be promoted to local businesses plus other organisations during 2017/18 to improve healthiness of food offer in public and private sectors. https://www.sugarsmartuk.org/get_involved/#act
	2.38	Apply to Children's Health Fund to support projects targeted at improving children's health	Funding received and projects carried out	Staff time	Determined by Children's Health Fund	Claire Alp Other partners as relevant to funding criteria			First rounds of funding have not aligned with current priorities. We will continue to look at funding opportunities as they arise.
	2.39	Develop and launch community award to recognise efforts of individuals / community bodies to improve health	Local press highlight support from Council / NHS partners	Officer time	Developed by Dec 2016	Claire Alp/ Oriean Kay *PHS*			Focus this year for communications has been on a number of high profile campaigns of which full details emerged after this action plan was developed (Be Food Smart, Great Weight Debate etc). Community engagement will be pursued in 2017/18 through the Sugar Smart programme.(see action 2.29)
	2.40	Explore the viability of developing a borough food partnership/ charter	Shared food vision for Havering across public, voluntary and private sector stakeholders	Officer time	By Dec 2016	Claire Alp			Capacity to deliver this is low. Food and nutrition will continue to be integrated into the Obesity Prevention Working Group's discussions, and the Great Weight Debate work will continue to gather public opinion until a more specific food partnership can be developed.

Prompting individuals to change, primarily through self-help									
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Increase and import self-help capacity particularly regarding healthy eating	**3.1**	Ensure courses offered by Havering Adult College (including Family Learning, Education 4 Independence and Food courses) have a healthy lifestyle focus and incorporate up-to-date evidence-based nutrition advice	Course syllabi updated	LBH officer time	In line with HAC curriculum development: Aim for courses to start September 2017. Review/ revise Feb 2018.	Claire Alp Vedia Mustafa *HAC*			Delayed due to problems with recruitment of suitable staff. Teacher now appointed and courses in development.
	3.2	Evaluate Change4Life Challenge Clubs and consider how to sustain them	Evaluation report published HSC health offer further developed potentially incorporating Challenge Clubs	LBH/ HSC officer time Student Dietician PH placement School buy-in	Scope/ develop by Sept 2016 Report written Sept/ Oct 2016	Sharon Phillips Claire Alp			Evaluation report completed by student dietitians during three-week public health placement in September 2016. HSC offer now includes a version of C4L Challenge Clubs. To date one primary school has purchased this programme.
	3.3	Early Help universal offer to promote healthy lifestyles including sessions run in Children's Centres and promotion of Healthy Start scheme	Early Help staff report that sessions run in Children's Centres (e.g. Music and Movement, Messy Play, Preparing for Birth) include advice on healthy lifestyles.	Early Help budget and staff time Partners' staff time (e.g. midwives) PH support as required to ensure up-to-date advice is provided	Develop during 2017/18	Helen Harding Helen Anfield Linda Parsons (Jacqui Hanton) (Jonathan Taylor) *Early Help*			Following restructure of Early Help team a wider piece of work has now commenced to integrate health services (e.g. Health Visiting) more effectively into Children's Centres. Programme of sessions will continue to be expanded as this develops and Healthy Start promotion will be further developed.
	3.4	Early Help targeted offer - TBC depending on restructure.	TBC	TBC	TBC	TBC			As above.
	3.5	Support Community Safety team to incorporate healthy recipes and signpost to support (e.g. NHS Choices, Healthy Start vouchers) into Cooking on a Budget booklet	Booklet updated to incorporate health aspects	Officer time Community safety budget to design/ print booklet	By end March 2017	Chris Stannett *Community Safety, C&R* Claire Alp	Potential for other services to use booklet (e.g. Social Workers)		Update no longer going ahead due to budget cuts. Chris will be happy to support future update if we can find other means of financing or incorporate into another piece of work e.g. if healthy cooking sessions in Children's Centres go ahead.
	3.6	Health and Sports Development to promote healthy eating in correspondence to sports clubs to raise awareness of evidence-based sources of information/ advice e.g. NHS Choices, HAC courses etc.	Healthy eating information included in communications to sports clubs/ community organisations	Officer time Dedicated space in communications (e.g. e-newsletter) to organisations	By end March 2018	Daniel Alleyne			Building up communications with clubs. Putting updated Healthy Weight webpages link into leaflets and on Havering Active website.

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	3.7	Continue to deliver coordinated physical activity opportunities to enable to residents to participate and change behaviour e.g. healthy walks, adult physical activity programme, dance programme, school holiday programme.	Programmes run	Culture and Leisure budget	Report Annually	Guy Selfe			Activities continue to be delivered. Further details available at: www.havering.gov.uk/sportsdevelopment
	3.8	Promote new online weight management service when launched by PHE.	Links to PHE weight management tools provided on LBH Healthy Weight webpage. Promote PHE weight management tools through communication channels and partners e.g. NELFT, Early Help Service	Officer time	Dependent on PHE timescale	Claire Alp			
Ensure that residents and professionals working with them are aware of relevant (self-help) resources	**3.8**	As part of obesity care pathway development, ensure the Family Services Directory and PH website list services and support relevant to healthy eating, physical activity and weight management	Residents can access the support that best meets their needs GPs and other health professionals sign residents to these directories	Officer time	By April 2017	Fatema Ahmed (Katie Gray *Early Years Alternative Provision)* Claire Alp			New Healthy Weight webpage has been developed for the LBH website: www.havering.gov.uk/achievingahealthyweight Information is currently being gathered for the new Family Services Hub. This website is due to go live in March 2017.
	3.9	Continue to recruit and train Health Champions	100+ Health Champions trained during 2016/17	PH grant	Health Champions trained by April 2018	Lindsey Sills	Communities/ businesses benefit from improved support/ knowledge		100 trained 2016/17. New contract to be issued for 1 year (2017/18).
	3.10	Continue to offer Health Champions follow-on modules in healthy eating and physical activity	2 healthy eating and 2 physical activity courses offered during 2016/17	PH grant	Courses run by April 2018	Lindsey Sills	Communities/ businesses benefit from improved support/ knowledge		2 of each delivered in 2016/17. Will continue to deliver as part of 2017/18 contract.
	3.11	Support HSC to pilot YMCA Young Health Champions programme, consider future offer to schools and links to RSPH Health Champions	YMCA Young Health Champions pilot run. Future offer to schools scoped and developed as part of the HSC offer.	Officer time	Pilot completed and offer developed by end 2016/17 school year	Sharon Phillips Claire Alp			HSC is piloting Young Health Champions during the 2016/17 school year. This won't be rolled out to other schools but will be used as a case study to
	3.12	Explore options for low-cost/ cost-neutral MECC online training for NHS staff	Recommendation made subject to funding	Staff time	Make a recommend-ation by end March 2018	Clare Burns *CCG* BHR NELFT Lindsey Sills			MECC is now integrated into RSPH Health Champions training syllabus revised Jan 2017. Update to be sought from NHS organisations regarding staff training in 2017.
	3.13	Align NHS Health Checks programme with PH campaigns	Promote One You campaign to GPs (due to be launched 7th March 2016)	Staff time	Communicate to GPs by September 2016	Lindsey Sills			Completed March 2016

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Ensure care and support provided to vulnerable residents addresses wider health needs including healthy eating and physical activity	**3.14**	Explore opportunities for social worker training on healthy eating and physical activity (potentially via PH advice or Health Champions healthy eating and physical activity modules)	Training delivered. Social workers confident in sourcing reliable, up-to-date healthy eating information and signposting carers to this. Healthy eating and assisted shopping support incorporated into Care Plans.	Officer time Health Champions programme budget	By end March 2017	Lindsey Sills Debbie Redknapp *JCU, CS*			Current priority for Children's Services is for Social Worker training to focus on systemic family therapy training so Health Champions training will not be pursued at this time.
	3.15	Encourage vulnerable families, in-house foster carers and adoptive parents to make use of available healthy lifestyle support and training e.g. HAC Family Cookery course	Vulnerable families, in-house foster carers and adoptive parents attend available courses Timely and improved attendance in relation to health assessments	Officer time Training budgets for courses Existing information/ resources (e.g. NHS Choices)	By end March 2018	Robert South *CS* Gary Jones/ Lisa Reid *CS*			Change in staffing. Action will be followed up in 2017/18.
	3.16	Integrate healthy eating and physical activity requirements into children's Care Plans	Children's social workers monitor via 6-weekly visits Independent reviewing officers monitor in biannual children's LAC reviews Supervising social workers monitor via annual review of foster carer	Officer time Existing information/ resources (e.g. NHS Choices) Consider capacity to monitor knowledge/ behaviour change amongst carers, children and young people (e.g. baseline and review questionnaire)	By end March 2018	(Robert South) *CS* (Gary Jones/ Lisa Reid) *CS*			Change in staffing. Action will be followed up in 2017/18.
	3.17	Explore opportunities to integrate greater support for healthy eating and physical activity into commissioned care packages	Included in contracts with placement providers	Officer time	By end Dec 2016	Debbie Redknapp *CS*			Contracts with placement providers now requires providers to support LAC to cook healthy meals from scratch.
Ensure obese women are effectively supported during pregnancy	**3.18**	Review antenatal care pathway		As a minimum, officer/ clinician time	Ongoing	Mark Ansell *PHS* *NELFT*			
Ensure mothers are supported with infant feeding	**3.19**	Ensure infant feeding support is promoted Offer support through infant feeding cafes	NEL infant feeding leaflet distributed Infant feeding cafés continue in two children's centres Havering Breastfeeding Steering Group continues to meet regularly with cross-organisation representation Children's Centre staff access UNICEF training	NELFT budget and officer time PH budget for Children's Centre staff training LBH staff time Breastfeeding Peer Supporters (NCT and LatchOn) time	Report Annually	PH / CCG / CSU commissioner			NEL Infant feeding leaflet distributed in Children's Centres. 1 member of the Early Help team has completed Level 3 UNICEF training, 1 further members is Infant feeding cafés are continuing to run in Collier Row and Elm Park Children's Centres.

Prompting individuals to change, primarily through self-help									
Strategy objective *What we are trying to achieve*	**Action No.**	**Project/ Action** *What we will do to achieve it*	**Outcome** *How we will know we've achieved it*	**Resources** *What we need to be able to achieve it*	**Timescale**	**Lead officer**	**Impact on other services and organisations**	**Progress** *RAG*	*Notes*
	3.20	NHS (maternity and HVs) and early years settings to adopt a consistent, evidence based approach to breastfeeding (ideally working towards Baby Friendly accreditation) and weaning practice	Increase in breastfeeding rates.			Helen Anfield *Early Help, CS* Claire Alp/ (Natalia Clifford)			Havering Breastfeeding Steering Group meetings will continue in 2017.
Ensure care pathway is in place for obese children and adults	**3.21**	Review and agree care pathway for obese children and adults	Equitable access according to need to limited resources	Officer time in first instance	Ongoing in line with STP development	Mark Ansell Clare Burns			No progress to date. Obesity is the the STP as one of the prevention priorities and pathway will be agreed in future.

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD, 15 March 2017

Subject Heading:	**Update on North East London Sustainability and Transformation Plan**
Board Lead:	**Conor Burke, Accountable Officer, Barking & Dagenham, Havering and Redbridge CCGs**
Report Author and contact details:	**Ian Tompkins, Director of Communications & Engagement, NEL STP 07879 335180** ian.tompkins@towerhamletsccg.nhs.uk

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

- ☒ Theme 1: Primary prevention to promote and protect the health of the community and reduce health inequalities
- ☒ 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: Quality of services and user experience

SUMMARY

This report (to be given verbally at the meeting on 15 March) provides a further update to the Board on the development of the north east London Sustainability and Transformation Plan (known as the NEL STP) and in particular the proposed shadow governance arrangements, which are currently 'work in progress'.

On 21 October we submitted an updated narrative, updated summary and delivery plans to address our local priorities to NHS England. Further work is continuing to develop the plan in more detail; additional updates will be presented to the Board as they become available. For more information go to http://www.nelstp.org.uk or email: nel.stp@towerhamletsccg.nhs.uk

RECOMMENDATIONS

The Health and Wellbeing Board is recommended to:

Note the officer update on the NEL STP (latest narrative attached).

No formal decisions are required arising from this report.

REPORT DETAIL

1. Background

1.1 In December 2015 NHS England planning guidance required health and care systems across the country to work together to develop sustainability and transformation plans (STPs).

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

2. Proposal

2.1 Latest STP narrative attached. Officers will update on any recent developments and issues.

3. Engagement

3.1 We recognise that the involvement of local people is crucial to the development of the STP. Since we submitted the original draft STP in June 2016 we have been engaging partners, including Healthwatch, local councils, the voluntary, community and social enterprise sector, and patient representatives. The initial feedback we received on the original draft was incorporated into the revised STP for the October 2016 submission.

3.2 Work to obtain further feedback is ongoing. Since October and continuing to February 2017, local Healthwatch organisations are working together to help us gather and understand the views of patients and communities. They will

focus on gauging public views on a) promoting prevention and self-care b) improving primary care and c) reforming hospital services.

4. Financial considerations

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

5. Legal considerations

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

6. Equalities considerations

6.1 An equality screening has been completed to consider the potential equality impact of the proposals set out in the NEL STP. This can be viewed at http://www.nelstp.org.uk and includes:

- An overview of all the initiatives included in the NEL STP narrative to determine at which level equality analyses should be undertaken i.e. NEL STP level, Local Area Level, CCG/borough level or London-wide level.
- An initial assessment of the NEL STP overarching 'Framework for better care and wellbeing'.
- Actions to be undertaken during further detailed equality analyses.

The screening recognises that the initiatives included in the STP will be implemented at different times, hence further equality analyses will need to be undertaken over the life of the STP programme.

BACKGROUND PAPERS

None

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

DRAFT- POLICY IN DEVELOPMENT

21 October 2016

North east London: Sustainability and Transformation Plan

Transformation underpinned by system thinking and local action

Contents

Guide to reading this document

- Acronyms used throughout the document are explained in the appendix, page 51.
- We assign specific symbols to each of our six key priorities, introduced on page 6. Where a section addresses a key priority, the relevant symbol is shown in the top right corner of the page.
- Deliverables are outlined at the end of each chapter or section, where applicable, and detailed deliverables are available in the appendix, pages 47-48.

1. Executive Summary

We want people in north east London (NEL) to live happy and healthy lives. To achieve this, we must make changes to how local people live, access care, and how care is delivered**. During 2016, 20 organisations across NEL have worked together to develop a sustainability and transformation plan (STP).** This builds on our positive experiences of collaboration in NEL but also protects and promotes autonomy for all of the organisations involved. Each organisation faces common challenges including a growing population, a rapid increase in demand for services and scarce resources. We all recognise that we must work together to address these challenges; this will give us the best opportunity to make our health economy sustainable by 2021 and beyond.

We have adopted a joint vision:

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.

NEL is an area with significant health and wellbeing challenges. Our population is set to grow by 18% in the next fifteen years, and five out of our eight boroughs are in the lowest quintile for deprivation in the UK. Health inequalities are high, with many residents challenged by poor physical and mental health driven by factors such as smoking and childhood obesity. People frequently move around the patch and are highly dependent on secondary care. This makes our challenges unique and places significant pressure on local services.

We have developed a NEL level framework that will ensure every patient receives the same level of high quality care. Our primary ambition is to support local people to manage their own health. On this basis we have built a framework designed to deliver consistent primary care across NEL, promote out-of-hospital services, ensure good mental health, encourage preventative activities and champion interventions which tackle the wider determinants of health and wellbeing. This framework will be guided by the principle of “system thinking and local action” to enable system-wide change, while allowing for local flexibility.

We want our hospitals to provide care that is safe, effective and efficient every time. The majority of our hospitals have underperformed in recent inspections and continue to fail to meet some of the expected standards around waiting times. We want our hospitals to attain a world class reputation for services, and plan to establish this through developing ambulatory care, surgical hubs and streamlined outpatient pathways. This will help us to tackle operational challenges and provide safe and compassionate secondary care.

Providers have a unique opportunity to increase their productivity through collaboration. Cost improvement programmes will no longer be enough to achieve the scale of efficiency required to address our system-wide financial challenge. The STP has given providers the impetus to co-design new opportunities for productivity and service efficiency improvements beyond traditional organisational boundaries. This will give us the strongest opportunity to achieve savings on the scale set out in the Carter Review.

Our vision for better care and wellbeing will be supported by system reform including the development of new and more collaborative commissioning and provider models. Across NEL, we have already started to develop innovative commissioning models (for example capitated budgets in Waltham Forest and East London, WEL) and work is ongoing to explore further opportunities through our devolution pilots (Barking, Havering and Redbridge, BHR and City and Hackney, CH). Our providers are also working differently to ensure their organisational governance and staffing models can support the shift to integrated care and an emphasis on out-of-hospital interventions.

As part of this transformation, we have identified workforce, technology and infrastructure as key enablers which will require investment and development. Without this, we will not succeed in implementing better care and wellbeing for people or a sustainable system-wide position.

Our total financial challenge in a ‘do nothing’ scenario would be £578m by 2021. Achieving ambitious ‘business as usual’ cost improvements as we have done in the past would still leave us with a funding gap of £336m by 2021. Through the STP, we have identified a range of opportunities and interventions to help reduce the gap significantly. This will be aided by Sustainability and Transformation Funding (STF) funding, specialised commissioning savings and potential support for excess Public Finance Initiative (PFI) costs. Significant work has started to evaluate the savings opportunities, particularly on specialised commissioning.

We have developed our governance structures to support the next stages of planning and implementation. Our robust governance structure allows individual organisations to share responsibility while balancing the need for autonomy, accountability and public and patient involvement.

The NEL transformation journey has started. We are committed to meeting all NHS core standards and delivering progress in every priority. Together we will deliver a sustainable health and wellbeing economy across NEL. **It’s a significant challenge, but one we welcome as it provides opportunities to make a real and lasting difference to the lives of local people**.

2. NEL Care, Quality and Wellbeing Challenges

There are a number of challenges NEL is facing from a health and wellbeing as well as a care and quality perspective which are summarised below and on page 5. For a summary of the financial challenges see chapter 7.

Health and wellbeing challenges

Demographics

- There is significant **deprivation** (five of the eight STP boroughs are in the **worst Index of Multiple Deprivation quintile**). Estimates suggest differentially high growth in ethnic groups at increased risk of some priority health conditions.
- There is a significant **projected increase in population** of 6.1% in five years and **18% over 15 years**. This population is also highly mobile, with residents who frequently move within and between boroughs.
- There are significant health inequalities across NEL and within boroughs, in terms of **life expectancy** and **years of life lived with poor health.**

Wellbeing

- NEL has higher rates of **obesity among children** starting primary school than the averages for England and London. All boroughs have cited this as a priority requiring system-wide change across the NHS as well as local government.
- **Health inequalities** remain a significant issue in NEL with diabetes, dementia and obesity all disproportionately affecting people in poverty.
- NEL has generally high rates of **physically inactive adults.**

Long-term conditions

- There is an increased risk of mortality among people with **diabetes** in NEL and an increasing 'at risk' population. The proportion of people with Type 1 and Type 2 diabetes who receive NICE-recommended care processes is variable. Primary care prescribing costs are high for endocrine conditions (which includes diabetes).
- **Cancer screening uptake** is below the England average and emergency presentation is 5% higher than the national average.

Mental health

- With a rising older population, continuing work towards early diagnosis of **dementia** and social management will remain a priority. Two of seven CCGs are not hitting the **dementia diagnosis target.** Right Care analysis identified that for NEL, rates of admission for people aged over 65 with dementia are poor.
- Most CCGs, but not all, are meeting **Improving Access to Psychological Therapies (IAPT) access targets.**
- Parity of esteem has not yet been achieved across NEL.
- Acute mental health indicators in the Mental Health task force report identify good performance, however **concerns have been identified with levels of new psychosis presentation.** Further work is required to quantify and respond to challenges such as **high first episode psychosis rates.**
- There is a **low employment rate** for those with mental illness.

Care and quality challenges

The care and quality challenges outlined below exist across NEL. They are present in some CCGs, but may not necessarily be in all. We recognise there are some areas of excellent care and quality; nevertheless, the challenge remains substantial. The rest of this document presents several solution and plans that will help reduce and ultimately resolve all of our challenges across NEL.

Core Standards

- Two of three acute trusts failing A&E 4hr target waits.
- Two of three acute trusts failing to return monthly 18 week RTT pathway data.
- Two of three acute trusts (six out of seven hospital sites) in special measures after CQC inspections.
- All seven CCGs failing 75% Category A ambulance response times within eight minutes.
- Variation in emergency bed days and GP referral rates across all seven CCGs.

7 Day Services / UEC reforms

- Inconsistent consultant assessment for emergency admissions across specialities in NEL providers (standard two).
- Inconsistent consultant ward reviews across specialities in NEL providers (standard eight).
- A need to support patient activation and self-care.

Mental Health

- Further work is needed to improve the wider determinants of mental health.
- Inconsistent diagnosis rates of dementia in NEL GPs, with 2 CCGs failing to meet the standard
- National Standard began in April 2016 for 50% of people with first episode psychosis to begin evidence-based treatment within 2 weeks. All CCGs/providers are meeting this target.
- Submission made on 16 September, identified £2.2m of funding across 3 years for perinatal mental health across NEL.

Learning Disabilities

- Do not currently meet National Service Model standards for patients with learning disabilities.
- Greater focus required on community and prevention services including dental care, type two diabetes, and breast screening.
- Workforce training required to equip staff with the skills and knowledge to support patients with learning disabilities and autism.
- Need to build capability and capacity within communities to support people with autism and avoid unnecessary hospital admissions.

Primary Care

- CCGs below national average on Patient Survey for success in getting an appointment and ease of getting through on the phone.
- Demand for appointments is rising with GP consultation rates increasing.
- Highly mobile population and high practice list turnover generating further demand.
- Challenge in securing the primary care workforce with example of more than 25% of GPs being beyond retirement age in one borough.

Maternity

- The increase in births presents a significant challenge to capacity for maternity services.
- There is currently under utilisation of midwifery led care pathways and birth settings.
- There is a lack of continuity of care across the maternity pathway and women's experiences of care are often reported as being poor.
- Variation in benchmarked data of UK perinatal deaths for births across NEL providers.
- Many more women with complex health needs are now becoming pregnant.

Patient Experience

- Inconsistent patient experience results from Friends and Family Test for A&E, inpatients, maternity and outpatients.
- Inconsistent patient experience results from Friends and Family Test for mental health providers.
- In some areas, only 22-29% of patients are dying in their preferred place of residence.

Cancer

- The cancer treatment pathway is very fragmented with many challenges.
- Emergency cancer presentations are 21.1% in NEL (20.6% England average indicates worse survival rates at one year).
- Lower one year survival rate for all cancers across all seven CCGs compared to all survival rates across England.

Right Care

- In cluster comparison of Right Care data, cancer survival is a key area of improvement across NEL.
- Mental health, patient experience, prevention and new models of care are other key opportunity areas for NEL commissioners.
- Potential savings through primary care prescribing:
  - £5-10m in endocrine
  - £3m in respiratory
  - £1-2m in each of CVD, GI and MSK.

Specialised Commissioning

- Delivery of constitutional standards for RTT, 62 day wait for cancer.
- Resolution of local derogations for certain specialties for example chemotherapy, specialised neurology, NICU.
- Key strategic intervention in NEL is the joint work on neuro-rehabilitation.
- Service reviews for the transfer of cardiac services from UCLH, trauma, and cancer Services.
- NICU capacity.

Workforce

- Unable to maintain services; there is a need to recruit and retain to ensure we are able to maintain services in the face of an ageing workforce.
- Over-reliance on agency use.
- A need for the development of new roles/extended scope and skills.
- A need for multidisciplinary teams working to support new care models.

Technology

There is a need across NEL to:

- Provide the infrastructure necessary to support new, connected, ways of working.
- Provide clinicians with a full view of the patient electronic health record in real time that is editable and supports bookings across services.
- Deliver population health through real time risk stratification scoring.
- Enable patients to view their own care records and to make bookings in to their primary care providers.

Our key priorities

Whilst each of our economies has a different starting point, on the basis of the NEL-wide challenges set out we have identified six key priorities which need to be addressed collectively.

The right services in the right place: Matching demand with appropriate capacity in NEL

See Better Care (p7)

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

Encourage self-care, offer care close to home and make sure secondary care is high quality

See Better Care (p7)

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

Secure the future of our health and social care providers. Many face challenging financial circumstances

See Better Care (p7)

Many of our health and social care providers face challenging financial circumstances. Although our hospitals have made significant progress in creating productivity and improvement programmes, we recognise that medium term provider-led cost improvement plans cannot succeed in isolation.
Our providers need to collaborate on improving the costs of workforce, support services and diagnostics. Our challenge is to create a roadmap for viability that is supported at **a whole system level** with NEL coordinated support, transparency and accountability.

Improve specialised care by working together

See Specialised Services (p22)

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

Create a system-wide decision making model that enables placed based care and clearly involves key partner agencies

See Governance (p36)

Our plans for proactive, integrated, and coordinated care require changes to the way we work in developing system leadership and transforming commissioning. We have plans to develop accountable care systems (ACS) with integrated commissioning with Local Authorities and capitated budgets. Across NEL, we recognise that creating accountable care systems with integrated care across sectors will require joining previously separate services and close working between local authorities and other partners; our plans for **devolution** have made significant progress in meeting the challenge of integration. New models of system leadership and commissioning that are driven by real time data, have the ability to support delivery models that are truly **people-centred and sustainable** in the long term.

Using our infrastructure better

See Infrastructure (p30)

Delivering new models of primary and secondary care at scale will require modern, fit-for-purpose and cost-effective infrastructure. Currently, our workforce model is outdated as are many of our buildings; Whipps Cross, for example, requires £80 million of critical maintenance. This issue is compounded by the fact that some providers face significant financial pressures stemming from around **£53m remaining excess PFI cost**. Some assets will require significant investment, others will need to be sold. The benefits from sale of resources will be reinvested in the NEL health and social systems. **Devolution** will be helpful in supporting this vision. **Coordinating and owning a plan** for infrastructure and estates at a NEL level will be challenging; **we need to develop approaches to risk and gain share that support our vision.**

3. Better Care and Wellbeing

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

Our shared framework for better care and wellbeing

How we will deliver our system vision

Promote prevention and personal and psychological wellbeing in all we do

In the first instance, we aim to prevent illness and promote personal and psychological wellbeing in our population, with a focus on tackling health inequalities. By taking a proactive approach to disease prevention, we are addressing unhealthy behaviours that may lead to serious conditions further down the line and thus reducing the burden on the healthcare system. We are committed to acting on the London Health Commission's research on prevention[1]. Through the sharing of information between the different stakeholders, we will ensure that people who are at risk are targeted and appropriate interventions are put in place before escalation.

We will also promote self management by helping people to identify resources available to them that promote personal health and wellbeing. Motivating people to take ownership of their health is crucial to our system vision. Healthy behaviours such as physical activity and leisure will be promoted through mechanisms such as social prescribing to empower people to maintain their health and wellbeing.

As environmental factors are important in influencing people's health and wellbeing, we will also work with local authorities to promote healthy environments to enhance the quality of life for people in NEL. We have significant health inequalities and deprivation, which presents an additional challenge. By linking in with housing, employment and education, we are better able to address the needs of our population.

Promote independence and enable access to care close to home

In our bid to deliver care close to home, we will use a delivery model to wrap support around the individual. This delivery model will integrate primary, community and social care.

1. People will be well informed regarding the resources and services that are available to them, empowering them to choose the most appropriate pathway for their care, reducing the number of unnecessary admissions and A&E attendances.
2. The foundation of our model is primary care collaboration at scale with hubs, networks and federations treating populations of up to 70,000 people, accessible 8am-8pm, 7 days a week.
3. For people with complex health and social care needs, we will deliver coordinated care to support their health and wellbeing.

Ensure accessible quality acute services

Whilst we need to ensure that people receive high quality care close to home, it is important that when people fall seriously ill or need emergency care, local hospitals provide strong, safe, high-quality and sustainable services. Given the significant population rise, our challenge is to ensure we reduce any unnecessary admissions and attendances, and have best in class length of stay for both planned and unplanned care.

In accordance with the Briggs report, 'Getting It Right First Time', our goal is to identify and administer the correct treatment at the appropriate time to standards. We also want to work towards achievement of the London Quality Standards.

1. We will enhance triage in urgent and emergency care settings so that patients receive the appropriate care at the right time according to the severity of their need. Only patients who require more intensive care are admitted, improving bed capacity.
2. If possible, we will take advantage of appropriate consolidation of planned care services to allow for better outcomes and efficiency. In this way, there will be more effective use of experienced staff and specialised equipment available, enhancing clinical productivity.
3. We want to avoid people spending more time than necessary in hospital. We aim to address this through mechanisms such as early support discharge and greater capability and capacity in the community to help people recover and return home.

[1] The London Health Commission was an independent inquiry established in 2014 by the Mayor of London to examine how London's health and healthcare could be improved for the benefit of our population. In response to its recommendations and unprecedented engagement with Londoners, all London health and care partners (Londoners 32 CCGs, 33 Local Authorities, NHS England (London) and PHE (London) and the GLA) committed to the overarching goal of making London the healthiest major global city and 10 supporting aspirations as laid out in 'Better Health for London: Next Steps'. We remain committed to this shared London vision and working with London partners in achieving this goal and aspirations.

Promote prevention and personal and psychological wellbeing in all we do

- Smoking cessation
- Diabetes: NEL-wide coverage of the NDPP
- Workplace health
- Development of other initiatives including: alcohol, childhood obesity, mental and sexual health, hypertension
- 'Making Every Contact Counts'
- Embed prevention throughout our transformation plans

We recognise that NEL is unique in its diversity and the strength of its communities. Each part of this plan recognises that the citizen and patient are part of a vibrant neighbourhood community. We will build on our existing local health and wellbeing strategies and public health initiatives to ensure services are built around, and support neighbourhoods, so the places where people live enable good health.

These places may include home, school, the workplace or community settings.

We are committed to acting on **Healthy London Partnership's** research that suggests we can improve the lives of residents and reduce demand on services through enabling people to change their behaviours. This is especially true with smoking, drinking and physical activity.

To encourage people to help themselves and take control of their lives, we will extend social prescribing as one of the ways to recognise the value of neighbourhoods and build on the social capital that people hold, while creating less dependence on services. Staff also need to be supported to be agents of change and 'Make Every Contact Count'. This will include a system-wide focus on smoking cessation.

Wider determinants of health

Working in partnership with and through local authorities and communities in this way allows us to tackle the wider determinants of health (in line with Marmot principles):

"The conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life ... Including economic policies, development agendas, social norms, social policies and political systems" - World Health Organization

Health interventions alone cannot deliver the change required to tackle these factors and enable our population to better manage their own health and wellbeing. We will focus our work across the system to deliver this change:

1) Early years, schools and healthy families

Local government is driving the "early help offer" by integrating health visiting, children's centres, nursery education and other services so children are ready to learn. A stronger focus on nutrition and dental health in the early years will enable a reduction in childhood obesity and unnecessary hospital admissions for dental caries.

The Healthy Schools programme is being driven by schools and is making an impact on healthy choices. Schools are a major contributor in focusing on prevention including raising awareness of addictions to drugs, alcohol and smoking. Working with Child and Adolescent Mental Health Services (CAMHS), schools help to build resilience and mental wellbeing in young children and communities.

As we develop new care models across NEL, we will seek to integrate education services at a neighbourhood level and look at how social prescribing can promote education interventions, as well as aligning the early years offer to those wanting to start families. We aim to widen the roll-out of education interventions to reduce the prevalence of obesity (and Type 2 diabetes) and improve the health and wellbeing of children and young people to exceed Public Service Agreement.

2) Environment, leisure and physical activity

Green open spaces and transport systems that promote physical activity and healthy lifestyles can have a major impact on health and wellbeing. We will continue to work together to expand ways to maximise these resources and encourage their use through social prescribing.

Tailored behaviour change support will address Type 2 diabetes and obesity levels through the National Diabetes Prevention Programme. We will also address hypertension through tailored behaviour changes.

3) Housing and planning

We recognise NEL has a lack of affordable housing, and high levels of overcrowding and homelessness, which will be exacerbated as our population grows. This requires us to collaborate to better influence decisions on new building developments, ensuring health impact assessments are conducted. We already utilise the Healthy Urban Development Unit (HUDU) model to help us access Community Infrastructure Levies (CIL) that guarantee there is funding to build the facilities that ensure our developments support health and wellbeing.

We will also monitor pilots for private sector licencing schemes to understand the impact on housing quality and feasibility to roll out across NEL.

We will ensure health and housing interventions are better aligned by commissioning joint pathways to ensure that those who need support, such as falls adaptations, are able to receive it in a timely manner.

4) Employment

The link between good mental health and wellbeing in employment is well established. We will learn from pilots (planned or underway) across NEL such as wellbeing hubs, which combine health and employment services in one location. We will extend the scope of these hubs to include housing support to address the shortage of affordable housing for our key workers.

One of the success measures of substance misuse services is employment. This principle will be widened to other services. We will explore options for outcomes based commissioning in this area through the BHR Accountable Care System (ACS) work.

There are also opportunities to better link the recruitment challenges we have in health and care services with employability services in the community. This will provide an opportunity to upskill local people to fill local vacancies.

We will work together to create additional internship and apprenticeship opportunities in the health sector for young people, building on the work already underway at Barts Health. As part of the WEL Transforming Services Together (TST) programme, we are specifically exploring new courses to support people into new roles such as physician associates and advanced nurse practitioners.

Multidisciplinary primary care staff will widen access to primary care including an expanded and integrated role for pharmacists and Allied Health Professionals (AHPs).

Through these combined activities, we aim to empower people of NEL, and reduce their dependency on services.

Promote independence and enable access to care close to home

- People will be well-informed about the resources and services that are available, empowering them to choose the most appropriate pathway for their care
- Support the development of primary care collaboration at scale with hubs, networks and federations
- Improve the population mental health and wellbeing
- Enable all people to access a consistent high quality integrated urgent and emergency care

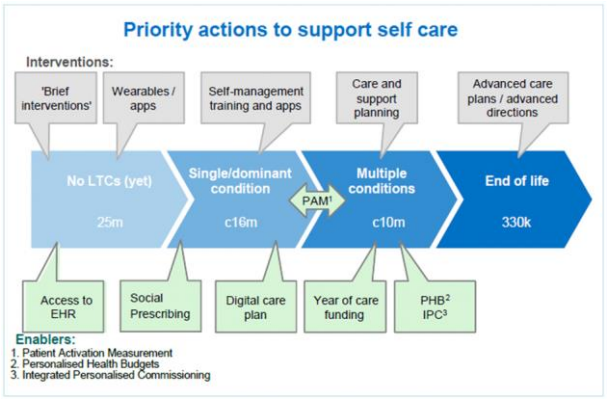
To bring alive the system-wide vision we have for NEL, we have identified a number of service transformation programmes.

Self-care management and patient activation

Self-care happens when patients are 'activated'. We will promote better self-care, not only by providing better information and resources, and easy access to advice (for example pharmacy) but also through the millions of encounters with health and social services in NEL every year.

A crucial enabler of self-care is IT literacy; residents need to have the skills and the access to technology to identify the right information at the right time and use technology as a route to proactive self-management.

Self-care approaches can be used at all stages of ill-health, with the greatest impact likely to be for those who are living with long-term conditions, frailty or at end of life (see national profile below).



Self-care has the potential to reduce activity across the pathway and can be applied for a range of conditions, as such the scope of potential impact is broad.

We intend to further develop and scale up our range of self-care schemes, based on local good practice, as well as evidence from the UK and internationally. These focus on:

- Enhancing patient education on how to self-manage.
- Peer support on a one-to-one or group basis (online or in person).
- Providing alternative care or services that facilitate self-care.
- Proactive management and planning for those with complex needs.
- Social change to promote healthy communities.

An example of how we already provide alternative care or services that facilitate self-care is through social prescribing. Through social prescribing, patients are empowered with the confidence to manage their own health so that they visit the GP only when needed. GPs therefore focus on higher risk patients and the demand for high-intensity acute services will be lowered.

Our social prescribing schemes integrate primary, community and social care, as patients are referred by their GPs to non-medical and community support services to provide psychosocial and practical support. We plan to scale up successful social prescribing schemes across the NEL patch to tackle diseases such as depression. In addition to our evidence based approach, we will also collaborate with the national Social Prescribing Network to guide the scaling-up process.

Screening and early detection

As part of our goal to achieve a step-change in uptake of screening, we plan to address the inconsistency in quality and levels of screening across the NEL patch and spread best practice. We plan to implement the NICE referral guidance, the 'faster diagnosis standard' and also increase early diagnostic capacity to reduce the number of patients with emergency cancer presentation, particularly colorectal cancer.

We are looking into integrating health screening services within our overall system framework. We would like to build on the bowel screening work in Newham, where they have been partnered with a voluntary charity, Community Links. Community Links calls every patient who has not been screened to improve screening rates. We already have local GP endorsement and it has been endorsed by the London Bowel Cancer Screening Hub.

Screening of complex diseases allows early diagnosis and detection, reducing patients with late or emergency presentation. In doing so, we aim to improve outcomes and reduce health inequalities in the long-term; this will support specialist services by reducing complexity of issues earlier.

Healthy living and smoking cessation programmes

Our prevention programmes targeted at reducing the risk factors for avoidable lifestyle conditions such as diabetes and cancer require coordination between primary and community care providers. We will proactively target at risk patients within the groups and work in a multidisciplinary way to provide support and prevent escalation of need. This is a focus of our local plans to develop place-based care models delivered through Accountable Care Systems.

Our current smoking cessation programmes have mixed results across the NEL patch. As a result of this and the impact it has on the health of our population we have targeted this as an initial priority area for our collaborative prevention work. We aim to reduce the number of people smoking by a further 5% by implementing 2021 by improving the interventions we deliver when smokers access other services – such as hospital and mental health services.

We also wish to widen the implementation of healthy living programmes such as the National Diabetes Prevention Programme to achieve Prostrate Specific Antigen obesity and diabetes targets. However, we have found it difficult to demonstrate its impact. To improve its impact, we will expand our mapping of diabetes prevalence and its risk factors to help identify at-risk patients.

Enhancing our primary care programme to deliver equality for people in NEL

The implementation of our common framework for better care and wellbeing, and the development of accountable care systems, require the radical transformation of primary care to lead the progression and development of a successful out of hospital health and care system in NEL.

Key Issues –national and local

At present primary care is under unprecedented strain, nationally demand for appointments has risen about 13% over the last five years, recently there has been a 95% growth in the consultation rate for people aged 85-89.

In response to a BMA survey of 3,000 GPs last year, over half of respondents consider their current workload to be unmanageable or unsustainable; and over half rated their morale as low or very low.

The primary care workforce is aging and facing a 'retirement bubble' which has the capability to put the system under greater strain.

Currently there is little support for struggling GP practices, with an increased number of practices facing closure or serious viability issues.

Significant unwarranted variation in outcomes between practices is a concern, there is little standardisation of practice and collaboration between GPs is very variable.

While patients have access to a number of excellent, high quality primary care services across all CCGs, as a whole, north east London needs to make significant progress to ensure equality and address these gaps.

Within north east London there are examples of how quality improvement initiatives have been used in partnership between commissioners and providers to deliver some good outcomes – e.g. some of the best outcomes nationally under Quality Outcomes Framework (QOF) in Tower Hamlets and City and Hackney and Quality Improvement (QI)initiatives supported by UCLP in Newham, BHR and East London Foundation Trust. We will work together to deliver equality for people in NEL drawing on available best practice.

Our shared vision

Our enhanced primary care offer will ensure that GPs will be able to focus on coordinating care for those with complex problems and long term conditions, providing continuity of care where that is important to patients and outcomes. This will be enabled by a greater role for other clinicians supporting those with minor illnesses. We will actively consider how the creation of new roles supports this.

There will be joint care planning to enable seamless delegation to the extended primary care team and collaboration with social care, freeing up time for patients and helping to deliver person-centred, planned and preventative care. This is already happening – for example through social prescribing models underway across north east London.

Primary care collaboration at scale is a crucial feature of our universal framework and will improve patient care experience.

Patients will also have greater accessibility to GPs, with practices working together in local networks to offer longer opening hours for appointments from 8 – 8, seven days per week, aided by e-consultations.

These are examples of how we are working together to implement the London Strategic Commissioning Framework for Primary Care, delivering proactive, accessible, and coordinated care.

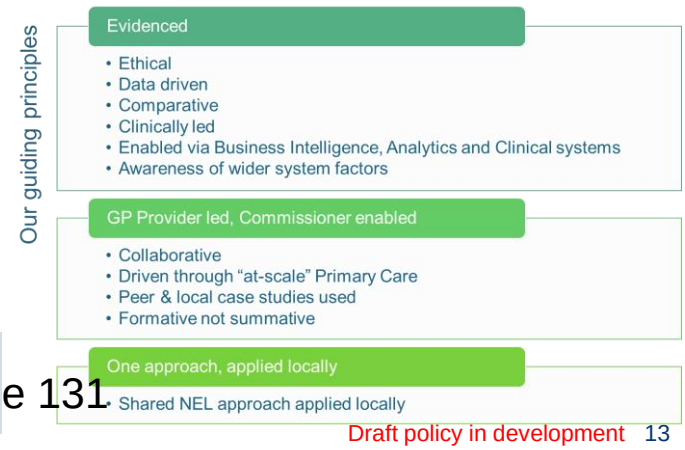
Working together

The change required to realise our common vision for primary care across NEL will be owned and driven locally, but aligned to a common set of principles:

- We need to support the stabilisation of practices in the short term to ensure continuity.
- We will develop and implement a common quality improvement approach, supported by a shared performance dashboard and peer review.
- We will steer this approach through a joint board and utilise Personal medical Services (PMS) reviews to move towards equalisation and support local delivery of the standards of the Primary Care Strategic (SCF)Commissioning Framework.
- We will look at the initiatives that are in place in CCGs to better manage demand through implementing optimal pathways across the primary and secondary care interface and at how we can support embedding this work across NEL.
- We will work together on key enablers that we need to address at a NEL level, with a focus on workforce, digital and estates.
- We need to support primary care collaboration at scale to improve quality and sustainability across practices.
- We will work together to share good practice including around primary care technology.
- We will look at options for adopting a common approach to primary care contracting across NEL.

Across NEL we are developing a programme of primary care transformation that contains three key priorities: quality improvement in primary care, organisational development of at scale primary care providers, and development of the NEL primary care workforce.

To support the delivery of our shared ambition for improving quality we will develop a NEL-wide Primary Care Quality Improvement Collaborative, underpinned by strong, dedicated clinical leadership.



Integrated health and social care

The integration of health and care services to deliver joined up care is a crucial part of our vision for person-centred services across NEL. Progress is at different stages and there are detailed borough level delivery plans in place for 2016-17. These have been developed jointly by CCGs and local authorities in order to meet the requirements of the Better Care Fund (BCF).

Each borough has a detailed action plan and stretching target for improving performance against the Delayed Transfers of Care measure, through better patient flow within secondary care and integrated discharge services. BCF plans also describe how seven days services in community and social care services will be implemented to support safe and timely discharge from hospital.

Across NEL our ambition is to go further in integrating health and social care services in order to implement person centred care models. A key part of doing this will be developing Accountable Care Systems that bring together providers of health and social care services around a single service model and a set of outcomes. There is also commitment to the integration of commissioning functions to support new population based contracting models. Through this work we will meet the national requirement for the full integration of health and social care services by 2021.

We are already making progress on the integration of health and social care at a borough level:

- In City and Hackney the One Hackney provider network uses an alliance contract to support the collective delivery of metrics and outcomes focused on integrating health and social care. This will be continued and expanded under devolution.
- As part of the ACS work in BHR there is a proposal to establish a Joint Strategic Commissioning Board between the three BHR CCGs and LAs. Pending approval this will launch in November 2016.

New models of community care

In order to deliver our vision of person centred care across north east London we will need to radically transform the way in which services are delivered in the community. This will see a shift towards the clustering of services for a geographically defined population across traditional health and social care, and primary and community care boundaries.

This will require providers to work in partnership to deliver care against population based and outcome focused contract models. This will form a core part of the plans for the development of Accountable Care Systems in each economy. It will require local providers to respond by adapting their service models, ensuring their workforce are supported and trained to deliver in new ways, and flexing their own organisation priorities to embrace a new approach to planning and contracting.

The Redbridge Health and Adult Social Care Service (HASS) is an integrated service for health and adult social care, jointly provided by NELFT and the London Borough of Redbridge, was introduced on 1/4/16. The HASS consists of four multidisciplinary community health teams which focus on early intervention and prevention to support people who are over the age of 18 and are vulnerable older people or adults with a learning disability and/or on the autistic spectrum, or a physical and/or sensory disability or a mental health issue.

Integrated urgent and emergency care (UEC)

The NHS Shared Planning Guidance set out three asks for urgent and emergency care systems by 2021:

1. All patients admitted via the urgent and emergency care pathway have access to acute hospital services that comply with four priority clinical standards on every day of the week.
2. Access to Integrated Urgent Care, to include at a minimum Summary Care Record (SCR) clinical hub and 'bookability' for GP content; with mental health crisis response in hospital and part of the Ambulance Response Programme.
3. Improved access to primary care in and out of hours.

In NEL we will work together to meet these asks through the implementation of our common framework for better care and wellbeing, in three different ways:

- At a local level the implementation of our person-centred service models will focus on meeting the eight criteria for Integrated Urgent Care and provide improved access to primary care.
- In BHR the Urgent and Emergency Care (UEC) vanguard will provide a an example of rapid movement towards our planned UEC model, with a fast-tracked timeline for meeting the eight criteria for Integrated Urgent Care.
- Across NEL we will work together to implement a 24/7 integrated 111 urgent care service that connects to clinical hubs at all levels, including dental and pharmacy hubs and CAMHS. We will also implement referral pathways between UEC providers.

The **NEL UEC** network has been reviewing our current emergency departments to evaluate whether they meet the London Quality Standards and UEC facility specifications. In 2016/17 we will be working to meet the four priority seven day standards for vascular surgery, stroke, major trauma, STEMI heart attack, and children's critical care. We will also establish a work programme and road map to meet these same standards for general admissions to achieve 95% performance by 2020, and meet all three of the asks set out above.

High quality integrated mental health care and support

Mental ill health has a very high prevalence in NEL, with inner east London CCGs in particular reporting the highest levels of new cases of psychosis in England, and very high levels of common mental health problems. Progress has been made to improve the quality of care and treatment across primary and secondary care. The STP represents an opportunity for health and care services across NEL to work together with the voluntary sector and communities to further improve health and life outcomes, and manage the projected increase in demand over the next five years.

We will do this by building community capacity and capability, including self-care and prevention and providing integrated primary and community care as close to home as possible. We will support children with and at risk of mental health problems through our Future in Mind commitments. These commitments are contained in each CCGs' Local Transformation Plan (LTP) for CAMHS. The LTPs are currently being refreshed and will reaffirm our commitment to improving the mental wellbeing of our young people, which will have a longer term impact on adult mental health prevalence. We will also improve access to dementia and perinatal mental health services, and services for people when they are in crisis.

Mental health services which **integrate primary, community and social care** support will prevent unnecessary admissions and provide a smooth transition to acute services if needed.

We know that people with mental health problems experience a range of health inequalities, and that there is significant variation in how they utilise wider health and care support. We will ensure that mental health is at the heart of our delivery model for integrated care to address this and improve the physical health of people with serious mental illness. This will also help us improve the mental health of people who are frail, or who have complex and/or long-term conditions.

To develop the excellent mental health services we want for the future, the infrastructure needs to be right. We will work together as provider and commissioner partners to ensure that improving outcomes for people with mental health problems, and developing high quality productive mental health services, are at the centre of our work on new models of care.

We are developing a five year NEL mental health strategy that will enable us to implement the Five Year Forward View for Mental Health. We have completed an analysis of demand and capacity, quantifying the affordability gap over the next five years.

Five areas have been agreed:

- Improve population mental health and wellbeing: In partnership with citizens and the voluntary sector, improve population-based approaches to mental health, tackling the wider determinants, reducing inequalities and managing demand
- Improve access and quality: Deliver 5YFV for mental health and GP 5YFV commitments regarding mental health
- Ensure services have the right capacity to manage increasing demand: Improve capacity and productivity by developing best practice urgent and community care pathways orientated around community and primary care, with a particular focus on psychosis pathways
- Supporting improved system outcomes and value: Integrated preventative mental and physical healthcare to improve outcomes and reduce utilisation of primary care, acute, community health services, social care
- Commissioning and delivering new models of care: Join up whole personal care commissioning, supported by new approaches to contracting to ensure good value, integrated services.

The strategy development addresses the mental health task force 'Must Do's' and we have work underway to:

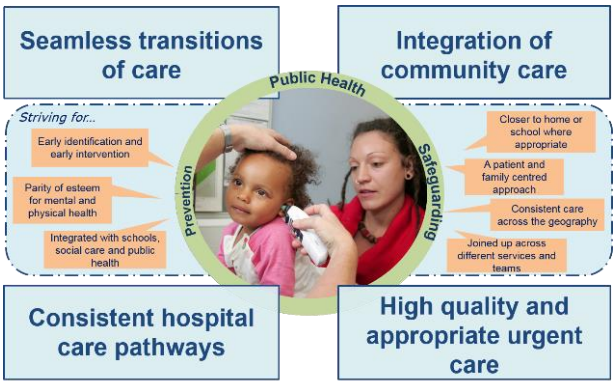
- Develop a Childrens' and Young People's (CYP) community eating disorders service
- Improve access for early intervention in psychosis. NEL has made good progress here and met the national target.
- Develop local suicide prevention plans across all CCGs to reduce suicide rates by 10% relative to 2016/17 baseline.
- Prevent child sexual exploitation.

Across partners we are committed to the principle of parity of esteem, that there is "No Health without Mental Health" and therefore it will be considered across all we do through the STP to improve quality, experience and value.

Integrated children's and young people's care:

Children and young people (CYP) are a key area of focus for NEL, given the high proportion of children and young people in NEL and the anticipated growth over the next five years. Across NEL, we aim to place children and young people at the centre of care and services in health, social care and education. Effective services from early years into adulthood will support this generation, and begin to establish healthy lifestyles and self-care as the norm for future generations. We will utilise national best practice frameworks with emphasis on local implementation and delivery.

The Transforming Services Together (TST) programme has identified four priorities which we will adopt across NEL to deliver this vision, as outlined below:



Realising the benefits in terms of improved care for children and young people will require collaboration between organisations to deliver the transformation that is needed. In accordance with the Children and Families Act (2014), commissioners and local authorities in NEL will develop local integrated care plans and identify opportunities for joint commissioning. Furthermore, local models of coordinated care have been developed, whereby multidisciplinary teams of health, social care and educational professionals collaborate to develop structured care plans, with input from parents, carers and patients. To support this we are starting to implement Integrated Personal Health Budgets for children and young people in parts of NEL from 2016-17 onwards. Care coordinators will proactively arrange and direct care.

We recognise that we need to do more of this across NEL and provide more care in the community, where it is appropriate to do so. The high numbers of referrals to general paediatrics and dermatology for conditions that could better managed in primary care, such as asthma and eczema, will be addressed through our 'patient pathway and outpatients' initiative. We plan to review referral criteria and guidelines for these conditions to identify opportunities to provide care in the community. Evidence-based clinical pathways for these conditions will be co-designed with children and young people and their families to better support them to manage their own conditions, even through the transition to adulthood.

We will work towards meeting London's Out of Hospital Standards for Children and Young People as we make these changes.

We recognise that a child's chances in life start with the conditions of their birth; we will improve maternity services to ensure that every child has the very best start.

The need to provide high quality and appropriate urgent care for children and young people will be addressed through our plans to develop integrated urgent and emergency care models across NEL. In particular through increased access to urgent appointments in primary care outside of core hours.

Integrating CYP plans locally

- Proactive care planning for younger populations with co-morbidities is being introduced in City and Hackney
- In Tower Hamlets community paediatric virtual ward service (Bridge) and a paediatric rapid access clinics have been established
- We are preparing to implement Integrated Personal Health Budgets for children and young people in City and Hackney, Tower Hamlets and Waltham Forest during 20161-7
- In Waltham Forest a 'Children's BCF' will be developed to pool budgets between the CCG and local authority and drive the integration of CYP health and social care services
- In BHR better support is being developed for looked-after children and those leaving care

Localised programmes for learning disabilities

Whilst we have relatively low numbers of people with learning disabilities in inpatient facilities, we know that we do not currently meet the National Service Model requirements for patients with learning disabilities.

The Transforming Care Partnerships in NEL are committed to working together to deliver the national service model. In particular, we will improve the resilience of our providers so that they can support people with learning disabilities who are exhibiting challenging behaviour. In doing so, we aim to reduce inpatient admissions. We will also work to increase access to local housing and education to reduce out of area residential provision.

The unnecessary admission of patients with learning disabilities can be reduced if we strengthen local support with input from primary, community and social care.

Community-based end of life care

We recognise the need for joined up care to ensure a better response from the health and social care systems to sudden, unpredictable or very gradual dying.

Nationally up to 81% of people say they would prefer to die at home. However, locally the majority of patients die in hospital - with four of our CCGs having the highest rate in England, 20% above the English average. This indicates that, among other things, we need to get better at having open conversations with families and patients around end-of-life options.

We plan to build stronger partnerships with social and voluntary sectors to increase the provision of community-based, 24/7 access to end-of-life care services. We will improve personalised care planning through better sharing of patients' preferences and care plans with other providers. We will utilise national best practice frameworks with emphasis on local implementation and delivery.

Our local plans aim to:

- Improve advanced care planning and systems for sharing of records to ensure a patient's preferences are understood by all (including exploring the use of software packages such as Coordinate My Care).
- Provide personalised care for those in last year of life, and increase the number of patients dying in their chosen place
- Improve patient and carer experience in the last year of life, and improve access to advice, support and care
- Improve information gathering on end-of-life-care to support quality improvements
- Ensure confident and competent workforce to support end-of-life-care patients

Transforming sexual health services

NEL experiences high prevalence rates for common Sexually Transmitted Infections (STIs) relative to England and London, including HIV, with some areas diagnosing HIV later than average. In addition three CCGs have above average teenage pregnancy rates and all CCGs have lower-than average prescriptions of long-acting reversible contraceptives (LARC).

We recognise that due to London's array of open access services and NEL's mobile population, a high number of our residents use services in central London. Therefore, we need to work collaboratively at scale to successfully improve access and outcomes. To do this, we are working with the London Sexual Health Transformation Programme (LSHTP), of which NEL is one of six sub-regions.

So far the NEL SHTP has been formed across Newham, Redbridge, Tower Hamlets and Waltham Forest to overcome these challenges by jointly planning and commissioning integrated sexual health services. A number of opportunities have been identified to:

- Improve access to sexually transmitted infections (STI) diagnostics outside the acute environment (for example self-sampling available online and in primary care).
- Improve access and uptake for LARC.
- Create appropriate STI treatment opportunities.
- Develop effective partner notification, which is mindful of the LSHTP model and is fit for purpose for NEL.

We will work together across NEL to ensure that we share good practice and adopt a consistent approach to the incorporation of sexual health services into local integrated delivery models.

Personalisation and Choice

As part of our commitment to deliver person-centred care we will be working with patients and health professionals to expand our offer of Personal Health Budgets (PHB) across NEL. Currently, adults and children in receipt of continuing care packages have the right to ask for Personal Health Budgets, which will help them to meet the outcomes agreed between themselves and their health professionals. PHBs operate within all individual boroughs across NEL but the number of children and adults to whom they are available varies. Changing how we commission services to offer more personalised care, whilst not destabilising services for others, is a complex challenge and individual CCGs will be looking to pilot approaches following consultation. Tower Hamlets CCG is one of the Integrated Personal Commissioning (IPC) 'demonstrator' sites, and, further to an NHS England (NHS E) request for Expressions of Interest in becoming an IPC 'early adopter' site. Newham and Waltham Forest CCGs have confirmed their intention to have a conversation with the national team about potentially making a formal application too.

Integrating beyond health and social care

We also recognise the potential to maximise the use of resources across public services by exploring opportunities beyond traditional health and social care boundaries. At a London level we have confirmed our interest in formally collaborating with the London Fire Brigade on local 'Fire as a Health Asset' initiatives. This will commence with a pilot programme based on a joint assessment of the Fire and Rescue Service initiatives that are likely to have most local impact.

Driving integration through devolution

- Both our devolution pilots in north east London are exploring the potential for integrating health services more closely with other public services.
- City and Hackney is also seeking devolved public health powers to take a more integrated approach to prevention, focusing on tackling the wider determinants of health.

Pathway redesign and best-in-class clinical productivity

To deliver the best outcomes for patients and make the best use of our resources across the health and care system in NEL we must identify and administer the correct treatment at the appropriate time to a high standard.

The importance of these principles have been established through 'RightCare' and in the 'Getting It Right First Time' Briggs Report. These show that we can reduce the need for revision surgery and reduce mortality rates. In this way we can also support the sustainability of high quality and efficient acute services across NEL.

To do this effectively it is important to take a system wide approach, recognising that there needs to be consistent, agreed procedures and guidance in place across the whole pathway to support clinicians in making the right decisions. Under the STP we are launching a NEL-wide clinical productivity programme that for the first time will take a system wide approach to identifying unwarranted variation and implementing effective care pathways.

Utilising benchmarking data to drive clinical productivity

This cross-cutting programme will utilise benchmarking data from RightCare and other sources to identify pathways and areas of spend where there is currently the greatest variation in the quality of care delivered, or the cost of its delivery. This will tell us 'where to look' in order to carry out further focused analysis to understand whether any variation is unwarranted and therefore presents an opportunity to drive out improvements in quality or savings through increased efficiency.

This system wide approach will be led by the north east London Clinical Senate, ensuring that this is a clinically led programme with a clear focus on quality improvement. We aim to learn from existing best practice throughout NEL and utilise this benchmarking approach to encourage its spread and drive greater consistency for patients.

We have agreed a process for identifying and exploring opportunities, which is designed to build on and complement existing work underway across NEL. Crucial to this will be an agreed decision tree to ensure consistent, transparent and appropriate decision making.

Identifying opportunities is only the first step in this process, and we recognise that the design and implementation of the changes required to drive out efficiencies requires collective leadership and commitment. To support this we are developing a NEL-wide approach build around the 'RightCare' Health System Reform approach:

1. A service review – to identify what is driving variation
2. A policy development process - to learn from existing practice and embed this in a deliverable policy
3. A business delivery process – taking learning from the above and translating it into a plan that can be agreed and delivered across the system
4. A programme approach to delivery – to drive through the process and behaviours change required within and across organisations.

Managing demand

Within this approach will be a focus on how we manage demand into the system as our population grows. This starts with our whole system approach to prevention and building healthy communities. It will also focus on learning from the outstanding examples within NEL of primary care clinicians being provided with the tools and information needed to make the correct referral, first time. This can both prevent unnecessary activity entering the pathway and ensure those who really need acute care most urgently get to the right place, sooner.

We are adopting the framework for demand management published by NHS England and will be conducting a review to establish the extent to which each element of the framework is in place and working effectively across NEL.

Pathway redesign

Work is already underway to improve clinical productivity within NEL through more efficient delivery of our outpatient care and optimising each clinical pathway. We plan to manage referrals to secondary care in a more effective way and streamline the referral to treatment process, including diagnostics.

In 2016-17 there is already a particular focus on the following pathways and projects:

- Ear, nose & throat 9ENT), Orthopaedics, Gastroenterology (BHR)
- Ophthalmology, Gynaecology (BHR and WEL TST)
- GP specialist advice service (WEL TST)
- Renal (NEL-wide)

Through our common approach we plan to learn from and build upon these examples to achieve a shift change in clinical productivity across NEL.

City and Hackney have put in place consultant advice lines with The Homerton Hospital for 40 clinical pathways and now have low rates of outpatient referrals. They have improved long term condition care and have low rates of admissions for conditions amenable for primary care.
In areas where we are most challenged we also have a 20% reduction target for face-to-face outpatient appointments over the next five years. This will in part in be enabled by the use of telehealth and other alternative platforms.

Improving the treatment of cancer in community and secondary settings

We recognise that we have much to do to deliver the ambitions outlined in 'Achieving World-class Cancer Outcomes, 2015-2020' written by the National Cancer Taskforce. Aside from reducing incidence through risk factor reduction (addressed earlier in 'prevention and proactive care'), we also need to raise our one year survival from c.65% to the national standard of 75% and also integrate 95% of cancer survivors with after care plans.

We will reduce variation in access and quality of service by implementing whole pathway improvements which has already begun under the leadership of the NEL Clinical Senate.

For better post-treatment care, we will accelerate the delivery of the 'recovery' package, including an agreed after-treatment plan. We will also implement stratified follow up pathways to increase the proportion of patients in long term care programmes.

NEL and north central London also have the poorest delivery of the cancer waiting time (CWT) standards out of the five London regions. By working with the Transforming Cancer Services team (TCST) and the National Cancer Vanguard, we will implement a system-wide programme to deliver sustainable CWTs.

Reduce unnecessary diagnostics

National evidence suggests that 25% of pathology testing is unnecessary and recent audit work in CH revealed that 20% of primary care initiated MRI requests could have been avoided.

Over the next five years, we plan to introduce a rolling programme of work focused on standardising the most requested tests across sites. This will reduce unnecessary testing and improve access to testing when it is most needed. We will give GPs the ability to book people in for tests directly without having to see a specialist where testing is appropriate. IT improvements will allow the sharing of test results between GPs and hospitals to reduce duplication.

Medicines Optimisation

Leading on from the Five Year Forward View, the opportunities for medicines optimisation interventions have been established through a number of national documents, including the GP Forward View and the Carter review. In NEL we recognise the potential value of these opportunities in building a sustainable health and social care system. Central to this is the role of pharmacists and their teams (community, prescribing clinical pharmacists and others across the primary and secondary care system) in improving patient care through pathway redesign, promoting patient empowerment and self-care and efficient use of NHS resources through procurement and reducing waste.

The NEL wide Medicines Optimisation Steering Group has been formed which will explore nine priority programmes, including:

- Promoting self-care, patient awareness and self-management to reduce unnecessary prescribing of medicines available over the counter.
- Developing consistent pathways and medicines usage across NEL for the management of long term conditions.
- Expanding e-prescribing in secondary care and work with other providers to avoid medicines related delayed discharges.
- Developing a pharmacy workforce strategy, to address gaps in primary and secondary care, and expand the role of prescribing pharmacists.
- Developing a common approach to decommissioning / de-prescribing with consistent responses for patients regardless of setting.
- Reviewing and optimising of biosimilar medicines.

Ensure accessible quality acute services for those who need it

- Future transformational planning and impact modelling of:
- Maternity: NEL Maternity Network
- Cancer (Board and Network)
- Surgical hubs
- Diagnostics
- Outpatient pathways: acute level improvement in addition to pathways
- Screening: uptake of national programmes

Through encouraging prevention, self-care and improved care close to home we envision that this will reduce demand. However given the significant population rise, our challenge is to ensure we reduce any unnecessary admissions and attendances, and have best in class length of stay for both planned and unplanned care. The only other alternative would be to increase the total beds across NEL significantly, which would require an additional hospital to be built. This is not practical or realistic.

As with the out-of-hospital components of our service vision, transformation is also required in our secondary care service model to improve patient experience. These are focused closely on the features of the hospital model: streamlined outpatient pathways, urgent and emergency care, ambulatory care, coordinated surgery and provider collaboration. Further details are set out below:

We will reduce long waiting times and unnecessary hospital admissions by making ambulatory care the default setting

To support our vision of urgent and emergency care being delivered in the right setting, we will develop ambulatory care hubs at each hospital. These hubs bring together clinicians and services that focus on the initial assessment and stabilisation of acutely ill patients.

A greater proportion of patients will be able to gain access to emergency consultant care, so patients with less urgent needs can be treated quickly and sent home. Only patients requiring more than 48 hours of care will be admitted to a specialised ward, thereby significantly improving bed capacity and support the flow of patients, which will help meet A&E targets.

Acute care hubs including ambulatory care will support our vision in ensuring that patients are seen at the right place in the right time. They will reduce demand on our secondary providers by ensuring that people are not admitted to hospital unless it is necessary.

Improve the quality of surgery services

We are exploring the creation of surgical centres of excellence at each site. At the moment WEL and Barts Health are more advanced in the stages of planning these changes than BHR and City and Hackney, but there is a commitment to expanding surgical centres of excellence across NEL[1].

Through consolidation of planned care across NEL, we can improve length of stay, reduce referral to treatment times (RTT) and improve clinical outcomes for our patients by standardising surgical offerings across sites. We are exploring the ability for each site to have a 'core' surgical offering, combined with a 'core-plus' set of services where safer procedures can be delivered at a higher volume. A 'complex' surgical offering would be consolidated and available in a few sites to make provision safer and more sustainable.

We are planning for patients to be able to access pre-operative appointments and low-risk surgical procedures at their local hospital, while avoiding long delays and cancellations. They will only travel if they need specialised offerings.

These surgical centres of excellence will operate in networks with strengthened cross-site working and inter-hospital transfer, leveraging the use of any free capacity to deliver emergency surgical interventions without delay. This will support the vision of **providers collaborating** to deliver efficient and high quality care and **will reduce our failure to meet quality measures such as transfer delays.**

Delivering the Seven Day Standard for Emergency Care

Across the NEL Urgent and Emergency Care (UEC) Network we have been reviewing our current emergency departments to evaluate whether they meet the London Quality Standards and UEC facility specifications.

Throughout 2016/17 we will be working to meet the four priority seven day standards (2,5,6, and 8) for vascular surgery, stroke, major trauma, STEMI heart attack, and children's critical care. We will also establish a work programme to meet these same standards for general admissions to achieve 95% performance by 2020.

[1] see: http://www.transformingservices.org.uk/downloads/Strategy-and-investment-case/TST-Part-3-High-impact-changes.pdf

Health commissioners and providers in NEL remain committed to the safe and timely transition of King George Hospital emergency department from a full admitting A&E department to a 24/7 urgent care centre in order to improve the quality and sustainability of acute services. This is in line with the original proposals and public consultation undertaken as part of the Health for north east London programme and the changes ultimately agreed by the Secretary of State.

Our operational plans for 2016/17 provide the foundation on which providers and commissioners will build towards implementing the changes by summer 2019. In order to achieve this, partners across the system will continue to work together to ensure the agreed enabling actions are executed and that the gateway process provides assurance of the required progress.

Our system plans are already delivering improvements and we have identified the following key conditions for successful implementation:

- The Independent Reconfiguration Panel (IRP) recommendations being met, including sustained performance improvement of the emergency pathway.
- Significant capital investment at both Queen's and Whipps Cross Hospitals to support the changes.
- Successful reduction in demand and length of stay at Whipps Cross hospital to create additional bed capacity.
- Effective workforce planning and recruitment to ensure that all clinical areas can be staffed safely
- Clear and effective public communication of the plans for changes, in particular to address the risk that partial closure leads to a bigger shift of activity than currently anticipated
- That the surrounding emergency care system maintains or improves its stability, in particular services at North Middlesex and Princess Alexandra hospitals.

Offer a greater choice of settings for births

We recognise that the projected increase in births is the most pressing challenge for maternity provision in NEL. To reduce the risk of needing interventions in obstetric-led wards and improve capacity management, we plan to offer expectant mothers a greater choice of delivery settings. There is currently under utilisation of midwifery led care pathways and birth settings.

We plan to increase the uptake of midwifery led births and expand home birthing services, in alignment with the National Maternity Review. Newham, Tower Hamlets and Waltham Forest CCGs are maternity choice and personalisation pioneers. Through the neighbourhood midwives pilot we will offer an expanded range of options to local women.

We are also focusing on models of care that allow continuity of care to be the normal offer for all women. With continuity of care, expectant mothers will experience better, safer care with a lower risk of intervention. To that end, we are establishing midwifery model of care pilots at Barts Health hospitals and at Queen's Hospital.

This chapter has focused extensively on introducing our system-wide vision. The remainder of this plan addresses the other critical inputs, including collaborative productivity and enablers, which will need to be simultaneously developed to fully address the NEL wide system challenges.

2016-17 deliverables	By 2021

✓ Continue implementation of TST and finalise ACS business cases in BHR and CH.
✓ Develop 24/7 local area clinical hubs, to be available to patients via 111 and to professionals.
✓ Primary Care:
  ✓ Strengthen federations.
  ✓ Develop a Primary Care Quality Improvement Board to provide oversight.
  ✓ Utilise PMS reviews to move towards equalisation and delivery of key aspects of Primary Care SCF.
✓ Extended primary care access model will be established with hubs providing extended access for networks of practices implementing the Primary Care SCF.
✓ Ensure community-based 24/7 mental health crisis assessment is available close to home.
✓ Active plan in place to reduce the gap between the LD TC service model and local provision.
✓ Establish a NEL cancer board to oversee delivery of the cancer elements of the STP.
✓ Establish a NEL-wide MH steering group and develop a joint vision and strategy.
	✓ New care models operational across NEL.
	✓ Implementation of SCF standards with 100% coverage in line with London implementation timetable.
	✓ Reduction acute referrals per 1000 population through improved demand management and primary / community services.
	✓ Access across routine daytime and extended hours (8am-8pm) appointments within GP practices and other healthcare settings.
	✓ Alignment with NHS E 2020 goals for LD transforming care.
	✓ 95% of those referred will have a definitive cancer diagnosis within four weeks or cancer excluded, 50% within two weeks ("find out faster").
	✓ Provide the highest quality of mental health care in England by 2020.
	✓ Deliver on the two new mental health waiting time standards and improve dementia diagnosis rates across NEL.

4. Specialised Services

- Development of single care models for specialist pathways (renal and cardiology)
- Review community neuro rehabilitation provision
- Earlier diagnosis and more efficient pathways in specialist cancer
- Specialist mental health planning

The provision of specialised services is a key component of the NEL health economy. Patients from across the UK are treated by our providers, and an allocated resource of more than £500m for the NEL population makes up a significant proportion of the income of our five NHS providers.

We need to transform specialised services so that our residents can receive the highest quality when they need complex care, be it at our providers in NEL or at other providers in London.

Given the challenges outlined in this document and the needs of our residents, we are focused on making specialised services a core component of our STP. Whilst we have had past successes in reconfiguring our cancer and cardiac provision across north central and east London, there is a need to address the demand, cost and quality of care challenges for all specialised services.

A number of specialised care issues must be addressed in NEL:

- A number of quality issues exist, including the meeting of waiting time targets.
- There is insufficient preventative action and active demand management.
- There is a predicted financial gap of £36m by 2020/21 due to a growing and increasingly ageing population, new technologies and new treatments. The financial gap is currently being reviewed by NHS E.
- On occasion, patients living in NEL have to travel to providers across London or nationally. While this may be reasonable where services are centralised, it is sometimes caused by capacity issues in local services.

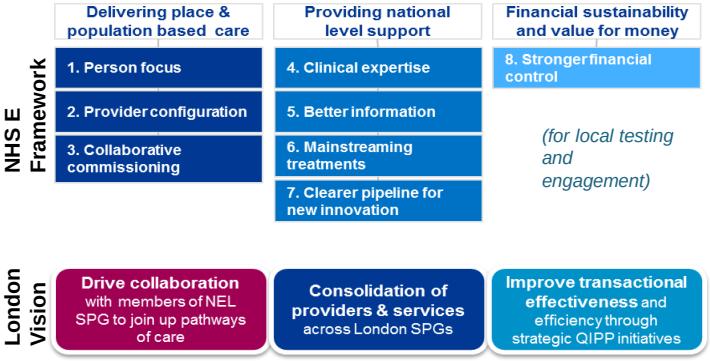
These challenges will require us to work closely with NHS E and other footprints to deliver greater productivity, better services and financial sustainability.

Our approach

The STP provides us with an opportunity to assess how our specialised services are delivered and to formulate a vision for how we expect them to look in the future. Through discussion with key stakeholders, we have subscribed to a vision for how specialised services are delivered:

"Working together to deliver evidence-based, high-quality and affordable specialised services with demand appropriately managed in the community and in secondary care through defined pathways".

We will work with NHS E's strategic framework and the London Specialised Commissioning team's supporting vision:



We have held several workshops with clinicians to identify initiatives to take forward improvements in specialist renal and cardiac care, and are now developing business cases and implementation plans.

Workshops were also held for cancer and neonatal/specialist paediatrics, which enabled some high-level opportunities to be identified. These will be worked up in due course in alignment with NHSE's pan-London programme.

We will also review the provision of neuro rehabilitation services to address pressures on the Royal London Hospital trauma centre.

Collaborative commissioning and planning

One of our key priorities is to work collaboratively with NHS E to develop the best way to commission services in NEL and for NEL residents, including supporting the development of a London wide commissioning structure. This may include developing new contractual arrangements to encourage the management of demand.

As patients in NEL move between other footprints for specialised services, we will need to work closely with other STPs to consider and plan patient flows between us.

We have already had success working with other STPs through the UCL cancer vanguard and the Barts/Royal Free renal collaboration.

We have developed a local delivery governance structure involving specialised commissioners. We will involve CCG and local authority partners in this delivery when considering opportunities to reduce demand for specialised care in the whole-system.

Prevention, demand management and early intervention

Specialised services must align with our preventative, person-centred service model. It is vital that we reduce demand for specialised services by empowering our population to self-manage their illnesses and lead healthy lives. When people develop conditions like diabetes, it is crucial that we screen them early and intervene early; this will ultimately lead to better health outcomes and will reduce pressure on specialist services.

Financial sustainability

Pathways must be reviewed and reconfigured to repatriate patients (where appropriate), resolve quality concerns, and reduce variation.

As part of our productivity programme, quality and cost improvements need to be achieved so that we can deliver specialised services in a financially sustainable manner.

Reaching our objective

To reach our objective of becoming a world-class destination for specialist services with excellent outcomes for residents, we have identified these areas of action:

- Transforming pathways (see next page for NEL 5 priority pathways)
- Drugs and devices efficiencies
- Improving value

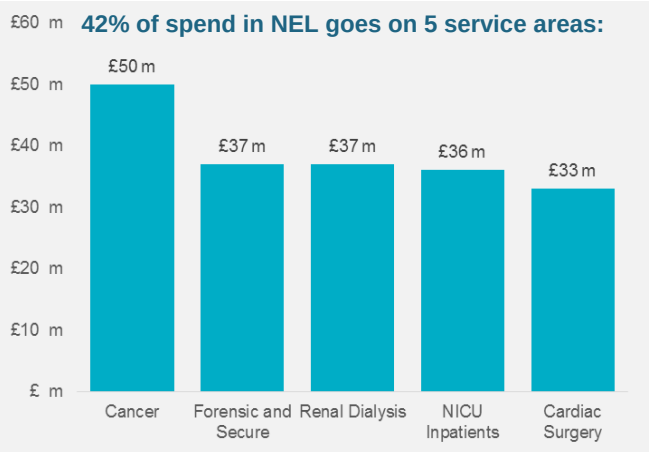
See separate appendices for a detailed chapter on specialist commissioning.

Approach to identifying priorities for Specialised Services

Any changes to Specialised Services need to be driven by evidence, targeted according to impact and feasibility, and aligned with the priorities of Transforming Specialised Services in London (TSSL).

We have identified the following NEL priorities based on five key dimensions:

- The views of the five NEL providers and the clinical senate.
- Variation and opportunities highlighted in Right Care, Commissioning for Value and Commissioning for Prevention analyses.
- Areas of high activity, high spend, and high London market share.
- Known quality issues from existing programmes/reviews.
- Feasibility in addressing the challenges within the timeframe.



The graph above illustrates the proportion of spending by service area, and the table below forms our local priorities which we will continue to align with TSSL.

These priorities will be iterated following further analysis by NHS E, and collaborative clinical planning sessions and involvement of patients to agree on a set of high impact and appropriate initiatives to improve specialised services

Cancer Realising the full benefits of the Cancer Cardiac programme; improving early identification and quicker access to treatments	• Reviewing the implementation of the Cancer Cardiac reconfiguration to ensure the full benefits of the change are being realised. • Earlier identification: enhanced diagnosis and better access to services through implementing stratified pathways in outpatient services. • Enhanced access to smoking cessation services to reduce incidence. • Improved pathways for faster identification and access to treatment, for example paediatric oncology (joint with Great Ormond Street Hospital), haemato-oncology, lung and breast cancers.
Cardiac Integrated pathways, with better prevention, identification, early intervention and access to new treatments	• Develop pathways across primary, secondary and tertiary care in order to strengthen prevention, earlier identification and quicker treatment, therefore reducing demand downstream for specialist services. For example, a primary prevention service could reduce the risk of cardiovascular disease through reducing cholesterol levels and smoking. • Improve case-finding, prevention and treatment for atrial fibrillation; in partnership with UCLP and local primary care leaders. • Ensure innovations in treatment can be accessed in the world-class Barts Heart Centre. New techniques in surgery and use of devices are being trialled to ensure better outcomes for patients.
Mental health Closer integration of specialised and secondary care pathways; repatriation and consolidation	• Step-down and step-up support for patients in forensic mental health services, and admission avoidance for Tier 4 CAMHS will be integrated through bilateral commissioning arrangements and pathways, ensuring the most appropriate use of resources across the MH pathway. • We will also develop an efficient pathway to enable patients with a learning disability in secure mental health settings to be repatriated to NEL and back into the community.
Renal Better community support, and prevention and secondary demand management improving outcomes and reducing demand	• Roll out of the community kidney services across NEL to improve identification of those with or at risk of Chronic Kidney Disease (CKD), improve patient information and education, and integrate care. Where this already exists, these services are delivered through electronic advice clinics and surveillance services offered by the Queen Mary University London (QMUL) clinical effectiveness team. This has reduced the number of new referrals to services. • Better prevention and secondary demand management through blood pressure control initiatives. • Slow the rise in end-stage renal failure by increasing identification or CKD and Acute Kidney Injury (AKI).
Neonatal Addressing the capacity gap to repatriate care and reduce use of inpatient facilities	• Providers in NEL act as neonatal centres for NEL and South Essex pathways; Royal London Hospital (RLH) is the primary neonatal surgical provider. Due to lack of capacity, 30% of neonatal surgical referrals are treated outside the STP footprint. • Admissions of patients are relatively low but there is some potential to reduce admissions through implementing a specialised services review of neonatal hypoglycaemia and jaundice management.

5. Improving Productivity

- Consolidation of corporate services: Developing a flexible and scalable shared services model for our back office functions where this will release value for NEL
- Bank and Agency: Agreeing NEL wide rates of bank and agency pay and a shared bank service
- Procurement: consolidating and standardising key consumables list and moving to NEL wide contracts where feasible e.g. on patient transport
- IT: Maximising opportunities for procuring and delivering services at scale.

Significant productivity opportunities exist across the health and social care landscape in NEL

The evolution of the health and social care landscape in the next two to five years provides opportunities for all partners to create a more productive system in NEL.

To this end, health providers in NEL have begun discussing opportunities for productivity across both clinical and non-clinical areas.

In two areas we have started early work to understand the scale of opportunities: providers have articulated CIP targets over and above the 'do minimum.'

Alongside this, for the following areas of non-clinical work, providers have developed task and finish groups aiming to reduce spend through consolidation and collaboration: pathology, back office finance and HR, procurement and IT.

This chapter gives an overview of the collaborative opportunities and detail of the work providers have recently to develop hypotheses.

NEL has undergone large changes over the past few years and we have recently seen a consolidation of acute providers, resulting in internal collaborative opportunities for the trusts in NEL due to their scale.

The internal productivity savings above the 'do minimum' from providers totals £84m of which £45m comes from Barts, £25m from BHRUT, £8m from ELFT and £6m from NELFT. The main contributors to this are: implementing Carter recommendations; theatre and Length of Stay (LoS) productivity; reducing spend on bank and agency staff; skill mix and establishment reviews; and internal clinical programmes.

There are both clinical and non clinical opportunities for productivity between providers.

1) Clinical productivity opportunities provide the most potential for collaborative gains

There are great opportunities for clinical services across NEL. We see two main stages to realising these benefits:

- Providers want to move all services in NEL to at least the current median in NEL and best in class if possible. This will be facilitated by having a data driven approach to understand drivers in differences across NEL and share best practice.
- In the longer term, a NEL wide clinical strategy developed for each service, where we may see services consolidate on fewer more specialised sites.

2) Non-clinical opportunities across the system are also being explored by providers

Through the STP development, our trusts have come together to assess the prospects for collaboration in non-clinical areas. To date these only consider a few areas of non-clinical spend but early hypotheses suggest that the benefits could total between £21m and £56m in these areas.

We could be making more productive use of estates across NEL. The output of this work will be considered alongside the overall NEL estates strategy development to make sure that they align.

There is also scope in other parts of the NEL health and care system:

1) Commissioners

For true collaboration across NEL, we need to ensure that there is equity in commissioning. This involves a system review on how the seven CCGs and their commissioning support can start working collaboratively to purchase care effectively in the best interests for the NEL population. There are efficiencies to be gained through commissioning at a more strategic level. As commissioning evolves, and an integrated and outcome based approach to contracting is developed as part of accountable care systems, more efficiencies will be released. Multi-year outcomes based contracts will have a significant impact on commissioners, as they will require different skills and potentially fewer resources.

There are further transactional savings which can be made, such as sharing estates with providers or local authorities. Commissioners are working together to identify collaborative productivity initiatives. For example the IT task and finish group mentioned above covers both commissioners and providers.

2) Primary care

Federations are developing across NEL to increase productivity and are saving money through consolidation of back office functions and procurement. There are also schemes planned to reduce variation in referrals and improve prescribing practices across NEL which will enable system-wide savings. Some of the significant opportunities in primary care are explored in the primary care annex.

3) Social care

Each of our eight local authorities has its own transformation programme. Health and social care integration means we can work together to reduce duplication in health and social care through multidisciplinary teams and joint assessments.

Collaborative opportunities

Providers in NEL have developed hypotheses for collaborative opportunities which could save between £21m and £56m

Over the past few weeks, NEL providers have come together to discuss potential opportunities and options for collaboration. This has considered some non-clinical opportunities with intent to explore other opportunities in the coming months. The result is a series of hypotheses about where collaboration could bring system-wide gain over and above internal CIP plans.

In this early phase, the savings hypotheses have been informed by NEL sector experts as well as by examples of other work across the country. Costs which could be addressed by collaboration in the next five years have been considered.

Detailed work will be done in the next phase to test these hypotheses. Internal CIP plans will be explored further as part of this to ensure that best practice is shared amongst providers. This will help support the internal work being done by the trusts themselves. Investments required for implementation will also be reviewed.

Four key priorities, outlined below, have emerged and will require detailed consideration in the next phase of this work.

1) Collaborative procurement

Our procurement leads have identified a number of areas where there may be collaborative opportunities. Initial high-level analysis suggests that our current spend across these categories is £231m.

Areas highlighted for potential collaboration by providers include:

- Soft facilities management: through consolidation of contracts across providers.
- Consumables: through the rationalisation and standardisation of catalogues, and purchasing across all trusts.
- Patient transport and home deliveries: by procuring transport services as a system, suppliers will be able to optimise their fleet over a continuous geography.

Early work suggests an indicative saving opportunity of £5-14m on this spend, equivalent to 2-5% of total spend. This broadly aligns with work the London Procurement Partnership has done with other London areas to find opportunities between providers. While this figure is lower than some estimates (such as the Carter Review), our varied provider landscape suggests our collective buying power may be less than other footprints. We should be able to realise some opportunities in the next 12-24 months as contracts come up for renewal. In other areas, more planning may be needed (and existing contracts either exited or extended) to realise full system-wide benefits.

2) Common bank and agency approach

At present, NEL spends £196m with agencies a year. Whilst each organisation has CIP targets aimed at reducing this, there are further opportunities to reduce this amount through a common approach. In particular, two solutions have emerged:

- Virtual bank: clinical staff from our trusts are doing bank and agency shifts at other trusts in NEL. A virtual bank will allow for a more data driven approach to managing bank and agency staff.
- Common approach with agencies: early conversations suggest that many of the trusts in NEL and our neighbours are using the same few suppliers. A common approach across the providers may provide a stronger platform for negotiations with agencies.

Examples in industry suggest that between 13%-25% could be saved through collaboration, demand management and better use of data. In NEL there is a potential collaborative saving of £4-12m over and above what providers do themselves (2%-7% of spend).

3) Consolidating pathology

NEL currently spends £71m on running pathology services. While some reports, such as Carter's Phase 2 Pathology report, have suggested that 10%-20% of pathology spend could be saved through consolidating services, work has already been begun in this area:

- Barts Health operates a hub and spoke model across its sites, with a major hub at the Royal London.
- BHRUT has consolidated its cold pathology to the Queen's Hospital site.
- The Homerton is currently considering options for its pathology service and will make a decision in 2016/17.

Therefore, our early hypothesis for testing is that NEL could save £2-5m (3%-7%) through consolidating services and making better use of automation. Different models need to be explored; there are precedents that NEL can learn from, such as South West London Pathology and the Kent Pathology Partnership.

4) Back office functions

NEL providers currently spend £113m on central procurement, finance, HR and IT functions. Business cases and projects developed elsewhere suggest that savings of 12%-25% could be realised by consolidating these functions.

In NEL we have realised some collaborative savings, with the Homerton, Barts Health and ELFT using a shared-service centre for payroll, and Homerton and Barts sharing their financial systems. Trusts also have aggressive internal CIP plans with regards to back office functions. We therefore hypothesise that we could save in the region of £5-16m across NEL through collaborative working (5%-14% of total spend) over and above CIP programmes.

A number of factors mean that much of this saving is likely to be realised in years 4-5 as existing long term contracts and ongoing work on the IT strategy across NEL. There are, however, shorter term actions that can be taken in the next 24 months to help maximise savings across the system. These include standardising processes, sharing best practice between the providers and beginning to evaluate potential future operating model options.

Collaboration and timescales

We are committed to exploring options for formal collaboration between providers

Formal collaboration presents an opportunity to achieve the benefits of collaboration in a way which shares risk (and rewards) amongst participating organisations while potentially reducing transactional costs. In addition to productivity advantages, formal collaboration may support the NEL health and care system to accelerate the realisation of clinical productivity gains and implementation of new system models of care. This work should not compromise either the sovereignty of the current providers or the development of future models of care such as ACSs.

Over the coming months, we will evaluate a number of options for formal collaboration between NEL providers

The focus of a NEL collaborative partnership will depend on the scale of ambition and partners involved. Practical arrangements should be as clear and simple as possible with the capacity to incorporate a wide range of schemes within a single approach.

At present, a partnership between the five provider trusts in NEL offers the most practical initial scope for the work in order both to realise economies of scale and to maintain a level of simplicity to ensure the ability to achieve gains in the short to medium term. To this end, we intend to develop a Memorandum of Understanding (MoU) between our five providers to ensure clarity of purpose and senior commitment. In the longer term, other providers such as primary care federations could contribute and share in the benefits.

The initial focus of the collaborative will be on productivity opportunities which offer the greatest potential joint benefit. In the longer term, the scope could develop to include:

- Collaborative productivity (such as procurement and back office functions).
- Infrastructure planning (such as estates and IT).
- Workforce development (such as workforce planning, leadership development and collective training).
- Service planning (such as pathway redesign across NEL).
- Identification of future productivity opportunities and best practice sharing.

We will need to develop an arrangement that is flexible and can develop over time. It is possible that a greater level of collaboration will offer greater benefit in the longer term.

We will need to review various contractual and governance arrangements to make this a reality, which could include a membership model (see South Yorkshire example) or a joint venture model.

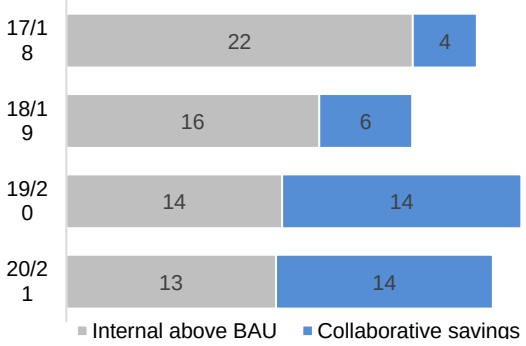
The options outlined would represent a radical shift in our thinking and approach; they are changes that have not been attempted in London yet and therefore we need to proceed sensitively. Through this STP we have the opportunity to develop our shared thinking around collaborative arrangements, and drive forward conversations that will enable the kind of transformative changes that will enable our system to be sustainable.

South Yorkshire may provide a useful guide to achieving the benefits of collaboration, bringing together seven acute providers with a collective turnover of around £3bn. This collaboration has a number of features:

- Driven by strong chief executive-level leadership enshrined in a MoU.
- Collectively funded with a total cost of around £700k per annum.
- Covers clinical and financial improvement, best practice sharing and informatics.
- Has delivered early benefits on shared procurement and shared patient records.

Phasing for realising collaborative savings

Our current hypothesis is that from 2017/18 we can realise non-structural collaborative benefits through benchmarking, sharing best practice and aligning ways of working to ease later implementation. The majority of collaborative savings, however, will be realised in 2019/20 and 2020/21 as some will require structural change and capital investment.



The more complex productivity savings, such as better use of estates and service transformation, are also likely to come in the later years of the STP delivery.

2016-17 deliverables	By 2021
✓ MoU between providers underpinned by principles of collaboration. ✓ Clear timescales for consolidating non-pay contracts. ✓ Joint approach for agencies in place with key suppliers. ✓ Options analysis of collaborative opportunities with pathology across NEL with agreement on a preferred option. ✓ Options analysis for consolidating back office functions completed with a preferred option across the system.	✓ Proactive approach to finding areas for collaborative working in NEL. ✓ Vision for shared back office approach and functions realised ✓ Joint infrastructure and workforce planning across NEL's organisations. This may be done only to inform rather than replace organisation plans. ✓ All trusts in NEL have implemented the findings of Carter and achieved agreed efficiency savings contributing to their financial sustainability.

6. Enablers for change

1. Workforce

Our workforce transformation needs to be based on the specifications of the new service models and through working closely with professional bodies and staff. As the development of these models will take time, we have focused our efforts in year one on establishing the infrastructure required to realise this change and will subsequently develop our approach in response to any changes in the models.

Developing the existing workforce is critical for the scale, pace and sustainability of the required transformation. We envision our 'workforce of the future' will have the capability to fully support the new service models. For example, the workforce should be able to work across integrated health and social care systems.

Our NEL workforce strategy recognises the local initiatives across our footprint, and seeks to agree the overarching priorities we will work on collectively. We have established a Local Workforce Action Board (LWAB) to deliver our vision.

Our current workforce is not sufficient to meet the challenges of growth in demand and system transformation.

- Given the anticipated growth in our local population, we will have varying gaps between supply and demand of professional groups, with a 30% shortfall in nursing and a surge of Specialist Training (ST3-8) doctors completing their training. The cost of meeting demand in primary care is unaffordable and we need to rethink how we work to maximise resources.
- Vacancy rates and turnover rates across secondary care are too high, leading to a strong reliance on temporary staff against a required reduction in agency spend.
- About 17.5% of registered roles in social care lie vacant, illustrating the difficulty of recruiting the right staff. We need to make NEL a better and more affordable place for NHS staff to live in.

Our five key priorities to transform the workforce are outlined below:

1) Retention of existing staff

It is more cost-effective to retain existing staff.

- We will analyse key reasons for people staying versus leaving the workforce through exit data and interviews with long-serving staff.
- We will create an action plan to maximise retention of people who plan to leave in the future and set our five year goals through our LWAB and map any savings.

2) Promoting NEL as a place to live and work

To recruit more staff, we need to make employment within NEL more attractive.

- Jointly market the benefits of living in NEL with social care to attract more health and social care workers.
- Create career opportunities via central recruitment of apprenticeships and engaging with local business partners to develop shared opportunities. Our Community Education Provider Networks (CEPN) can support this engagement with local communities.
- Keeping the NEL health and care workforce healthy.
- Address the lack of affordable housing for our health and social care workforce with the Mayor of London office.

3) Workforce integration to support new models of care

- Our Year One focus will be to standardise and promote new 'integrated' roles such as care navigators.
- We will work with local authorities and schools.
- We will transform the workforce using education initiatives to enable staff to work across all settings. As new service models develop, we will be in a position to train and deploy the required workforce.

4) Whole systems organisation development

There are operational and financial benefits of working together.

- We plan to streamline our HR functions to offer faster mobility of staff across a greater footprint, through integrated HR policies and services (for example central recruitment to support general practice).
- In year one, we will mobilise our LWAB to steer local transformation programmes. We will also break down the education and training barriers for social and health care. We will build on this work to establish clear HR and OD operational models to be deployed.

5) Primary care transformation

To support the shift of patients from hospitals, we need our primary care workforce to have the right skills.

- Our primary care practitioners will need to act as a single point of care coordination to support the new models of care. Furthermore, we will need to provide a shared resource bank to support and build GP federations.
- In year one, we will build on our existing workforce modelling work to assess new roles (e.g. care navigators and physician associates) and new ways of working. We cannot rely solely on creating new roles but need to also consider extending the skills of our existing workforce to work in multidisciplinary teams. This will include supporting the development of community pharmacists and allied health professionals. We will work with local education providers to ensure there is training available.
- We will also develop our CEPNs using the model in place in CH where the CEPN has taken the lead for workforce development planning and implementation. This will ensure they can support us in implementing the new roles and delivery of workforce development initiatives in years two to five.

2016-17 deliverables	By 2021
✓ Local Workforce Action Board. ✓ Development of retention and joint attraction strategies to promote health and social care jobs in NEL. ✓ Standardisation, testing and promotion of new/alternative roles. ✓ Preparation to maximise the benefits of the apprenticeships levy as a sector. ✓ Enhanced workforce sustainability models for our Community Education Provider Networks ✓ Preparation for the removal of bursaries through strategic engagement with HEIs. ✓ Developing the education infrastructure to realise changes with our education providers.	✓ Retention improvement targets set in year one and bank/agency reductions, delivered. ✓ Full implementation of the right roles in the right settings. ✓ Integration of roles at the interface of health/social care. ✓ All staff to have structured career pathways. ✓ Aligned/converged HR processes.

2. Digital enablement

A significant and immediate opportunity exists for digital to transform our current delivery models and seed completely new, integrated models of health and social care. We recognise the strength of both the clinical and financial case for digital and its potential impact in strengthening productivity, providing ease of access to our services, minimising waste and improving care. We will accord priority to quickening the pace of appropriate digital technology adoption, realigning the demand on our services by reducing the emphasis on traditional face to face care models.

Our current technology landscape and its direction

NEL Informatics have defined a series of key themes for the delivery of this vision. This achieves three key themes of shared care records (including care co-ordination), advanced informatics, and patient access. These themes are supported by the delivery of fit for purpose infrastructure.

NEL is signed up to the Healthy London Partnership's aims of access for clinicians and patients. We are fully engaging in the HLP digital programme which is connecting up all health and care systems across London and all of our approaches, although different, are supportive of this London-wide transformation programme.

Our system vision:

1) Shared care records enhancing collaboration

Providers will collaborate with health, social and community care. Systems will therefore need to be interoperable to allow for providers from primary, community, social and secondary care to work together. At present, fully interoperable systems across providers remains a crucial objective; we have already made some good progress towards interoperable systems through the east London Patient Record (eLPR) programme. CH and WEL, have already started to share the health records between GPs and providers. In BHR, interoperability has also made progress and the area is aiming towards a shared care record across sectors.

eLPR links between Barts Health, ELFT, GP practices and Homerton allow doctors in hospitals to view ten pages of GP held patient records and GPs to access discharge summaries, future appointments and test results for radiology and pathology. This is already used around 6000 times a week by clinicians across the system and this usage continues to rise. The integration of other care providers is planned with social care integration starting with LB Newham, LB Hackney and City of London Corporation in 2016/17 and then expanding to other councils in subsequent years. Further care settings are also planned with urgent care and GP out of hours systems to be integrated in 2016/17.

As further organisational systems are joined, the richness of patient information available to all will increase.

2) Patient Enablement

Patients require the ability to view their own health records and book appointments with their GP. This functionality is already available in GP practices across NEL but it is not widely enabled or well communicated. At present, our GPs offer very few appointments online for fear of reducing access to patients without access to technology. Currently all of the NEL CCGs are planning to enhance the availability of current technologies for patient access and booking. Bids for money from the Estates and Technology Transformation Fund (ETTF) are being made to employ extra resources to make a significant effort to increase the use in each CCG. We are also piloting the use of alternative online channels for patients' appointments including the use of video consultations. It is crucial that we share best practice and that this functionality is integrated across NEL.

3) Proactively preventing patients from escalating ill health, and evidence-based interventions

At present, each CCG has separate corporate business intelligence (BI) tools. In the future we will need advanced system-wide analytics to provide insight and prompt early interventions at both the patient and system level to enable informatics driven health management programmes.

There has been some progress on this in WEL where the Discovery Project will be used to enable real time reporting on programmes by providers and commissioners, supporting outcomes-based mechanisms and to use predictive analytics to anticipate individual patient health needs. Detailed work is underway which has seen data feeds established and the system itself created in its initial form. A Community of Interest Company is being created that will hold the application and the data from all sources. This set of capabilities will need to be delivered on an NEL level by 2021.

Looking forward

Our technology roadmap will need to progress according to the key aims of interoperability, patient access and unified analytics. A NEL local digital roadmap has been developed.

2016-17 deliverables	By 2021
✓ Gap analysis: ensuring we have sufficient capacity to deliver on the transformation objectives set out in the other work streams ✓ Further refinement of a common technology vision and strategy for NEL. ✓ Establish detailed implementation plan for 2017/18 and beyond. ✓ Improve delivery against targets in online utilisation, shared care records, e-referrals and e-discharges.	✓ Full interoperability by 2020 and paper-free at the point of use ✓ Every patient has access to digital health records that they can share with their families, carers and clinical teams ✓ Offering all GP patients e-consultations and other digital services ✓ Utilizing advanced/preventive analytics towards achieving population health and wellbeing

3. Infrastructure

Estates are a crucial enabler for our system-wide delivery model. We need to deliver care in modern, fit-for-purpose buildings and to meet the capacity challenges due to a growing population.

Our diverse population is projected to grow at the fastest rate in London (18% over 15 years to reach 345,000 additional people) and this is putting pressure on all health and social care services. Due to rapid population growth, we will need to increase our infrastructure to handle the increased number of GP attendances, outpatient attendances and an estimated additional 7,000 births p.a.

The principles underpinning our emerging strategy are:

- Better health and care outcomes assisted by delivering health and social care delivery from a fit for purpose estate
- Partnership between commissioners, providers, and other public sector organisations to align incentives for estate release and support the delivery of new models of care
- Alongside the estate currently used for health service delivery, there are significant opportunities for out of hospital services to be delivered using local authority estate, such as children's centres and libraries, e.g. BHR CCGs; WF Council, NELFT and WFCCG have mapped the health estate against the wider local authority estate, and are using this to develop local opportunities. Across NEL we want to undertake similar mapping to facilitate the delivery of our strategic aims for the health and care estate.
- Optimising the utilisation and costs of the health and care estate.
- Provide expertise and resource for the development of infrastructure programmes for NEL

We have agreed to a number of priorities for our estates roadmap

- Respond to clinical requirements and other changes in demand to put in place a fit for purpose estate
- Increase the operational efficiency of the estate and maximise utilisation of the core estate
- Enhance capability to deliver; and
- Enable delivery of a portfolio of estates transformation projects (ETTF and provider capital programmes / cross – Boundary Projects).

This covers both clinical and administrative estates, both of which will need to be rationalised.

Priorities for estates

- Implementing the changes required to support new models of care, such as surgical centres of excellence and primary care delivered at scale.

In many places services will be delivered from facilities where **primary care** practices can work together with their own access to on-site diagnostics (e.g. blood testing and ultra-sound). The smallest facility that services will be offered from will cater for 10-15,000 patients.

- Improving estates to deliver quality care.
- Development of urgent and emergency care facilities as part of the KGH reconfiguration of emergency services.

Provider organisations, together with commissioner and partner organisations are working across NEL in an ambitious programme to redesign the delivery of health and social care services across the whole footprint including Whipps Cross, King George, Queen's, St George's, Newham, Homerton and Mile End. Whipps Cross will continue to provide acute services, and major health and wellbeing community facilities are proposed for St George's, Whipps Cross, Mile End and St Leonard's sites.

- Review the location of acute inpatient mental health services to improve productivity and provide more flexibility for the delivery of other services across acute sites in NEL
- Reducing the amount of unoccupied land in NEL.
- Focusing on utilisation, reducing non-patient occupied areas

Summary of indicative investment and savings opportunities
Estimated net capital investment: £500-600m
Annual net savings: £10-20m

2016-17 deliverables	By 2021
✓ Agree common estates strategy and governance and operating model. ✓ Establish detailed implementation plan, which reflects opportunities for savings and investments as well as demand and supply implications resulting from other workstreams and demographic factors. ✓ Achieve a consolidated view for utilisation and productivity, PFI opportunities, disposals, and new capacity opportunities and requirements across the patch. ✓ Explore sources of capital, working with NHS and local Authorities for example One Public Estate.	✓ Realise opportunities to co-locate healthcare services with other public sector bodies and services. ✓ Dispose of inefficient or functionally unsuitable buildings and sites in conjunction with estates rationalisation. ✓ More effective use of 'void' space and more efficient use of buildings through improved utilisation. ✓ Investment in capital development works to support strategy delivery.

7. Five year affordability challenge

Introduction to NEL finance and activity modelling

Since the 30 June submission, substantial progress has been made on the NEL STP finance and activity plan. However, it is important to note that further work on detailed financial modelling, especially related to solutions and investments, is still planned or ongoing at this stage.

The basis for the financial modelling has been the refreshed draft five year CCG Operating Plan and provider Long Term Financial Model templates. These have been prepared by individual NEL commissioners and providers, all of whom followed an agreed set of key assumptions on inflation, demographic and non-demographic growth, augmented with local judgement on other cost pressure and necessary investments in services.

The individual plans have then been fed into an integrated health economy model in order to identify potential inconsistencies and to triangulate individual plans with each other. Activity has been modelled across NEL utilising the TST model.

Key changes since the June submission include:

- FY17 figures are now based on M6 FOT rather than initial Operating Plans, reflecting a deterioration of the position at BHR CCGs by c£37m and at ELFT by c£6m. The Barts Health forecast remains unchanged with a deficit of c£83m though this might only be achieved through greater use of non-recurrent measures.
- 5YFV investments are now assumed to require funding equal to the entire FY21 STF allocation of £136m. However, since some of these investments are being planned for as part of the solutions, there should still be a remainder of c£26m available for direct financial support. This is significantly less than the £65m assumed in the June submission.
- Specialised Commissioning cost pressures had previously been notified as c£134m in FY21, but this figure has now been revised to c£36m. Since one of the underlying assumptions is that Specialised Commissioning cost pressures will be offset by savings of equal size, this change has no overall net impact.
- London Ambulance Services have been included and treated in the same way as Spec Comm
- For CCGs, historic carried forward surpluses are explicitly considered in the modelling and projections.
- The risk adjustment has been amended to reflect both the changes above and the latest view in relation to the level of risk in the mitigation plans.

The NEL NHS FY21 affordability challenge is £578m in the 'do nothing' scenario to break even

A number of different scenarios, based on different levels of CIP and QIPP delivery have been developed for NEL to identify the potential five year NHS affordability challenge.

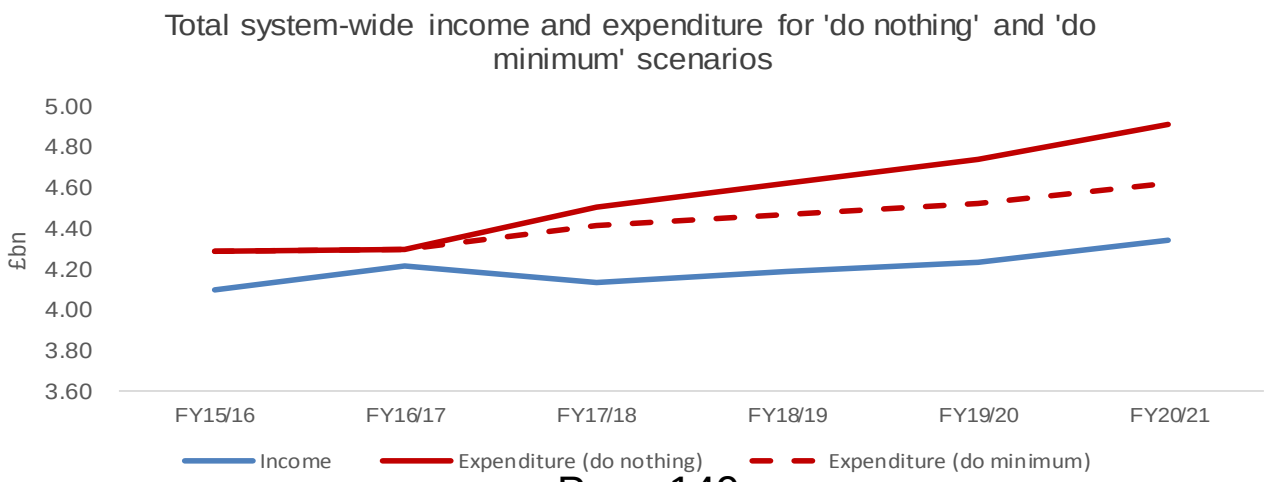
The forecast NEL FY20/21 'do nothing' affordability challenge is c£578m to break even (an additional c£30m to reach 1% surplus target for commissioners). This assumes growth and inflation in line with organisations' plans but that no CIP or QIPP would be delivered in any year.

In the 'do minimum' scenario[1], in which 'business as usual' efficiencies of 2% across all years have been included, the affordability challenge would be c£336m by FY20/21.

Specialised commissioning[2] and any differences in contract assumptions[3] are included in these projections. The local authority position is modelled separately and a summary is available in this chapter.

A number of factors are driving our rising expenditure. One significant factor is our growing and ageing population in line with GLA projections. We also face a non-demographic demand growth which are due to factors such as new technology and increases in disease prevalence; we have assumed that this growth is approximately 1% per year. Pay and price inflation have been assumed in line with NHS I guidance. This results in a steady increase in expenditure over the planning period.

We see significant increases in CCG allocations throughout the planning period. However, Sustainability and Transformation Funding (STF) and some other non-recurrent provider income (such as gains by absorption) primarily affect the initial years and have no impact in the projections of in-year movements from FY18 onwards.

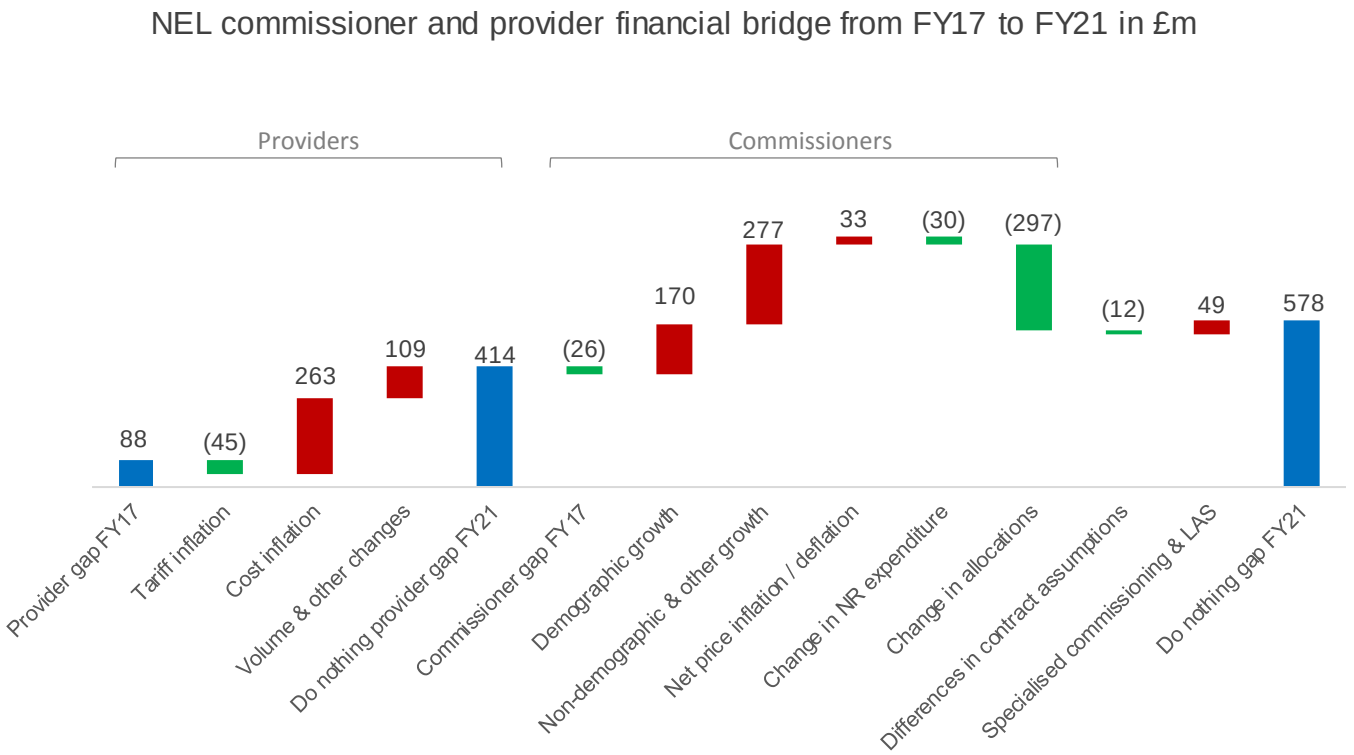


[1] 'Do minimum' scenario includes: no QIPP delivery and only 2%CIP delivery for FY18 onwards
[2] Specialised commissioning is estimated to be an additional c£36m pressure for NEL.
[3] Contract assumption differences between CCG expenditure and provider income are modelled as an additional affordability pressure to the system.

FY20/21 bridge in 'do nothing' scenario

The forecast NEL provider deficit in FY16/17 is c£88m which will rise by £319m to £414m in FY20/21. NEL CCGs are projecting a £26m surplus (including carried over surpluses from prior years) but CCG allocations uplifts of £297m are not sufficient to offset cost pressures over the planning period. Differences in contract assumptions net out to around £12m by FY21 overall and specialised commissioning and LAS add a £49m pressure, resulting in a total financial challenge of £578m in the 'do nothing' scenario to reach a break even position.

Achieving a 1% surplus target for commissioners increases the gap by another c£30m to around £610m.



Detailed bridges for each organisation which provide further transparency about the assumptions underpinning this scenario and the challenge faced by each individual organisation are found in the finance appendix.

NEL local authority challenge

All NEL local authorities and the Corporation of London have provided financial data for the STP modelling, though it is recognised that further detailed work is required to confirm assumptions and what effect local authority funding challenges and proposed services changes will have on health services and vice versa.

For the 'do nothing' scenario, the combined FY17 Local Authority challenge is estimated as £87m reaching £238m by FY21. This figure is based on adult social care, Better Care Fund, children's services and public health at all local authorities.

If Children Services were excluded from the gap analysis, the gap in FY17 would be estimated as £60m reaching £174m by FY21.

A 'do minimum' scenario, where 'business as usual' savings are assumed, will still need to be completed.

Closing the gap – work stream view

Starting from the 'do nothing' gap of £578m, 'business as usual' efficiencies of 2% provider CIP per year would reduce the affordability gap to £336m. This assumption is aligned with the implied efficiency requirement in the tariff guidance issued by NHS Improvement (NHSI) and with the average assumptions made by the other London STPs. Furthermore, reported average CIP achievement over the last three years has been above 2% for NEL providers.

A number of providers have put forward savings plans slightly higher than 2%; these are valued at £84m and will be realised after FY16/17 and would bring the gap down to £251m. Delivery risks around these targets are being assessed and closely monitored so that a realistic risk rating can be included in our planning. The FY21 position shown in the closing the gap charts below is the recurrent position. For Barts Health, there are challenges evident in achieving the planned level of recurrent CIPs this year even though the FY17 control total remains unchanged at this point and ought to be delivered through greater use of non-recurrent CIPs.

The bridge below includes transformational savings of c£136m from the Hackney devolution pilot, the WEL TST programme, the BHR ACS programme and the Healthy London Partnership (see Better Care section). Some of the targeted savings of these programmes can only be delivered in close collaboration with local authorities and have to be considered in this context.

A further contribution of £38m to closing the gap is expected from collaborative productivity opportunities. Key areas across all categories of provider productivity include bank & agency spend, back office, procurement, theatre productivity, diagnostics, length of stay and pharmacy (see Productivity chapter). Due to the consolidated provider landscape in NEL, some efficiencies that would be considered 'collaborative' elsewhere can be captured by provider internal initiatives in NEL.

Infrastructure savings opportunities of £10m relate predominantly to the acute reconfiguration at KGH, which is reliant on capital investments of c£75m. Additional major capital investment costs relate predominantly to the Whipps Cross site, and while a range of different options are being explored, a solution will have to be found in any scenario. Business cases are under development for both KGH and Whipps Cross.

In addition to risk assumptions already made in organisations' base line plans, a further risk adjustment of 5% has been applied across all solutions.

By FY21 STF is expected to be £136m, which is equal to the amount assumed to be required to deliver the NHS Five Year Forward View investment priorities. However, c£26m of those investments were already included in existing plans.

As a result, NEL projects excluding specialised commissioning and London Ambulance Service (LAS), if additional funding for excess PFI cost (estimated at £53m) can be made available, a surplus of up to £37m by FY21, which would meet CCG business rules.

Selected key sensitivities are illustrated on the next page.

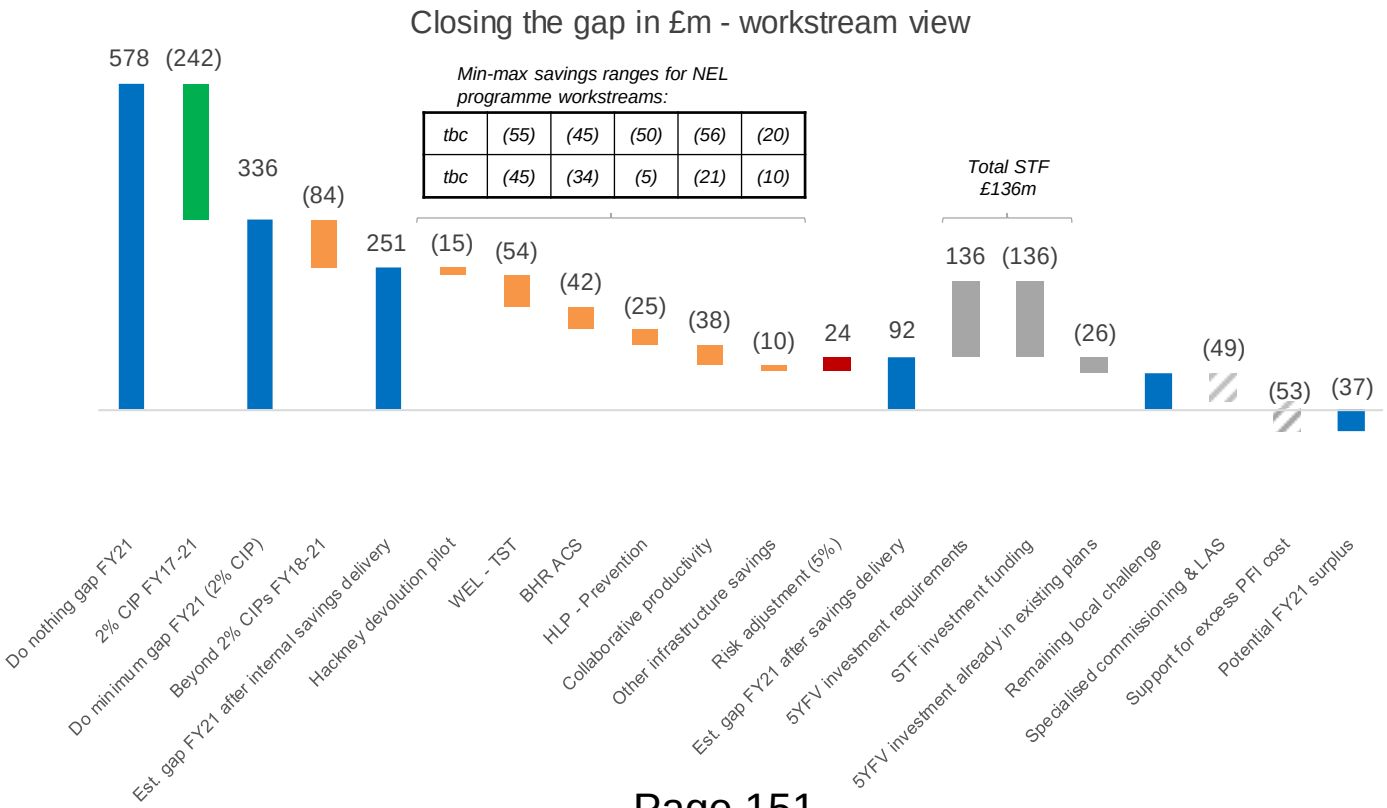


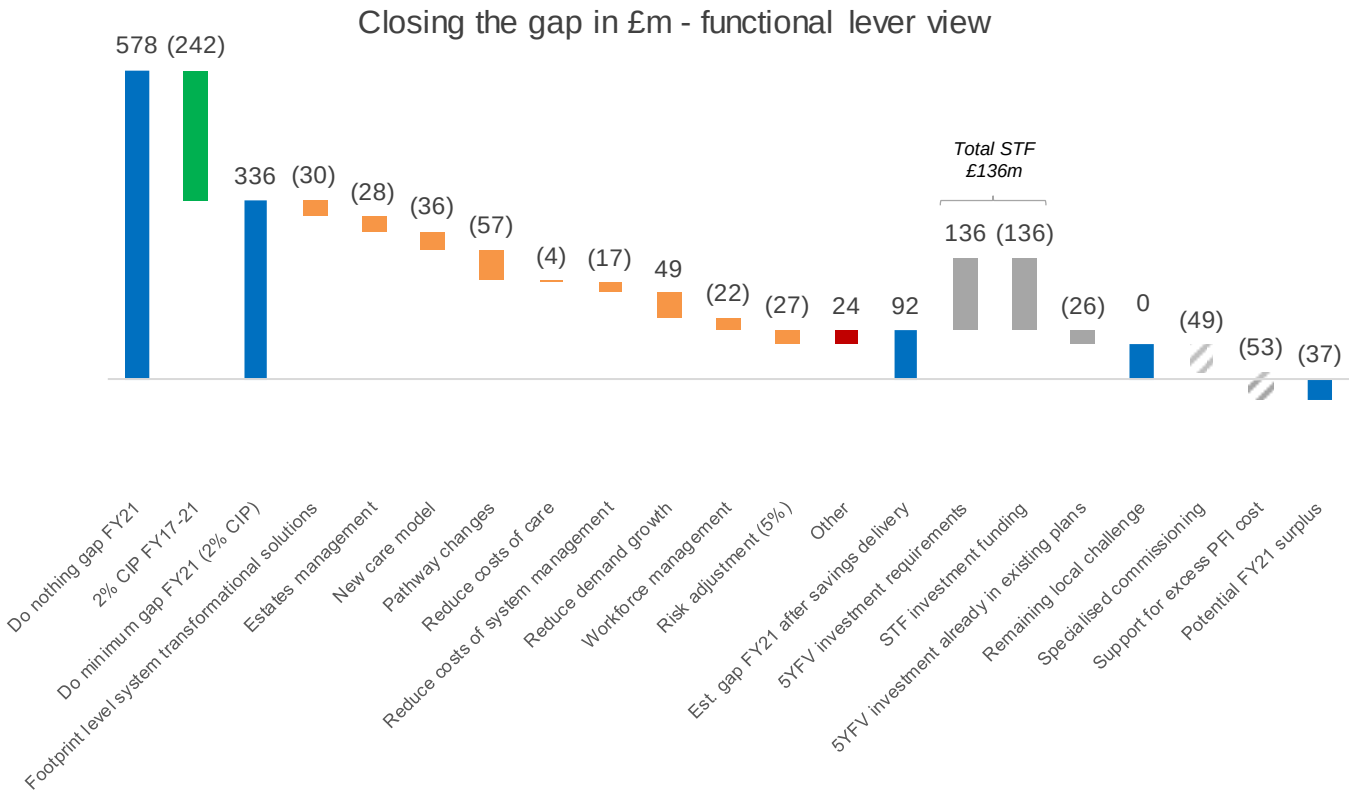
Illustration of selected key sensitivities

It has to be noted that the financial projections are to a high degree dependent on the assumptions made. For example,

- CCGs assumed average demographic growth of c1.5% p.a. Should actual growth be 0.5% p.a. above that level for FY18 to FY21, CCG spend would be around 60m higher in FY21
- CCGs assumed average non-demographic growth, other recurrent cost pressures and investments of 2.2% p.a. Should actual pressures be 1% below that level in FY18 to FY21, CCG spend would be around 122m lower than planned in FY21
- CCGs and local providers assume in total £483m in annual savings by FY21. Should delivery fall short by 25%, costs to the system would be around £121m higher

Closing the gap – functional view

An alternative analysis of how NEL aims to close the gap can be provided by describing and classifying the efficiencies along functional levers that align with the Five Year Forward View.



NEL workstreams in columns, functional levers in rows Values are in £m	2% CIP FY17-21	Hackney devolution pilot	WEL - TST	BHR ACS	HLP - Prevention	Beyond 2% CIPs					Collaborative productivity	Infra-structure	Specialised comm. & LAS	PFI support	Total
						BHR	HUH	ELFT	BH	NELFT					
BAU efficiencies – provider	(242.4)														(242.4)
Footprint system transformation									(10.1)	(1.9)	(18.4)				(30.3)
Estates management			0.0	(15.2)					(2.6)			(10.0)			(27.8)
New care model		(5.0)	(21.8)	(8.8)											(35.6)
Pathway changes		(5.0)	(20.5)	(8.8)		(14.5)			(7.3)		(0.9)				(57.1)
Reduce costs of care			(2.9)								(0.9)				(3.8)
Reduce costs of system mgmt						(6.8)		(0.6)		(1.8)	(7.6)				(16.9)
Reduce demand growth		(5.0)	(8.8)	(8.8)	(25.0)						(0.9)				(48.5)
Workforce management						(3.9)		(6.6)		(2.4)	(8.6)				(21.5)
Other								(1.0)	(24.7)		(1.0)		(49.5)	(53.0)	(129.2)
Total	(242.4)	(15.0)	(54.1)	(41.6)	(25.0)	(25.2)		(8.3)	(44.7)	(6.1)	(38.4)	(10.0)	(49.5)	(53.0)	

Finance outlook

It is recognised that a number of key questions will still need to be answered over the next months:

- Specialised commissioning gap: specialised commissioning is important for all of our providers. To date, the specialised commissioning gap is not yet fully broken down to CCG level and the opportunity analysis is in early stages. NEL recognises the importance of specialised commissioning for its providers. We welcome and will fully participate in the announced specialised commissioning programme initiated by NHS London.
- Organisation level financial balance: the bridges in the finance appendix indicate the magnitude of the financial challenge for each organisation. We appreciate that the impact of business as usual (BAU) and transformation efficiencies on each organisation and their ability to achieve financial balance needs to be worked up in more detail. In parallel, system-wide risk sharing agreements are being explored.
- Monitoring of delivery: operating plans are based on delivery of substantial savings in this financial year. We recognise the associated risks and the necessity to monitor delivery carefully to ensure plans are based on realistic assumptions and are updated without delay once the level of achievement versus operating plans becomes clearer.
- Firming up savings estimates and delivery plans: for several of the NEL work streams, savings estimates and delivery plans will be worked up in greater detail over the next months.

Next steps

The five STPs in London are working jointly to understand the implications of out of area flows on constituent STPs and ensure these implications are accounted for, and where necessary mitigated, in local plans. An approach is expected to be defined by December 2016. This is being taken forward by a working group of the STP finance leads, and will be overseen by the London Strategic Finance Group. Further work is also underway within specialised commissioning, overseen by the London Board and Executive.

8. Governance and system leadership

Developing our system level governance

We established robust governance arrangements to oversee the development of the NEL STP. However, as we move into the next phase of the programme, focusing on the mobilisation and implementation of our delivery programmes, the governance and leadership arrangements are being updated to ensure they continue to remain effective with appropriate membership.

We are developing an authentic governance framework for NEL that recognises the strengths of the sector, as well as its unique challenges. The development of effective and owned governance arrangements represents a significant piece of cultural development across the system that needs to be undertaken inclusively and with an evidenced approach.

This will be an iterative process as the ways of working evolve. We have agreed a route map that involves a consultative and deliberative approach to the development of the new ways of working and decision making. We will establish a shadow governance arrangement, reflecting our current starting point, which will be reviewed and refined as we build our method of working together and there is further clarity about the new operating requirements and landscape.

The shadow arrangements will be put in place at the end of October 2016, with a route plan to implement the refined governance arrangements that will be worked up over the course of the six months, by April 2017.

This timeframe will also enable wider engagement, with local people, clinicians, staff, and other stakeholders to help shape our method of working and governance. The benefit of this approach is that it builds on the existing good foundations and means we will develop robust governance, that is supported by all partners, has been tested and is less likely to unravel at the first challenge.

As part of this route map and consultative approach a Governance Working Group has been established with representation from across NEL including commissioners, providers, Local Authorities, patients and Healthwatch. This group has made significant progress in the development of the shadow governance arrangements, developing a draft Memorandum of Understanding, draft governance structure and initial terms of reference.

Governance principles

The Governance Working Group has agreed a set of governance principles , which are captured in the draft Memorandum of Understanding and summarised below:

Participation: Representation and ownership from health and social care organisations, patients and lay members

Accountability: Define clear accountabilities, delegation procedures, voting arrangements and streamlined governance structures to support continuous progress and timely decision making. Delegation to appropriate groups.

Sovereignty: Recognise the sovereignty of the health and social care partners. Operate in a manner that is compliant with legal duties and responsibilities of each constituent organisation and the NHS as a whole. Ensure alignment with local organisations' governance and decision making processes recognising statutory and democratic procedures

Subsidiarity: Ensure subsidiarity so that decisions are taken at the most local level possible, and decisions are only taken at a system level where there is a clear rationale and benefit

Professional leadership: Demonstrate strong professional leadership and involvement from clinicians and social care to ensure decisions have a robust case for change and support

Accessibility: Ensure complete transparency in all decision making to support the development of mutual trust and openness. Provide the necessary assurance to system partners on key decisions. Collaborative working and information sharing between working groups.

Good governance: Recognise that good system level governance will require robust planning and horizon scanning to align with local governance and decision making processes. However, where unavoidable local organisations will try to be as flexible to support the system level governance

Collaboration: All parties will work collaboratively to deliver the overall NEL STP strategy, in the best interests of the patient

Engagement: Local people will be engaged and involved in the NEL STP governance to ensure their views and feedback are considered in the decision making processes.

Governance structure

Through the Governance Working Group we have developed a shadow governance structure, and initial terms of reference for the key governance forums This draft governance structure is included in the appendices.

This governance structure recognises and respects the statutory organisations, while providing the necessary assurance and decision making capability for system level delivery. In addition to reinforcing some of the existing governance forums (i.e. re-focusing the membership of the NEL STP Board), several new bodies have been added to strengthen the level of assurance and engagement, most notably:

- **Community council** – A council of residents, voluntary sector, councillors and other key stakeholders to promote system wide engagement and assurance
- **Audit Chairs Committee** – An independent committee of audit chairs to provide assurance and scrutiny
- **Finance Strategy Group** - To provide oversight and assurance of the consolidated NEL financial strategy and plans to ensure financial sustainability of the NEL system.

Ongoing dialogue with stakeholders

Continuous and meaningful communications and engagement is central to achieving our vision to transform local health and care services and ultimately delivering the vision set out in the Five Year Forward View.

Our communications objectives are:

- To inform and involve local communities in the development of the STP and our emerging vision for health and care in NEL.
- To clarify and reassure how the STP will interface with other plans that are currently in development or delivery.
- To involve local people in the creation of plans and services.
- To reassure people that this is a piece of work which will make a positive impact on their lives and the quality of care they receive.

Since 30 June we have been engaging partners, including Healthwatch, local councils, the voluntary, community and social enterprise sector, and patient representatives. We have:

- Published the draft and summary versions of the plan on our website and published regular updates
- Offered to meet all MPs which has resulted in a number of 1:1 meetings
- Arranged for elected members from each borough to meet the STP Executive
- Actively sought involvement of the eight local authorities facilitated through the local authority representative on the STP Board.
- Local authorities are represented on the Governance Working Group and have taken part in the workshops developing the plans for transformation (with a Director of Public Health leading the work on prevention).
- Engaged the Local Government Association (LGA) to provide support to individual Health and Well Being Boards (HWBs) to explore self-assessment for readiness for the journey of integration and to a NEL-wide strategic leadership workshop to consolidate outputs from individual HWB workshops.
- Engaged with council and partner stakeholders such as the Inner North East London and Outer North East London Health Scrutiny Committees; Barking, Havering and Dagenham Democratic and Clinical Oversight Group; the eight Health and Wellbeing Boards; Hackney and Tower Hamlets councillors; and Newham Mayor's advisor for Adults and Health
- Met with local Save our NHS, 38 Degrees and Keep our NHS Public campaign groups
- Presented at meetings to discuss specific clinical aspects of the STP, for instance the NEL Clinical Senate; the NEL maternity network and maternity commissioners' alliance; mental health strategy meetings; and clinical workshops on the specialist commissioning of cardiac services and children's services. The proposals have also been discussed at a number of Local Medical Committee forums.
- Discussed the plans with NHS staff.
- Discussed the plans in open board meetings of all our NHS partners and offered opportunities to talk to patients and the public at various annual general meetings and patient group meetings.
- Held wider events on specific topics and developments, e.g. urgent care events involving patients and a wide range of stakeholder such as the London Ambulance Service and community pharmacists.

The feedback has been incorporated into the revised STP for the October 2016 submission.

We published a plain English summary version of the plan on our website www.nelstp.org.uk.

Forward plan for engagement

From 21 October to 31 December, Local Healthwatch organisations will be working together to help us gather and understand the views of patients and communities. Our joint aim is to ensure engagement is relevant to local needs.

Healthwatch organisations will focus on gauging public views on a) promoting prevention and self-care b) improving primary care and c) reforming hospital services; with a local emphasis on:

- The Barking, Havering and Redbridge devolution pilot
- The Hackney devolution pilot
- Transforming Services Together in Newham, Tower Hamlets and Waltham Forest
- The vanguard project in Tower Hamlets

We will continue to offer alternative formats for our communications materials to ensure that we are reaching groups that are sometimes missed.

We will also continue to work with clinicians, local authorities and staff to ensure they are actively involved in the development of the STP.

We will encourage patient involvement at the design stage and work jointly with local authority engagement colleagues to reduce the burden on patients and the public and to help ensure a joined up approach; undertaking formal consultation when required.

We are committed to National Voices' six principles for engaging people and communities that set the basis for good, person-centred, community-focused health and care and will embed these across our work. We also believe that staff have a crucial role to play in the success of the STP. We want them to contribute to its development, to understand and support its aims, and feel part of it, and be motivated by it.

We recognise that any changes proposed in the STP may require public consultation, and are committed to the government's principles for consultation (2016).

We will look at how to tailor consultation to the needs and preferences of particular groups, such as older people, younger people or people with disabilities that may not respond to traditional consultation methods.

Meeting our equalities duties

We are committed to ensuring that everyone has equal access to high-quality services and care, regardless of gender, race, disability, age, sexual orientation, religion or belief. We will work closely with patients, staff, partners and voluntary organisations to help reduce inequalities and eliminate any discrimination within NHS services and working environments. As part of the development of the final STP we will carry out engagement with people who have protected characteristics as set out in the Equality Act 2010. We will conduct equality impact assessment (EIA) screenings to identify where work needs to take place and where resources need to be targeted to ensure all groups gain maximum benefit from any changes proposed as part of the STP.

An overarching EIA screening is underway which will identify which work areas will require detailed EIAs.

9. System reform

Delivering our system vision through local Accountable Care Systems

A common framework to implement our shared vision is being developed. It will focus on sharing the best elements of our local plans in developing local place based accountable care systems.

We have been exploring new service models through devolution pilots and transformative models of care

Each health economy in NEL has been developing innovative service models. In CH and BHR this has been achieved through two of London's flagship devolution pilots. In WEL it has taken the form of a large scale transformation programme, within which sits the Tower Hamlets Vanguard programme

Our shared foundations

We will continue to support these programmes to develop locally, whilst ensuring we collaborate and learn from each other where it makes sense. We recognise the need to take the best from existing plans and scale the benefits. This has enabled us to come to a NEL service model founded on place-based, integrated, person-centred care delivered at scale. We have formed a NEL wide group to share learning.

An ambition for integrated community based service models

Localities, networks or hubs servicing populations of 50,000 will be the centre of integrated working in each area, providing a range of community health and social care services in the local area.

Joint accountability for care

This model requires different providers of health and care services to work together in new ways, removing the traditional barriers joint working. To enable this we will develop local systems whereby all providers are jointly accountable for the delivery of the model. This accountability will be based on a shared responsibility for improving the health and wellbeing of our local population.

New approaches to contracting and payments

To drive this change in accountability we will need new contracting models, underpinned by capitated population based budgets. We will move away from commissioning on a tariff based or block contracting approach, and towards commissioning for outcomes. Whereby payments are made based on the joint delivery of a locally agreed set of outcomes to improve the health of the population.

These systems will ultimately encompass the whole population within an area, although at first specific cohorts may be targeted during the development phase

Centring care in the community

Our systems will be underpinned by the development of high quality primary care at scale, as the foundation of an integrated community based model of care. The extended primary care offer will be supported by integrated locality based multidisciplinary health and social care teams.

We will integrate other core services such as urgent care and mental health into this model, ensuring patients experience seamless care and only need to access acute services when absolutely necessary.

We will use local delivery models to ensure care is delivered in the right setting every time. BHR is also exploring the development of health and wellbeing hubs with a range of services designed to address the wider determinants of good health.

Integrating the commissioning of care

To enable providers to work together in this way we also need to align the way in which we plan and pay for local services. To do this we will fully integrate our health and care commissioning functions between local authorities and CCGs at a borough level.

We will build strong local governance systems across providers and commissioners to oversee the transformation that is required, and establish joint decision making. We will shift the focus from organisation-based performance to system wide population outcome measures.

Our common principles

We will do all of this openly and collaboratively, actively engaging with our local partners, stakeholders, and our population. We will continue to develop these systems locally but actively seek to collaborate across NEL where it makes sense to do so, to make the best use of our combined resources and collectively drive forward the system wide transformation that will enable our local systems to flourish.

We are using the STP as a starting point to achieve system-wide change

This STP provides us with the impetus to harness the best that each area has to offer and move towards a visionary, system-wide transformation plan. This offers us our only opportunity to achieve a sustainable position as a NEL health economy and will enable a healthy population to thrive.

We will collaborate on our common challenges to give ourselves the best possible chance of success, whilst allowing local programmes to flourish.

Making our framework a reality

Plans to implement integrated place-based care were underway before we began working on the STP, with each local health economy pursuing an innovative and ambitious programme to make this a reality.

We will support and enhance these programmes by working together, but they will continue to operate independently with separate programme and governance structures which allow each area the flexibility to best meet local needs.

We are already implementing new models outlined in the Five Year Forward View including a Multi-Specialty Community Provider (MCP)

There are two vanguard programmes already underway in NEL, and each of our delivery models embraces the models outlined in the Five Year Forward View. It is only with new models of care and supporting business models that the full range of benefits from a place based service model can be achieved.

BHR's Devolution pilot

BHR are using the opportunity of devolution to bring health and wellbeing services together as an Accountable Care System. Their devolution business case outlines a plan to achieve fully integrated health, social and other LA services, which places people at the centre and achieves care at scale.

Such changes are only possible with wide-scale system reform, and therefore the plan is underpinned by the pooling of health and social care budgets, commissioning by outcomes, and an ACS business model to enable aligned incentives and collaborative working.

In this model, there will be a single leadership team accountable for both the development of the ACS and BAU activities. An ACS model represents an opportunity to address BHR's current system challenges. This will ultimately work towards the creation of a person-orientated, sustainable service model that will radically improve the lives of local people and build strong resilient communities across BHR.

BHR is already piloting a small scale ACS building on its work as Year of Care and Prime Minister's Challenge Fund (PMCF) pilots - Health 1000 is a specialist primary care provider led by a Consultant bringing together primary care, community health, and social care enabled by a capitated budget. It serves a small population of complex patients with five or more long term conditions who are supported by an integrated team to keep them well and out of hospital.

Health and wellbeing services are clustered in a locality delivery model, with boroughs divided into localities. A new staffing model is being created within localities to deliver health, social care and wellbeing services. This model will extend across traditional organisational boundaries and seek to ensure clinicians and others are able to work in the locality.

WEL – Transforming Services Together (TST)

The TST programme has developed the vision around accountable care systems for Newham, Tower Hamlets, and Waltham Forest.

- Care delivered close to home, with accessible GPs working at scale in collaborative provider networks serving at least 10,000 people. This will be combined with integrated health and social care targeted towards to at-risk patients in their own homes, helping them stay well and manage their illnesses.
- Hospitals that are strong and sustainable with the development of acute care hubs that allow patients to be seen and treated without being unnecessarily admitted. Hospitals will also work in collaborative networks, with hubs which will all deliver a core set of surgeries. Some hubs will also provide specialised surgical procedures.

WEL is taking a phased approach to capitated budgets to ensure payment is outcomes based. Within WEL, Tower Hamlets has developed an Integrated Provider Partnership called Tower Hamlets Together (THT) with Barts Health, East London NHS Foundation Trust, the London Borough of Tower Hamlets and Tower Hamlets GP Care Group, which will provide community health services and form the basis of their ACS. This is a lead provider model where payment is based on outcomes rather than activity. Newham and Waltham Forest are planning a similar model.

CH's Devolution pilot

CH are using the opportunity of devolution to develop a fully integrated commissioning function with governance across the CCG and the two LAs. Through this, they will commission for outcomes and encourage provider collaboration in order to deliver integrated, person-centred care.

They have developed a range of integrated service models and commissioning arrangements already with the help of the Better Care Fund. This includes an integrated care model underpinned by an alliance contract, a health and social care independence team that focuses on intermediate care and reablement, and a fully integrated mental health service.

CH is exploring ways to further improve the quality and coordination of out of hospital services through the "One Hackney" provider network, which uses an alliance contract to support the collective delivery of metrics and outcomes.

A priority will be to implement a single point of access for crises backed up by rapid access to clinical support, and further enhance use of proactive risk stratification and targeted actions for patients who are most at risk of admission.

In addition CH is developing a prevention strategy facilitated by devolution status that is directed towards population health priorities, exploring additional public health powers that can be devolved.

Enabling accountable care

Our ambitious vision for accountable care systems NEL-wide will require fundamental changes to how we work and operate the health and care system. Place-based care requires providers, local authorities and CCGs to work together to focus on outcomes. At present, most providers across sectors are not incentivised to work together to deliver integrated care or rewarded on outcomes.

It will also require a step-change in the development of supporting systems that enable integrated care: digital interoperability, shared care records, fit for purpose infrastructure to host community networks or hubs, and the properly trained and equipped workforce to deliver it.

Provider reform

Our plans for developing Accountable Care Systems that are person-centred can only be achieved through providers collaborating with a focus on patient outcomes and affordable high quality services. Old ways of working, in which providers are incentivised to compete for activity will no longer support this vision. We will need to enhance our collaboration with each other and with our national stakeholders to create a system of incentives that encourages providers to work towards our vision of person-centred care.

Our providers already have significant plans for improving their clinical and collaborative productivity. Overall providers will need to:

- Develop new models for joined up working. With increased accountability they will need to develop inter-organisational forums and processes for decision making and holding each other to account.
- Change their focus towards outcomes: Capitated budgets will require significant provider reform as they reorient their systems towards achieving outcomes rather than activity.
- Collaborate to deliver integrated care: Integrated care will need to depart from traditional, competitive and silo-ed behaviours by focusing on patient pathways.
- Make the most of opportunities for efficiency and productivity through collaboration, for example by sharing back-office functions.

Enablers for change

The delivery of place-based accountable care requires integrated digital systems that can talk to one another, and allow clinicians across providers to access the same information about their patients. Technology can also drive proactive care by utilising risk stratification tools that identify patients who are at high risk and enable actions to be taken to manage their care before they reach crisis.

Our new models of community care will also require estate that can house a range of providers, services, and multidisciplinary teams in the same place to encourage integrated behaviours.

This will also require a new staffing model to deliver health, social care and wellbeing services on a place basis. This model will extend across traditional organisational boundaries and seek to ensure clinicians and others are supported to access the training and development required to work in new ways.

We have grasped the opportunity of the STP to build joint infrastructure, digital and workforce plans that will enable local change by tacking system wide barriers to reform.

Our systems reform 'asks'

Our plans to reform the system through devolution and the development of Accountable Care Systems share common foundations. Taken together they are the vehicle for achieving our system vision, and as such, they are aligned with a common set of 'asks' for the STP as a whole.

Within that, we have collaborated to form a number of 'asks' that will enable our local plans. These 'asks' include:

- **Regulation:** Accountable Care Systems and integrated care require whole system collaboration and a shared commitment to patient outcomes. As such, they need consistent regulatory responses that treat the underlying partners in care as a single system. We request that where plans exist for accountable systems, the system be regulated as a whole, despite the fact that there are distinct underlying organisations.
- **Governance**: We welcome the freedoms of devolution pilots and are looking to achieve similar standards across NEL. We request flexibility on health and social care funding arrangements and freedom to break from existing regulation to deliver system-wide objectives.
- **Accountability:** We request specific governance arrangements that are agreed with the centre between NEL and our accountable care systems. We request that these arrangements cover safety, quality, finance and health and wellbeing standards and outcomes.
- **Commissioning:** We request the ability to develop and account for single system-wide budgets for all health, wellbeing, and social care services.
- **Contracting:** We request that there is flexibility around tariffs and payment mechanisms.

Taking reform forward

The challenge now is to leverage these innovations and collaborate with local, national and regional partners to achieve our system vision of integrated and joined-up-care, where local authorities and NHS providers intentions are aligned.

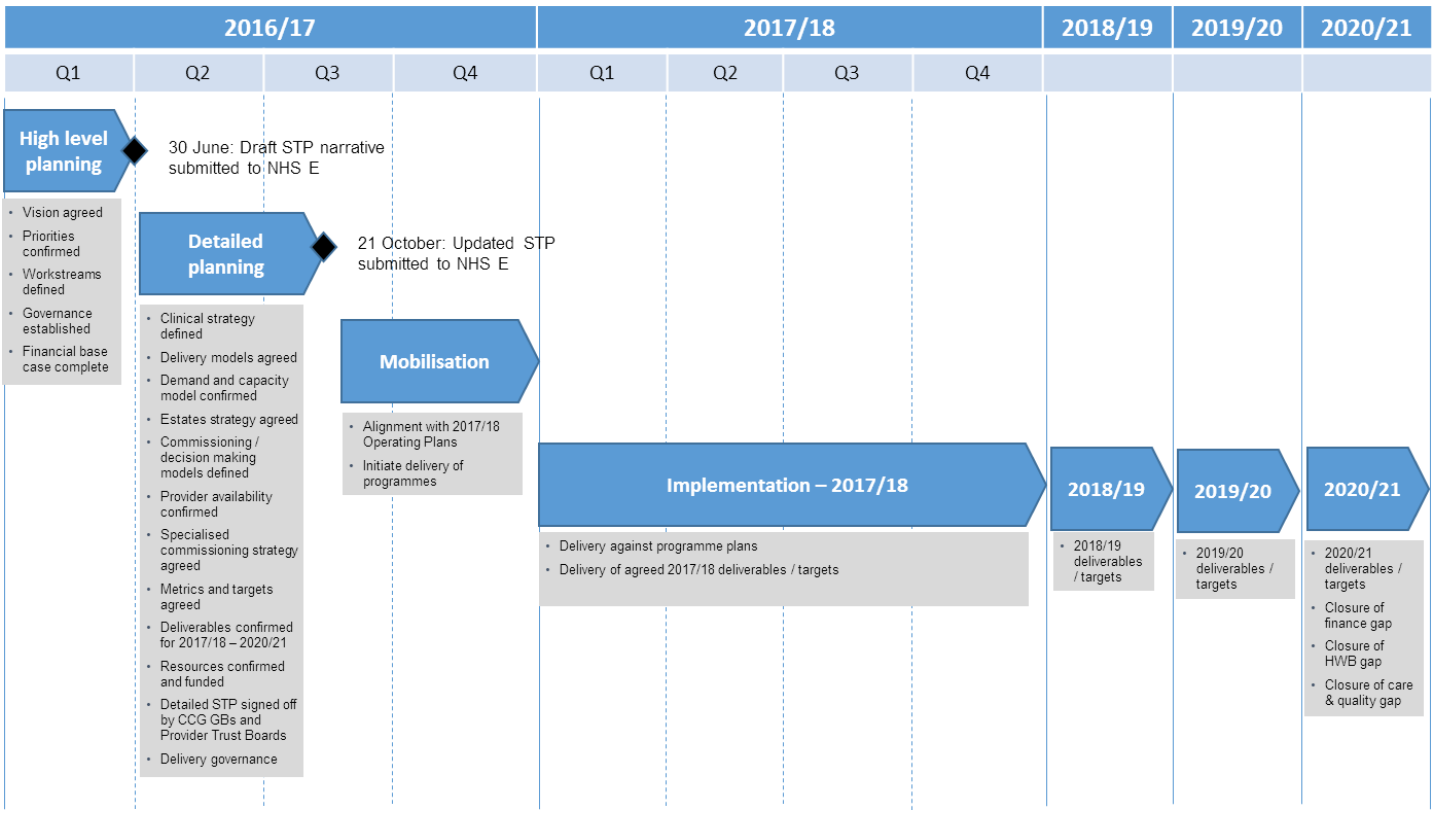
The first step towards this will be through an integrated approach to operational planning for the next two years. By taking an open-book approach to planning together we will start to break down traditional boundaries and build contracts that align to our shared objectives.

We will implement our local Accountable Care Systems over the next four years, at a pace that allows the co-design and engagement that is required to successfully embed change.

BHR are leading the way and plan to establish their ACS in April 2018. The other two systems in NEL will follow their own timetables, learning from the work in BHR, elsewhere around NEL, and across the country.

We will hold each other to account to ensure that we deliver the new models of care needed in north east London.

10. Making progress



Through our STP development process we have developed a delivery structure comprised of four work streams (transformation, productivity, infrastructure, specialised commissioning) and four supporting enablers (workforce, technology, finance, communications and engagement). Senior responsible owners, delivery leads and programme managers have been aligned to each area. The work streams have been mobilised, developed delivery plans and will drive these plans forward.

We recognise that the further development and delivery of the plans in the NEL STP involves significant financial modelling, project management and design resources. It is crucial that we secure these resources in order to ensure an appropriate level of grip and the realisation of benefits. Therefore we have agreed that all partners will contribute resources and have devised a set of core principles that will define the appropriate level of investment from each organisation.

We are implementing a robust benefits management process as part of our delivery plan to ensure that all benefits are clearly articulated, quantified, tracked and realised.

Throughout this process we will continue to ensure that there is total alignment between the five year plans outlined in the STP and the operational plans that our CCGs develop.

Managing risks to the delivery of our plans

We have established a robust proactive risk management process. The key risks to the delivery of our STP that we are currently managing are:

- The plans defined in the NEL STP may not be sufficient to address the full scale of the financial gap.
- The system partners may not able to work together collaboratively to deliver the cross-system plans to close the health and wellbeing, care and quality and financial gaps.
- Due to the size of NEL and the range of stakeholders in this area, it may not be possible to secure the required level of stakeholder buy-in for the STP.
- There may be a legal challenge to the plans outlined in the STP.
- There may be adverse media coverage of the NEL STP, leading to public suspicion of the plans.

11. Our 'Asks'

We will work together to achieve our system vision, but this will require significant collaboration with the centre and a reform of the way our system relates to national and regional bodies. These 'asks' are NEL wide and are reflective of the individual asks that support our devolution pilots.

Governance and accountability	1. In order to achieve our long term aims we need consistent accountability and governance over the next five years. We request clear and specific governance arrangements are developed and agreed between NEL and our accountable care systems, and regulators. We request that these arrangements cover safety, quality, finance and health and wellbeing standards and outcomes. 2. We welcome the freedoms of devolution pilots and are looking to achieve similar standards across NEL. We request flexibility on health and social care joint funding & commissioning arrangements (see note below) and freedom to break with existing regulation to deliver system-wide objectives.
Estates	3. This sector has a number of PFI funded arrangements including the UK's largest hospital development. To succeed, we need to have central support to cover PFI costs above normal levels. 4. We request that we are allowed to retain control of capital receipts and use them for reinvestment, including NHS Property Services, to support the STP vision. 5. We request that there is a support for a consistent NEL approach to estates management across providers/agencies, including NHS Property Services and Community Health Partnerships (CHP) for all relevant assets.
Commissioning and contracting	6. We request that the role of central commissioning arrangements is explored especially in areas of devolution. We want to develop and account for a single system-wide budget for all health, wellbeing, and social care services. 7. We request specific financial risk regulations are modified to reflect the consequences of holding health economy wide budgets and provisions are made for the first two years while transitional arrangements are executed (which may include double running).
Specialised Commissioning	8. We welcome the opportunity for collaboration with NHS E as the main commissioner of specialised services. We request the ability to review and vary clinical specifications/standards and contract for outcomes, in collaboration with NHS E, to improve value for our population.
Regulation	9. For system-wide leadership to work, we need regulators to support system accountability. We request a consistency of response across regulators so that all organisations are able to respond in a way that maximises system gain. For example when dealing with an ACS, we request the system be regulated as a whole, rather than applying a regime to the underlying organisational units. 10. We also request that all regulators and other external bodies work with us to agree the assurance criteria, accountability structures and provision relating to risk mitigation new care models.
Investment	11. To achieve transformation we will need funding, either through STF funding or through other means. We request that we have access to CCG surpluses and the 1% top slice in order to reinvest in achieving our system vision. 12. We request support to devolve some central Public Health England (PHE)budgets to strengthen public health and specialised service transformation in NEL.
Primary Care	13. We request that the resources identified in the GP Five Year Forward View to support the management of workload and care redesign are delegated to the STP to manage. We will establish a new governance arrangement that will involve our GP federations, Royal College of GPs, LMCs and UCLP to oversee the programme to deliver the support and improvements we need at pace.

Note: This is linked with devolution asks regarding amendments to existing statutory provisions, including section 14Z3 of the NHS Act 2006 (as amended by the Devolution Act 2016) to ensure that London CCGs and London local authorities can commission jointly, including via the establishment of a joint committee.

12. Conclusion

We have set out a bold plan for how we intend to work together as one system to deliver outstanding health and wellbeing services for all local people. We began by recognising the six key priorities that we needed to answer as a system. A summary of the actions we are going to take in response to each question is set out below:

The right services in the right place: Matching demand with appropriate capacity in NEL

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

- Shifting the way people using health services with a step up in prevention and self-care, equipping and empowering everyone, working across health and social care.
- Ensuring our urgent and emergency care system directs people to the right place first time, with integrated urgent care system, supported by proactive accessible primary, community and mental health care at its heart.
- Establishing effective ambulatory care on each hospital site and mental health community based crisis care, to ensure our beds are only for those who really need admission, so we don't need to build another hospital.
- Ensuring our hospitals are working together to be productive and efficient in delivering patient-centred care, with integrated flows across community and social care.
- Addressing demand for acute and mental health inpatient services: streamlining outpatient pathways, introducing new technology, delivering better urgent and emergency care, coordinating planned care/surgery, maternity choice, improving psychosis pathways, and encouraging provider collaboration
- Ensuring our estates and workforce are aligned to support our population.

Encourage self-care, offer care close to home and make sure secondary care is high quality

We have a unique opportunity to bring alive our system-wide vision for better care and wellbeing. We are already working together on a system-wide clinical strategy:

- Transforming primary care and addressing areas of poor quality/access, this will include offering accessible support in localities and hubs from 8am to 8pm (seven days a week), with greater collaboration across practices to work to support localities, and address workforce challenges.
- Investing in mental health, community, Learning Disability, & substance misuse services to improve quality and tackle health inequalities. Ensuring parity of esteem and good mental wellbeing, embedding this throughout all of our services.
- Ensuring our hospitals are working together to be productive and efficient in delivering patient-centred care, maximising new technologies and pathway redesign.

Secure the future of our health and social care providers. Many face challenging financial circumstances

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

- We have significant cost improvement plans, which will be complimented by a strong collective focus on driving greater efficiency and productivity initiatives. This will happen both within and across our providers (for example procurement, clinical services, back office and bank/agency staff).
- The providers are now evaluating options for formal collaboration to help support their shared ambitions.
- ACS development (CH/BHR devo business cases Oct 31 2016) in development with LA and efficiencies being established.

Improve specialised care by working together

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

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

Create a system-wide decision making model that enables placed based care and clearly involves key partner agencies

We are committed to establishing robust leadership arrangements, based on agreed principles, that provide clarity and direction to the NEL health and wellbeing system, and can drive through our plans.

This will be achieved through genuine partnership between the health system and Local Authorities to create a system which responds to our population's health and wellbeing needs.

Using our infrastructure better

We need to deliver care in modern, fit for purpose buildings and to meet the capacity challenges produced by a growing population. We are now working on a common estates strategy which will identify priorities for FY16/17 and beyond. This will contain a single NEL plan for investment and disposals, utilisation and productivity and managing PFI, with a key principle of investing any proceeds from disposals in delivering the STP vision.

Appendix

Note that further appendices are available in a separate document.

‘Ten Big Questions’

Our approach to the ‘Ten Big Questions’ outlined by NHS E

As a whole, our STP meets the ten questions outlined by NHS E in the guidance. This is done in various sections. A tick below indicates that the section covers the relevant question.

	1. Better Care	2. Specialised Services	3. Productivity	4. Enablers	5. Finance	6. Governance
How are you going to prevent ill health and moderate demand for healthcare?	◀	◀				
How are you engaging patients, communities and NHS staff?	◀			◀		◀
How will you support, invest in and improve general practice?	◀			◀		
How will you implement new care models that address local challenges?	◀	◀		◀		◀
How will you achieve and maintain performance against core standards	◀	◀		◀		◀
How will you achieve our 2020 ambitions on key clinical priorities?	◀	◀	◀	◀	◀	◀
How will you improve quality and safety?	◀	◀	◀	◀	◀	◀
How will you deploy technology to accelerate change?	◀			◀		
How will you develop the workforce you need to deliver?	◀		◀	◀		
How will you achieve and maintain financial balance?	Financial balance runs throughout our plans. It is tackled in-depth in the finance section.					

Key Deliverables

	2016-17	By 2021
Better Care and Wellbeing	✓ Continue implementation of TST and finalise ACS business cases in BHR and CH. ✓ Develop 24/7 local area clinical hubs, to be available to patients via 111 and to professionals. ✓ Primary Care: ✓ Strengthen federations. ✓ Develop a Primary Care Quality Improvement Board to provide oversight. ✓ Utilise PMS reviews to move towards equalisation and delivery of key aspects of Primary Care SCF. ✓ Extended primary care access model will be established with hubs providing extended access for networks of practices implementing the Primary Care SCF. ✓ Ensure community-based 24/7 mental health crisis assessment is available close to home. ✓ Active plan in place to reduce the gap between the LD TC service model and local provision. ✓ Establish a NEL cancer board to oversee delivery of the cancer elements of the STP. ✓ Establish a NEL-wide MH steering group and develop a joint vision and strategy.	✓ New care models operational across NEL. ✓ Implementation of SCF standards with 100% coverage in line with London implementation timetable. ✓ Reduction acute referrals per 1000 population through improved demand management and primary / community services. ✓ Access across routine daytime and extended hours (8-8) appointments within GP practices and other healthcare settings. ✓ Alignment with NHS E 2020 goals for LD transforming care. ✓ 95% of those referred will have a definitive cancer diagnosis within four weeks or cancer excluded, 50% within two weeks(“find out faster”). ✓ Provide the highest quality of mental health care in England by 2020. ✓ Deliver on the two new mental health waiting time standards and improve dementia diagnosis rates across NEL.
Transforming Hospital Services	✓ Establish joint vision for surgical hub model across NEL. ✓ Establish midwifery model of care pilots at Barts Health and Queen’s Hospital (community hubs are already in place at Homerton). ✓ Midwifery services will be reorganised to ensure that women can be offered continuity of care and improved choice for each part of the maternity pathway. ✓ Increase numbers of women giving birth at home and in midwifery-led birth centres – with new midwifery-led unit opening at RLH. ✓ Develop a clear roadmap for the safe transfer of our existing patients from KGH and ensure that care outside of the hospital will be resilient to support this transition. ✓ Begin implementing full ambulatory care model on all Barts Health sites.	✓ Implemented phase 2 and 3 7DS standards. ✓ Establish surgical hubs at each hospital site that work together in a network. ✓ Midwifery services will be reorganised to ensure that women can be offered continuity of care for each part of the maternity pathway. ✓ Community care hubs will be established with full IT integration to allow seamless communication across the maternity pathway. ✓ Safely complete King George Hospital’s changes.
Productivity	✓ MoU between providers underpinned by principles of collaboration. ✓ Clear timescales for consolidating non-pay contracts. ✓ Joint approach for agencies in place with key suppliers. ✓ Options analysis of collaborative opportunities with pathology across NEL with agreement on a preferred option. ✓ Options analysis for consolidating back office functions completed with a preferred option across the system.	✓ Proactive approach to finding areas for collaborative working in NEL. ✓ Vision for shared back office approach and functions realised ✓ Joint infrastructure and workforce planning across NEL’s organisations. This may be done only to inform rather than replace organisation plans. ✓ All trusts in NEL have implemented the findings of Carter and achieved agreed efficiency savings contributing to their financial sustainability.

	2016-17	By 2021
Specialised Commissioning	✓ Agreed service priorities governance structure for the programme. ✓ Understand of the gap and size of the opportunities. ✓ Agreement as to level of commissioning for each service (national, London, local). ✓ Governance structure for managing any new commissioning arrangements in place. ✓ Plans in place for redesigning pathways and services by 2020/21.	
Workforce	✓ Local Workforce Action Board. ✓ Development of retention strategies ✓ Standardisation, testing and promotion of new/alternative roles. ✓ Enhanced workforce modelling based on new service models. ✓ Joint attraction strategies to promote health and social care jobs in NEL. ✓ Preparation to maximise the benefits of the apprenticeships levy as a sector. ✓ Sustainability models for our Community Education Provider Networks. ✓ Preparation for the removal of bursaries through strategic engagement with HEIs. ✓ Developing the education infrastructure to realise changes with our education providers.	✓ Retention improvement targets set in Year One and bank/agency reductions, delivered. ✓ Full implementation of the right roles in the right settings. ✓ Integration of roles at the interface of health/social care. ✓ All staff to have structured career pathways. ✓ Aligned/converged HR processes.
Infrastructure	✓ Agree common estates strategy and governance and operating model. ✓ Establish detailed implementation plan for 2016/17 and beyond, which reflects opportunities for savings and investments as well as demand and supply implications resulting from other workstreams and demographic factors. ✓ Achieve a consolidated view for utilisation and productivity, PFI opportunities, disposals, and new capacity opportunities and requirements across the patch. ✓ Explore sources of capital, working with NHS and local authorities for example One Public Estate.	✓ Realise opportunities to co-locate healthcare services with other public sector bodies and services. ✓ Dispose of inefficient or functionally unsuitable buildings in conjunction with estates rationalisation. ✓ More effective use of 'void' space and more efficient use of buildings through improved space utilisation. ✓ Investment in capital development works to support of strategy delivery.
Technology	✓ Create a common technology vision and strategy for NEL. ✓ Establish detailed implementation plan for 2016/17. ✓ Start to deliver against targets in online utilisation, shared care records, and eDischarges.	✓ Full interoperability by 2020 and paper-free at the point of use. ✓ Every patient has access to digital health records that they can share with their families, carers and clinical teams. ✓ Offering all GP patients e-consultations and other digital services. ✓ Utilizing advanced/preventive analytics towards achieving population health and wellbeing.

The Nine Must Do's

Must Do	Deliverable	Addressed in NEL STP	Reference
1. STPs	Implement agreed STP milestones, so that you are on track for full achievement by 2020/21	Yes	Included in 8 Delivery Plans
	Achieve agreed trajectories against the STP core metrics set for 2017-19		Awaiting publication of national metrics
2. Finance	Deliver individual CCG and NHS provider organisational control totals, and achieve local system financial control totals.		Awaiting confirmation of control totals for all organisations
	Implement local STP plans and achieve local targets to moderate demand growth and increase provider efficiencies	Yes	Plans defined and business cases under development
	Demand reduction measures	Yes	Finance template
	Provider efficiency measures	Yes	Finance template
3. Primary care	Ensure the sustainability of general practice in your area by implementing the General Practice Forward View, including the plans for Practice Transformational Support, and the ten high impact changes	Yes	• Practice Resilience Plans outlined in NEL Primary Care Plan (and Care Close to Home Plan) • Primary Care Quality Improvement Collaboration referenced in narrative
	Ensure local investment meets or exceeds minimum required levels		Ongoing work to confirm funding sources
	Tackle workforce and workload issues	Yes	• Workforce Delivery Plan • Care Close to Home Delivery Plan (slide 5) • NEL Primary Care Plan
	By no later than March 2019, extend and improve access in line with requirements for new national funding	Yes	• Care Close to Home Delivery Plan (slide 5) • Detailed plans for extended access submitted to HLP • GP Access Fund requests for 2017-19 submitted to NHSE
	Support general practice at scale, the expansion of MCPs or PACS, and enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes	Yes	Care Close to Home Delivery Plan (slide 6)

The Nine Must Do's

Must Do	Deliverable	Addressed in STP	Reference
Urgent and Emergency Care	Deliver the four hour A&E standard, and standards for ambulance response times	Yes	• Care Close to Home Delivery Plan (Workstream 3 – slide 8)
	By November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services	Yes	• Care Close to Home Delivery Plan (Workstream 3 – slide 8) Awaiting outcome of NWL pilot
	Implementing the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each STP footprint	Yes	• Care Close to Home Delivery Plan (Workstream 3 – slide 8)
	Deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an A&E department	Yes	• Care Close to Home Delivery Plan (Workstream 3 – slide 8)
	Initiate cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis	Yes	• Care Close to Home Delivery Plan (Workstream 3 – slide 8)
Referral to treatment times and elective care	Deliver the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT)		• Acute Services Delivery Plan
	Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018	Yes	• Acute Services Delivery Plan (Surgery Workstream 3a– slide 7) • Digital Delivery Plan (slide 21)
	Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups	Yes	• Acute Services Delivery Plan
	Implement the national maternity services review, Better Births, through local maternity systems	Yes	• Acute Services Delivery Plan (Maternity workstream 1 – slide 5)
Cancer	Working through Cancer Alliances and the National Cancer Vanguard, implement the cancer taskforce report	Yes	• Acute Services Delivery Plan (Cancer workstream 2 – slide 6)
	Deliver the NHS Constitution 62 day cancer standard	Yes	• Acute Services Delivery Plan (Cancer workstream 2 – slide 6)
	Make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage 1 and stage 2; and reducing the proportion of cancers diagnosed following an emergency admission	Yes	• Acute Services Delivery Plan (Cancer workstream 2 – slide 6)
	Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types.	Yes	• Acute Services Delivery Plan (Cancer workstream 2 – slide 6) • Acute Services Delivery Plan (Screening workstream 3d – slide 10)
	Ensure all elements of the Recovery Package are commissioned	Yes	• Acute Services Delivery Plan (Cancer workstream 2 – slide 6)

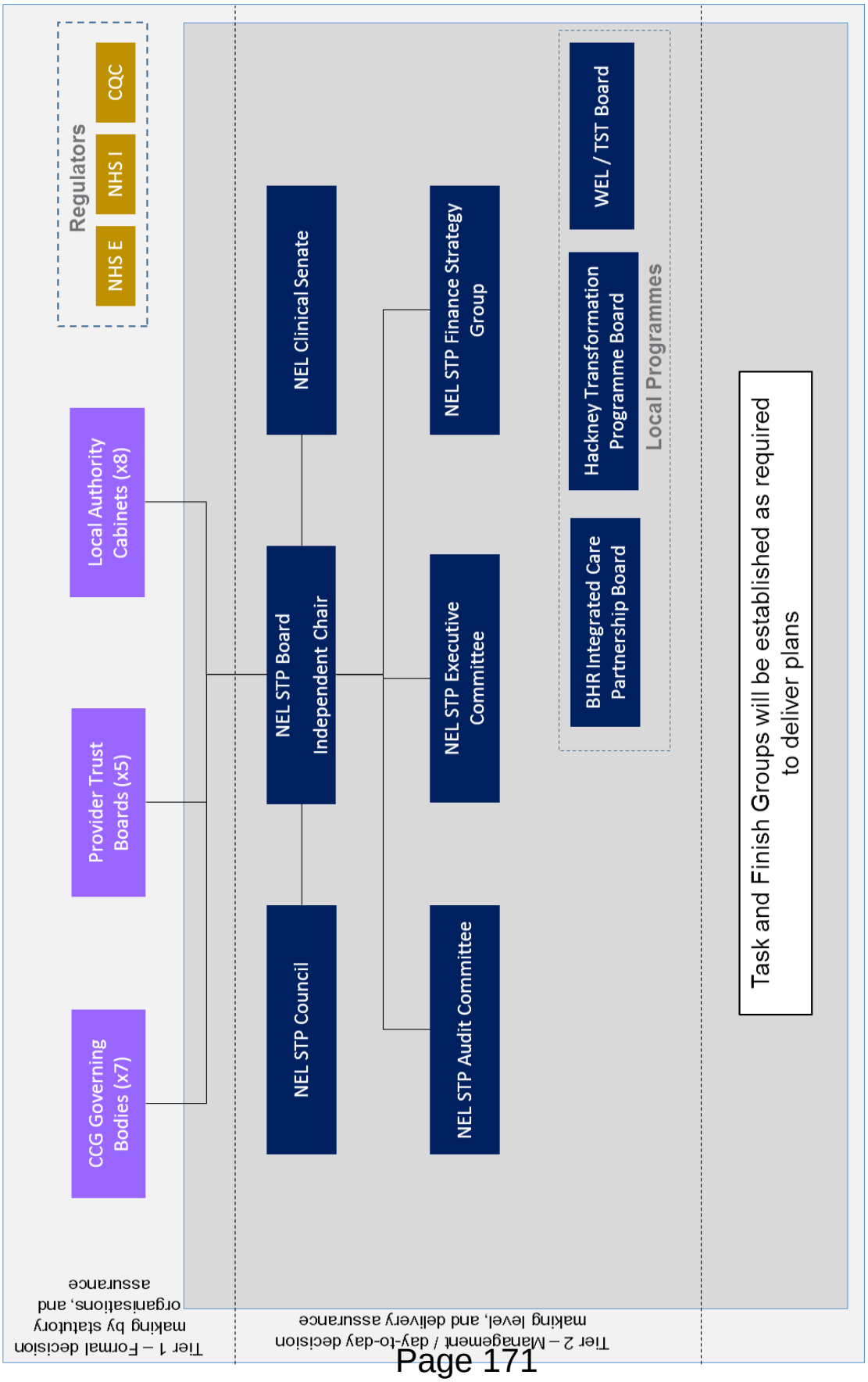
The Nine Must Do's

Must Do	Deliverable	Addressed in STP	Reference
Mental health	Deliver in full the implementation plan for the Mental Health five Year Forward View for all ages, including: including: - Additional psychological therapies - More high-quality mental health services for children and young people - Expand capacity - Increase access to individual placement support for people with severe mental illness in secondary care services - Commission community eating disorder teams - Reduce suicide rates	Yes	Care Close to Home Delivery Plan (Mental Health workstream 2 – slide 7)
	Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals	Yes	• Care Close to Home Delivery Plan (Mental Health workstream 2 – slide 7)
	Increase baseline spend on mental health to deliver the Mental Health Investment Standard	Yes	• Care Close to Home Delivery Plan (Mental Health workstream 2 – slide 7)
	Maintain a dementia diagnosis rate of at least 2 thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia	Yes	• Care Close to Home Delivery Plan (Mental Health workstream 2 – slide 7)
	Eliminate out of area placements for non-specialist acute care by 2020/21	Yes	• Care Close to Home Delivery Plan (Mental Health workstream 2 – slide 7)
Mental health	Deliver in full the implementation plan for the Mental Health five Year Forward View for all ages, including: including: - Additional psychological therapies - More high-quality mental health services for children and young people - Expand capacity - Increase access to individual placement support for people with severe mental illness in secondary care services - Commission community eating disorder teams - Reduce suicide rates	Yes	Care Close to Home Delivery Plan (Mental Health workstream 2 – slide 7)
	Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals	Yes	• Care Close to Home Delivery Plan (Mental Health workstream 2 – slide 7)
	Increase baseline spend on mental health to deliver the Mental Health Investment Standard	Yes	• Care Close to Home Delivery Plan (Mental Health workstream 2 – slide 7)
	Maintain a dementia diagnosis rate of at least 2 thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia	Yes	• Care Close to Home Delivery Plan (Mental Health workstream 2 – slide 7)
	Eliminate out of area placements for non-specialist acute care by 2020/21	Yes	• Care Close to Home Delivery Plan (Mental Health workstream 2 – slide 7)

The Nine Must Do's

Must Do	Deliverable	Addressed in STP	Reference
People with learning disabilities	Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism	Yes	• Care Close to Home Delivery Plan (LD workstream 4 – slide 9) • Narrative Plan – Section 3
	Reduce inpatient bed capacity by March 2019 to 10-15 in CCG-commissioned beds p/million population, and 20-25 in NHS England-commissioned beds p/million population	Yes	• Care Close to Home Delivery Plan (LD workstream 4 – slide 9) • Narrative Plan – Section 3
	Improve access to healthcare for people with learning disabilities	Yes	• Care Close to Home Delivery Plan (LD workstream 4 – slide 9) • Narrative Plan – Section 3
	Reduce premature mortality by improving access to health service, education and training of staff	Yes	• Care Close to Home Delivery Plan (LD workstream 4 – slide 9) • Narrative Plan – Section 3
Improving quality in organisations	All organisations should implement plans to improve quality of care, particularly for organisations in special measures	Yes	• Primary Care Quality Improvement Collaboration referenced in narrative • NEL organisations have own organisational quality plans in place
	Drawing on the National Quality Board's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services	Yes	• Productivity Delivery Plan (Bank and Agency Workstream 1 – slide 5)
	Participate in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare	Yes	• NEL organisations have own organisational quality plans in place

Draft shadow governance structure



List of Acronyms

Acronym	Name
ACS	Accountable Care System
AKI	Acute Kidney Injury
Barts	Barts Health NHS Trust
BAU	Business As Usual
BCF	Better Care Fund
BHR	Barking, Havering and Redbridge
BHRUT	Barking, Havering and Redbridge University Hospitals NHS Trust
BI	Business Intelligence
CAMHS	Children and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CEPN	Community Education Provider Network
CHP	Community Health Partnerships
CH	City and Hackney
CIPs	Cost Improvement Programmes
CKD	Chronic Kidney Disease
CQC	Care Quality Commission
CWT	Cancer Waiting Time
CYP	Children and Young People
DS	Dental Services
ELFT	East London Foundation Trust
GLA	Greater London Authority
GOSH	Great Ormond Street Hospital
HEE	Health Education England
HEI	Healthcare Environment Inspectorate
HLP	Healthy London Partnership
HUDU	Healthy Urban Development Unit
HWBB	Health and Wellbeing Board
IAPT	Improving Access to Psychological Therapies

Acronym	Name
IMD	Index of Multiple Deprivation
IT	Information Technology
IPC	Integrated Personal Commissioning
LA	Local Authority
LARC	Long Acting Reversible Contraceptives
LoS	Length of Stay
LWAB	Local Workforce Action Board
LMC	Local Medical Councils
MCP	Multispecialty Community Provider
MDTs	Multidisciplinary Teams
MRI	Magnetic Resonance Imaging
NEL	North east London
NELFT	NELFT Foundation Trust
NHSE	NHS England
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
PFI	Private Finance Initiative
PHB	Personal Health Budgets
PHE	Public Health England
PMS	Primary Medical Services
PSA	Public Service Agreement
QIPP	Quality, Innovation, Productivity and Prevention Programme
QMU	Queen Mary University
QOF	Quality of Outcomes Framework
RCGP	Royal College of General Practitioners
SCF	Strategic Commissioning Framework
STB	Sustainability and Transformation Board
STI	Sexually Transmitted Infection
STEMI	Segment Elevation Myocardial Infarction
STF	Sustainability and Transformation Fund
TCST	Transforming Cancer Services Together
THIPP	Tower Hamlets Integrated Provider Partnership

List of acronyms

Acronym	Name
TSSL	Transforming Specialised Services in London
TST	Transforming Services Together (working across Newham, Tower Hamlets and Waltham Forest)
UCLP	UCL Partners
UEC	Urgent and Emergency Care
WEL	Tower Hamlets, Newham and Waltham Forest Clinical Commissioning Groups

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD, 15 MARCH 2017

Subject Heading:	Better Care Fund Planning for 2017-19
Board Lead:	Barbara Nicholls, Director, Adult Social Care and Health
Report Author and contact details:	Caroline May, Head of Business Management, Adult Social Care Caroline.May@Havering.gov.uk t. 01708 433671

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

- ☒ Theme 1: Primary prevention to promote and protect the health of the community and reduce health inequalities
- ☒ 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: Quality of services and user experience

SUMMARY

The purpose of this report is to provide the Health and Wellbeing Board with an update on the way in which the Better Care Fund (BCF) will be implemented in the financial years 2017/18 and 2018/19. As with previous years, it is likely that the planning and submission requirements will require an accelerated process that may require consideration by HWB outside of its usual meeting process.

At time of preparation of this paper, neither National Policy Framework nor Planning Guidance has been released yet; this paper therefore reflects the latest understanding of what these documents are likely to require.

There is a new requirement for plans to cover two years, not one year as previously, and these plans are, as before, required to be jointly developed and approved by the Health and Wellbeing Board.

The BCF has been established by Government to provide funds to local areas to support the integration of health and social care. It aims to ensure a closer integration between health and social care, putting person centred care and wellbeing at the heart of the decision making process. The BCF is a vital part of both NHS planning and local government planning.

2015/16 was the first year of the BCF nationally. Section 75 of the National Health Service Act 2006 gives powers to local authorities and health bodies to establish and maintain pooled funds out of which payments may be made towards expenditure incurred in the exerciser of prescribed local authority functions and prescribed NHS functions.

The BCF policy required the pooling of budgets and a section 75 agreement about how integration will be taken forward and the funding prioritised to support this. In Havering, the indicative pooled fund totals £18.62m in 2017/18, with the local government settlement published on 20th February 2017 indicating an increase of £1.4m for 2018/19 in funds available primarily for the protection of adult social care.

RECOMMENDATIONS

1. Delegate authority to the HWBB Chair to approve the final submission of the BCF Plan 2017/19 to NHS England for submission as required by the guidelines, subject to obtaining approval from the Council and the Havering Clinical Commissioning Group (CCG).

2. Note the intention to consider a three borough approach in year two of the plan, which will be subject to further consultation and agreement with the HWBB.

3. To receive, at the first opportunity, the final submission that was made, and subsequently to receive monitoring reports at six monthly intervals.

4. Delegate authority to the HWBB Chair to approve BCF statutory reporting returns each quarter.

REPORT DETAIL

1. 2017/19 Planning

1.1 The Department of Health (DH) and the Department for Communities and Local Government (DCLG) will publish a detailed policy framework for the implementation of the Better Care Fund in 2017-19, developed in partnership with the Local Government Association, Association of Directors of Adult Social

Services and NHS England. This is expected in mid-March 2017 and for the first time will be a two year plan.

1.2 For 2017-19 it has again been agreed that the BCF planning and assurance process should be integrated as fully as possible with the core NHS operational planning and assurance process as well as reflecting the direction of travel agreed by the Integrated Care Partnership in pursuit of increasing the level of integration and cooperation across the three boroughs (Havering, Barking & Dagenham and Redbridge).

1.3 Local partners are expected to be required to develop, and agree, through the relevant Health and Wellbeing Board (HWBB):

i. A short, jointly agreed narrative plan including details of how they are addressing the national conditions;
ii. Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes;
iii. A scheme level spending plan demonstrating how the fund will be spent;
iv. Quarterly plan figures for the national metrics.

1.4. For 2017-19, the guidance is expected to set out an option for HWBs to 'Graduate' from being required to produce and monitor a BCF plan, focussing instead on a clear and agreed integration plan. This largely mirrors the plans of the Integrated Care Partnership in pursuit of increasing the level of integration and cooperation across the three boroughs of Barking & Dagenham, Havering and Redbridge (BHR).

2. Graduation from BCF planning

It is the government's policy intention that all areas move beyond minimum requirements for BCF and move towards fuller integration of health and social care by the end of this parliament. The timescales over which all areas will 'Graduate' are yet to be decided and will depend on when areas are ready, the time it takes for earlier waves to graduate and the levels of support needed for areas. It is expected that after the initial wave of invited areas, all other areas will be able to express an interest in graduation.

The criteria for graduation will be confirmed in the Policy Framework but is likely to include consideration of the quality of joint planning, maturity of local integrations of health and social care, current trajectory against national metrics and the degree to which budgets are or will be pooled, including potentially the expectation that additional funds are pooled above the minimum set out. The benefits of graduation will include areas becoming exempt from performance reporting on a quarterly basis and not needing to submit a full BCF plan for future periods.

The 2015 Spending Review set out models around joint commissioning, accountable care organisations and devolution. Models for integration are

expected to be included in any graduation material, when it is sent to local areas for expressions of interest to graduate from the Better Care Fund. It is possible that some areas such as the BHR partners will graduate from BCF through a joint plan.

3. Options for consideration

The scheme based approach used in our previous plans has had limited success in driving integration and joint working. It is proposed that the 2017/19 Plan should include a more direct approach to integration of services and /or commissioning, such as the development of the Intermediate Care Tier model. This would bring the commissioning interests of both the local authority and the CCG closer together, around services separately commissioned by each currently, to find a more streamlined, more effective joined up services that support two of the key principles of the BCF: reducing non-elective admissions to acute hospital and reducing Delayed Transfers of Care.

In light of the BHR Integrated Care Partnership vision and direction of travel, as well as the likely graduation principles, there is merit in reviewing the depth to which the BCF plan might be aligned or joined across BHR HWB's. Given the delay in the issue of guidance and policy, and the likely speed with which the plans will be required, it is unlikely that there is sufficient time available to bring the three plans together in 2017/18. However, a staged approach could be adopted which would allow the detail of that joint plan might be formed through 2017/18 to be implemented in 2018/19. This may be structured in such a way as to provide the flexibilities of each borough to ensure that the "protection of social care" element is still fulfilled directly, but the remaining pool is then used to support a more integrated plan.

The principal options appear at this stage to include submission of a Havering-only plan, or perhaps a joint plan across the three boroughs, probably staged across the two years.

4. Policy Requirements

4.1 The legal framework for the Fund derives from the amended NHS Act 2006, which requires that in each area the Fund is transferred into one or more pooled budgets, established under Section 75, and that plans are approved by NHS England in consultation with DH and DCLG. The Act also gives NHS England powers to attach additional conditions to the payment of the Better Care Fund to ensure that the policy framework is delivered through local plans. In 2017/19, it is expected that NHS England will set three conditions, which local areas will need to meet through the planning process in order to access the funding. The conditions require:

i. That a BCF Plan, covering a minimum of the pooled Fund specified in the Spending Review, should be signed off by the HWB itself, and by the constituent Councils and CCGs;

ii. A demonstration of how the area will meet the national condition to maintain provision of social care services in 2017/18 and 2018/19;
iii. That a proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement.

5. Timeline (to be updated once published)

5.1 The timetable has not yet been published, but it is expected that there will be approximately 6 weeks between publication of the guidance and policy and the expected first submission. There will be an assurance process which is said to have been minimised compared to previous years.

6. Assurance and Plan Approval

6.1 It is expected that there will again be no national assurance process for BCF Plans for 2017-19. Early indications are that it will be a two stage assurance process, shared across NHS and local government, and that ratings will be 'simplified':
i. First regional panels, moderated by NHS regional, calibrated and then rated 'compliant' or 'non-compliant'
ii. Second approved by HWB, assured by regional panels, moderated at NHS regional, rated 'approved' or 'not-approved'

The full detail has not yet been laid out.

IMPLICATIONS AND RISKS

Financial implications and risks:

Funding Requirement
Under the NHS Mandate for 2017/18, NHS England will be required to ring-fence £3.624 billion within its overall allocation to CCGs to establish the BCF. Full BCF 2017/18 funding allocations have not yet been confirmed. Havering's expected minimum funding allocations over 2016/17, 2017/18 and 2018/19 are per the table below:

Description	2016/17 £'000	2017/18 £'000	2018/19 £'000	Variance 17/18	Variance 18/19
Revenue funding via CCGs	16,352	16,352	18,352	0	2,000
Disabled Facilities Grant (DFG) funding *	1,426	1,426*	1,426*	0*	0*
Total	**17,778**	**17,778**	**19,778**	**0**	**2,000**

* DFG Allocation details not yet released.

In the Spending Review of 2015, it was announced that additional BCF funding of £105m (17/18), £825m (18/19) and £1.5bn (19/20) would be allocated nationally, described as the "Improved Better Care Fund". Havering's allocations are £0 (17/18), £2m (18/19) and £4.2m (19/20).

In 2016/17 there was also Local Authority non-recurrent revenue funding of £850k contribution from base budget. In 2017/18 it is expected this contribution from base budget will remain and is over and above the minimum requirement.

The Disabled Facilities Grant (DFG) allocations were increased from £829k to £1.4m in 2016/17. This was to encourage areas to think strategically about the use of home adaptations, use of technologies to support people in their own homes, and to take a joined-up approach to improving outcomes across health, social care and housing. Further detail is awaited on allocations and of any new expectations within the guidance.

Risk Share

In 2015/16 there was a performance element totalling £857k within the pool. This was related to the non-elective admissions performance metric, which had a target activity reduction. A connected risk share was apportioned between the local authority and the CCG. The performance fund was not achieved and so this element of the pooled fund was not passed onto the council and instead was paid directly to health to offset acute pressures. Changes in the 2016/17 guidance removed the requirement for a performance fund, and after lengthy discussions, it was agreed that there would be no risk share arrangement, on the basis. For 2017/18 and 2018/19, it is expected that Local areas are expected to re-consider including a risk sharing arrangement which is specifically linked to the delivery of their plan. There will be further discussions between the Council and the CCG to determine the approach and the level of risk that will need to be finalised before final submissions and the changes to the Section 75 Pooled Fund.

There is no contingency element built into the funding envelope with regard to non-elective admissions further to the removal of the risk share. This was a decision that was taken locally by Havering CCG after discussion with the Council and NHS England.

Better Care Fund 2017/19 First Submission

The first submission draft plan is awaiting the guidance and planning discussions will require further approval by the Joint Management and Commissioning Forum and is subject to HWB chair sign off for the second submission as required to meet the submission deadlines, as yet unpublished.

Section 75

There will be a requirement to amend the s.75 to reflect the 2017/18 position and also update the relevant schedules. As per s.75 the accounting arrangements will remain the same including the invoicing processes between the two partners.

Legal implications and risks:

There are no legal implications arising directly from this report at this stage.

Subject to discussions surrounding the possibility of a joint plan with other boroughs, there will a need to ensure that appropriate arrangements are made jointly if required and that each borough's interest are fully reflected.

Human Resources implications and risks:

There are no human resources implications arising directly from this report.

Equalities implications and risks:

The Better Care Fund provides an opportunity to transform care so that people are provided with better integrated care and support. It encompasses a substantial level of funding and it will help deal with demographic pressures in the health and social care system. The Better Care Fund does not appear to have any adverse effects on people who share Protected Characteristics and no further actions are recommended at this stage.

BACKGROUND PAPERS

None

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Havering Health and Wellbeing Board - Forward Plan 2017/18

All meetings will start at 1pm (until 3pm) Rooms to be confirmed for each meeting.

HWB Meeting 10 May 2017. Deadline for papers **28 April 2017** To be held in room tbc	
Update on Referral to treatment delays	Sarah Tedford / Louise Mitchell
Update on STP	Ian Tompkins
Transforming Care Partnership: Six Month Update	Barbara Nicholls
Draft locality boundaries Paper	Barbara Nicholls
Dementia Strategy- for sign off	Gurdev Sani
Report from End of Life Steering Group (tbc)	Gurdev Sani
Drugs and Alcohol Strategy Update	Elaine Greenway
Local Plan Development	Neil Stubbings
Forward Plan	

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