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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD
AGENDA

1.00 pm	Wednesday, 20 September 2017	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:	Andrew Blake-Herbert, Chief Executive Tim Aldridge, Director of Children's Services Barbara Nicholls, Director of Adult Services Mark Ansell, Interim Director of Public Health
Havering Clinical Commissioning Group:	Dr Atul Aggarwal, Chair, Havering Clinical Commissioning Group (CCG) Dr Gurdev Saini, Board Member Havering CCG Conor Burke, Accountable Officer,Barking & Dagenham, Havering and Redbridge CCGs Alan Steward, Chief Operating Officer, Havering CCG
Other Organisations:	Anne-Marie Dean, Healthwatch Havering Matthew Hopkins, BHRUT Ceri Jacob, NHS England Jacqui Van Rossum, NELFT

For information about the meeting please contact:
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What is the Health and Wellbeing Board?

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

What does the Health and Wellbeing Board do?

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

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

1. WELCOME AND INTRODUCTIONS

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

Councillor Brice-Thompson

13.00

2. APOLOGIES FOR ABSENCE

Apologies have been received from have been received from Councillor Ford, Barbara Nicholls and Jacqui van Rossum.

3. DISCLOSURE OF INTERESTS

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

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

4. MINUTES OF LAST MEETING AND MATTERS ARISING (NOT ON ACTION LOG OR AGENDA) (Pages 1 - 10)

To approve as a correct record the minutes of the Committee held on 19 July 2017 (attached) and to authorise the Chairman to sign them.

Councillor Brice-Thompson

13.05

5. ACTION LOG (Pages 11 - 12)

Attached.

Councillor Brice-Thompson

13.10

6. UPDATE ON REFERRAL TO TREATMENT DELAYS (Pages 13 - 18)

Attached.

Jon Scott and Louise Mitchell, BHRUT.

13.20

7. LOCAL PLAN DEVELOPMENT (Pages 19 - 24)

Report attached.

Chris Hilton and Lauren Miller

13.30

8. JOINT COMMISSIONING STRATEGY (Pages 25 - 48)

Report attached.

John Green

13.40

9. TRANSFORMING CARE PARTNERSHIP: SIX MONTH UPDATE (Pages 49 - 52)

Report attached.

Lee Salmon

13.50

10. CAMHS TRANSFORMATION (Pages 53 - 68)

Report and presentation attached.

Carol White

14.00

11. HEALTHWATCH HAVERING ANNUAL REPORT (Pages 69 - 104)

Attached.

Anne-Marie Dean

14.15

12. SEND EXECUTIVE BOARD UPDATE (Pages 105 - 112)

Report attached.

Tim Aldridge

14.30

13. THE DEVELOPMENT OF A JOINT HAVERING AND BARKING & DAGENHAM SUICIDE PREVENTION STRATEGY (Pages 113 - 116)

Report attached.

Elaine Greenway

14.40

14. EAST LONDON HEALTH AND CARE PARTNERSHIP (Pages 117 - 146)

Report attached.

Ian Tompkins

14.50

15. FORWARD PLAN (Pages 147 - 150)

Attached.

Mark Ansell

14.55

16. DRAFT REFRESHED HEALTH AND WELLBEING BOARD STRATEGY INDICATOR UPDATE (for information) (Pages 151 - 152)

Attached.

Mark Ansell

17. DATE OF NEXT MEETING

15th November 2017, Havering Town Hall

MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD
Town Hall
19 July 2017 (1.00 pm – 3.00 pm)

Present:

COUNCILLORS

Elected Members	Wendy Brice-Thompson (Chairman) Gillian Ford and Roger Ramsey
Officers of the Council	Andrew Blake-Herbert, Chief Executive Tim Aldridge, Director of Children's Services Keith Cheesman, Adult Services (substituting for Barbara Nicholls) Elaine Greenway, Public Health (substituting for Mark Ansell)
Havering Clinical Commissioning Group (CCG)	Dr Maurice Sonomi (substituting for Dr Atul Aggarwal) Dr Gurdev Saini, Board Member, Havering CCG Alan Steward, Chief Operating Officer, Havering CCG
Other Organisations	Anne-Marie Dean, Healthwatch Havering

Also present:

Zoe Anderson, BHR CCGs
Pippa Brent-Isherwood, Head of Business and Performance, LBH
Caroline May, Head of Business Management, Adult Services
Gloria Okewale, Public Health Support Officer
Ian Tompkins, East London Health & Care Partnership

All decisions were taken with no votes against.

1 WELCOME AND INTRODUCTIONS

The Chairman advised those present of action to be taken in the event of fire or other event that may require the evacuation of the meeting room or building.

2 APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Robert Benham, Barbara Nicholls (Keith Cheesman substituting) Mark Ansell (Elaine Greenway substituting) Dr Atul Aggarwal (Dr Maurice Sonomi substituting) Conor Burke and Jacqui Van Rossum.

3 DISCLOSURE OF INTERESTS

The following interest was disclosed:

Agenda item 14. UPDATE ON NORTH EAST LONDON SUSTAINABILITY AND TRANSFORMATION PLAN.
Councillor Gillian Ford, personal interest, family relationship with presenter of item (Ian Tompkins).

4 MINUTES

The minutes of the meeting of the Committee held on 10 May 2017 were agreed as a correct record and signed by the Chairman.

5 ACTION LOG

The following items were noted:

17.10 – Update on referral to treatment delays was now on the forward plan and could therefore be removed from the action log.

17.11 – The joint dementia strategy had now been updated. It was noted that LGBT work was now included in the dementia strategy.

17.12 – Integrated Care Partnership communications plan to be an item at the September 2017 meeting of the Board.

17.14 – The health and wellbeing strategy indicator set had now been completed and this item could be removed from the action log.

6 HAVERING CAMHS UPDATE

Due to the presenter having sent apologies, this item was deferred to the next meeting of the Board.

7 CCG SYSTEM DELIVERY FRAMEWORK

It was noted that the three local CCGs had a combined £55 million deficit and were under legal direction to address this with £35 million of savings to be found jointly between BHRUT and the CCGs. The reduction of the backlog in referrals to treatment would help with the financial deficit and the CCGs also had a financial recovery plan.

Some £44 million of savings had been found thus far with £32.9 million of this identified by the CCGs and work would continue to close the remaining gap. Savings schemes were reviewed every two weeks and £4.2 million of savings had been delivered up to the end of 2016/17.

Savings could be derived from planned work where a lot of referrals from primary care could be treated in other facilities than Queen's Hospital. Redirection schemes could also be used for urgent care and, in children's services, appropriate assurances could often be given to parents via their GP.

It was planned to maximise use of estates in order to reduce void charges. Any large moves of clinics or GP surgeries would be engaged on and brought to the Board. All contracts would be reviewed in order to ensure that they provided value for money and opportunities such as managing respiratory cases in the community were also being investigated. Corporate spending was also being reviewed in areas such as car parking and the use of agency staff.

Meetings were being held with providers in order to identify savings and a referral management service would decide if patients could be better seen outside of hospital. Efforts would be made to better manage incidences of pressure ulcers which could result in a significant financial saving. A system-wide discharge programme was also under development in order to reduce the length of time people stayed in hospital. The CCG was required to consult on any measures that would have a significant impact on patients or residents.

The contract for Harold Wood Clinic was monitored and reports of people being regularly turned away would be investigated by the CCG if details could be provided and feedback given to the Board. More details could also be provided to the Board re the cost of treating pressure ulcers.

Medicines management would also be reviewed as cheaper generic drugs could often be used, if clinicians agreed, with for example much cheaper generic cholesterol tablets giving the same outcome as a branded drug. It was noted however that doctors should be mindful of prescription variations as some generic alternatives may not be the same as branded drugs.

The Board **noted** current delivery against the System Delivery Framework.

8 CCG - CONSULTATION ON SERVICE RESTRICTION

The CCG had consulted on proposals to save £5.2 million via changes to services such as IVF, prescribing and cosmetic surgery. The consultation had run for eight weeks and included public drop-in sessions, events and the distribution of leaflets. A total of 661 responses had been received which had shown overall support for stopping funding of services such as cosmetic surgery and weight loss procedures. There had been less support for proposals to cease funding IVF cycles.

A clinical evaluation had looked at the clinical impact of the proposals, patient experience and equalities issues. It had been agreed to cease funding 22 services and continue funding 10 services with one service (tummy tuck surgery) carried over for further work. The revised proposals would produce a potential saving of £3.03 million per annum.

The changes had begun to be implemented on 10 July although this would only be for new referrals, patients already in the system would be unaffected. Information on having treatments carried out privately would also be supplied to patients. It was also noted that applications for funding could still be made for one-off cases, on the basis of exceptional medical need etc.

Funding would cease for head lice treatments although public health advice would still be available for parents via school nurses. Whilst funding was stopping for cosmetic procedures, these could still be funded if they were related to treatment for cancer, burns or major trauma.

The Chair of Healthwatch Havering added that she felt the consultation on the service changes had been well managed and that Healthwatch had been closely involved. Clarification would be sought on precisely when prescriptions for gluten-free foods would cease.

It was noted that Dr Andrew Rixom, Consultant in Public Health, had given very helpful input to the Clinical Experts Panel.

The Board **noted** the decisions reached.

9 HAVERING END OF LIFE CARE ANNUAL REPORT 2016/17

It was noted that it was hoped to unify Havering's end of life care strategy with those for Barking & Dagenham and Redbridge. This area had already been cited as an example of good joint working in the Care Quality Commission report on end of life care.

A single Do Not Resuscitate (DNR) form had been produced and six Death Cafes had taken place allowing group discussion on all aspects of death. The use of the Gold Standard Framework had reduced the numbers of deaths in hospital and electronic end of life care plans were now available.

An IT issue had however meant that plans were not being removed if a patient had died.

The end of life care navigators project had been taken over by Age UK and the children's hospice was also represented on the end of life steering group. It was noted that St Francis Hospice was also now working with BHRUT.

It was felt that the public needed to be better prepared for death and associated subjects. End of life care issues would also be fed into the dementia strategy. Work in discussing end of life issues with family members could perhaps be picked up by the voluntary sector and links could also be made with young carers.

The Board **noted** the report and progress made with end of life care in Havering during 2016/17.

10 **BETTER CARE FUND PLANNING FOR 2017-19**

Guidance had recently been received on the planning cycle. Funding had been added for social care responsibilities which had allowed the funding of six schemes in 2016/17, most of which had performed to expectations.

Reablement services at the Council had been integrated with those of NELFT and the new reablement team was performing well. This had allowed people to get home from hospital more quickly. Staff were now co-located and both the Council and NELFT were trying to resolve associated IT issues.

Other areas focussed on by the 2016/17 plan included carers & the recommissioning of the voluntary sector, services for people with learning disabilities and long term conditions.

The new Better Care Fund plan had to be submitted by 11 September 2017 and a joint plan for the three boroughs was being worked on. Details of further joint working with the local boroughs would be brought to a future meeting of the Board. The division of funding between the Council and health bodies was currently being worked on and the overall funding available had risen from £18m to £23m.

A risk share agreement would only be required if there was a need to go beyond the CCG operation plan but this was thought to be unlikely. The Section 75 agreement would be readdressed and this could also be done jointly with the other boroughs.

Funding for the Health 1000 project had been agreed for 2016/17 but consideration was also being given to taking this into the Havering localities. The boroughs were working together to reduce inequalities and produce a uniformity of services across the area.

Officers were unaware of people being discharged home from hospital late at night and asked for further details. The target of the Home First team seeing patients within two hours of their arriving may need more resources to be met fully.

The Leader of the Council added that Better Care Fund resources were pegged to the 2% Council Tax levy for social care and felt that this was fair on Havering. Officers felt that work would need to be undertaken with the other boroughs on whether these allocations could be pooled and the Council had already held discussions on this with the CCG. It was accepted that a challenge of the Accountable Care System was how resources were shared across the area.

The Board **agreed**:

1. To 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. The intention to prepare a three borough, two stage approach for 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. To delegate authority to the HWBB Chair to approve BCF statutory reporting returns each quarter.

11 BHR TRANSFORMING CARE PARTNERSHIP UPDATE

This item was deferred to a future meeting of the Board.

12 INTEGRATED CARE PARTNERSHIP PROGRESS REPORT

Work was currently midway through the process of understanding what was required re joint commissioning with the System Delivery Partnership Board a key component of this work. It was aimed to move towards the establishment of three localities within Havering.

Pilot work was focussing on services for children and families within the localities and 15-20 families had been identified to take part in the pilot. For adult services, a whole borough drive would be established to support intermediate care. This would include GPs, pharmacies and community groups and aim to ensure a smoother way of using services. Cases of for example a patient being fit for discharge but still occupying a hospital bed due to housing issues could be dealt with in a more collaborative way under this approach.

It was hoped to bring the Borough Commissioning Plan to the next meeting of the Board.

The Board **noted** the progress made and agreed to receive further regular reports on the Integrated Care Partnership.

13 DRUGS AND ALCOHOL STRATEGY UPDATE

Officers advised that there was a dual reporting process for the strategy to both the Board and the Community Safety Partnership. It also emphasised that only small numbers of people in Havering had a substance abuse problem. New indicators showing progress with the strategy could be provided to the Board.

A new drugs strategy had been released in July 2017 which included a local drugs information system. A higher proportion of clients with alcohol problems had been treated – a success of the strategy. Challenges included an increase in the number of drug related deaths although this was an issue nationally due to the aging population.

Areas where Havering performed worse than the national average included admission episodes for alcohol-related conditions and officers added that it was important to have access to specialist alcohol treatment.

The proportion of people waiting more than three weeks for drug treatment had improved significantly following the reconfiguration of the service and the centralising of processes. Performance had also improved recently for the proportion of patients completing alcohol treatments.

It was suggested that the indicator covering the proportion of foster carers attending information sessions on substance misuse should also include carers of Looked After Children. It was felt that the strategy could also cover the relationship with the Local Safeguarding Board and the impact of substance misuse on Child Sexual Exploitation.

The Chair of Healthwatch Havering thanked officers for an improved format of the report.

The Board:

1. **Noted** the progress made in year one, as set out in the:
   - Drug and Alcohol Harm Reduction 2017 Progress Report, which provides a brief summary
   - Refreshed Draft Action Plan 2017-18 which provides in-depth information about actions that were scheduled for 2016-17 (as well as descriptions planned for 2017-18).

2. **Agreed** the proposal that future reports include an indicator set that was more tailored to a health and wellbeing agenda, and which is based on the Local Alcohol Profile and the Public Health Profile of substance misuse.

14 UPDATE ON NORTH EAST LONDON SUSTAINABILITY AND TRANSFORMATION PLAN

The East London Health and Care Partnership (ELHCP) had been launched in July 2017 with a launch event attended by 350 people. The Health & Housing Forum would now be meeting on 18 October and would look at themes including healthy communities, care at home, key worker housing and homelessness. The delivery plans for the Sustainability and Transformation Plan (STP) were currently being refreshed and would then be published.

Council officers were now on the Partnership Board and a meeting had been held with Cabinet Members in June. It was emphasised that the ELHCP was not a threat to local strategies and decision making and there was not a wish to change local arrangements. There was a wish to look at the role of Health and Wellbeing Boards in partnership and scrutiny Members had also been approached to become part of the assurance group.

The Partnership's community group had also now started with a diverse range of organisations represented including the Fire Brigade, Police, Councillors and Healthwatch. It was also planned to involve young people in the plans more. The partnership website had been redesigned and a public facing summary of the proposals had been produced. A series of public events had also been planned for autumn 2017.

A consultation was currently under way on the development of payments between commissioners and providers and it was suggested that the Partnership's finance director could attend a future meeting of the Board in order to provide further details.

The Board **noted** the report.

15 FORWARD PLAN

The Board noted that the updates on Havering CAMHS and on the Transforming Care Partnership had been deferred to the September 2017 meeting of the Board.

16 DRAFT REFRESHED HEALTH AND WELLBEING BOARD STRATEGY INDICATOR UPDATE (FOR INFORMATION)

The Board agreed the list of indicators as shown in the report and the list of annual reports to come to the Board. It was further agreed that this would be included as a reference item for each meeting of the Board.

The Board **agreed**:

1. That the Indicator Set be included as a reference paper for each meeting, noting that many of the indicators will remain unchanged where data are published annually.
2. In addition to the Indicator Set and annual cycle of reports, to receive the following annual reports:
   - Public Health Outcomes Framework
   - Adult Social Care Framework
   - CCG Outcomes Indicator Set

The Board noted that the content of the Indicator Set will be reviewed when the strategy is rewritten (in 2018).

17 DATE OF NEXT MEETING

20 September 2017, 1 pm, Havering Town Hall, committee room 2.

Chairman

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

No.	Date Raised	Board Member Action Owner	Non-Board Member Action Owner	Action	Date for completion	RAG rating	Comments
	19 July 17	All	n/a	HWBB members to provide details of any late night hospital discharges to Keith Cheesman	20 Sept 17		
	19 July 17	Barbara Nicholls	John Green	Borough Commissioning plan (Joint Commissioning Strategy) to be presented to the September HWBB meeting.	20 Sept 17		
	19 July 17	Barbara Nicholls	Lee Salmon	BHR Transforming care partnership update to be deferred to a future meeting of the Board.	20 Sept 17		
	19July 17	Mark Ansell	Elaine Greenway	The following annual reports to be included in the Forward Plan for presentation to the HWB annually: • Public Health Outcomes Framework • Adult Social Care Framework • CCG Outcomes Indicator Set	Jan 18		

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading: **Update on Referral to Treatment (RTT) Delays**

Board Lead:

Report Author and contact details: **Jon Scott (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.

We are pleased to announce that in June 2017 we met the national RTT incomplete standard of 92% (of our patients waiting less than 18 weeks) with performance of 92.2%. Our unvalidated data for July 2017 indicates we have maintained this performance for a second month.

As of the end of June 2017, we were 4.7% ahead of our recovery trajectory to deliver the RTT national standard by the end of Sept 2017. We have treated 1,556

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 July 2017 we reported 11 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 that BHRUT has delivered the national RTT incomplete standard for June 17 (July data is not yet published nationally, but unvalidated data suggests we have achieved the standard for a second month).
- To note progress of RTT activity and the reduction in long waiting patients
- To note progress with the clinical harm reviews of patients who have waited a long time for their treatment
- 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 Planned Care Quality Improvement 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 with no harm found.

Phase 5

- Commenced 15th March 2017
- Focused on non-admitted patients who have been waiting between 30 and 40 weeks
- 225 patients in this cohort, a random sample of 10% of patients (23 in total) have been reviewed with no harm found.

GP Planned Care Quality Improvement Programme

We continue to work closely together at a system level with BHRUT to manage referral activity inflow to the Trust whilst enhancing the patient pathway at a specialty level. This is clinically led work and includes priority areas such as Gastroenterology, Musculoskeletal (MSK) and Dermatology pathways.

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 or are on a complex care pathway

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, including a robust demand and capacity plan for each specialist area, which would allow us to return to delivering the RTT standards.

Based upon the specialty modelling and plans, the expectation was to deliver the national 92% RTT incomplete standard by the end of September 2017. We have delivered this plan three months ahead of schedule by meeting the 92% standard in June 17.

In June 2017 we met the national RTT incomplete standard of 92% with performance of 92.2% of our patients waiting less than 18 weeks. As of the end of June 2017, we were 4.7% ahead of our recovery trajectory to deliver the RTT national standard by the end of Sept 2017. We have treated 1,556 more patients

than anticipated. July performance and data has been submitted to NHS England but will not be published until mid-Sept 17.

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 was a significant challenge to return to meeting the RTT standards and there remains an equally challenging one to sustain performance, which has involved undertaking a significant amount of extra operations (5,000) and outpatient appointments (95,000) over a 18-month period. The whole system has worked hard to tackle the challenge.

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 Planned Care Programme Board.

External assurance is also provided through meetings with NHSE and NHSI. The Trust also has a weekly Access Board that feeds into the Planned Care 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:	Local Plan Development
Board Lead:	Cllr Wendy Brice-Thompson
Report Author and contact details:	Chris Hilton, Assistant Director of Development chris.hilton@havering.gov.uk 01708 434844

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 provides an update on the progression of the Havering Local Plan and discusses the role of the Local Plan in promoting and influencing health and well-being.

RECOMMENDATIONS

Board members are asked to review the report and note its content.

REPORT DETAIL

1. Background - The Havering Local Plan

1.1 The Council is currently consulting on a new Local Plan for Havering which will guide future growth and development within the borough up to 2031. The Plan sets out the Council's vision and strategy and the planning policies that are needed to deliver them. The Plan indicates the broad locations in Havering for future housing, employment, retail, leisure, transport, community services and other types of development. Once adopted, the Local Plan will be the primary tool used for assessing planning applications.

1.2 Over the lifetime of the Local Plan the population of the borough is expected to continue to grow and become more diverse. There is a need to build more homes and develop the infrastructure to accommodate this growing and changing population. The Local Plan seeks to ensure that there is the necessary growth in homes, jobs and critical infrastructure to support and sustain new and existing communities.

1.3 A key challenge is how to provide sufficient homes and infrastructure for a growing and changing population, whilst at the same time promoting health and wellbeing and facilitating healthy lifestyles. There is a need to improve health and wellbeing in Havering and reduce health inequalities and the Local Plan has an important role to play. This is explored in further detail below.

2. Planning for Health

2.1 The Council recognises that health and wellbeing is influenced by the natural and built environments. Carefully planned environments provide the circumstances where good health can be more easily achieved and where the healthier option is the easier and more obvious choice. Prevention, we know, is better than cure. Healthier choices, better diets and more physical activity can help to avoid poor health from the outset. Good planning can help design out environments that can contribute to obesity and can also facilitate community cohesion, social interaction and reduce opportunities for criminal and anti-social behaviour which can all impact on the wellbeing of Havering's residents.

2.2 Although it is difficult to quantify, with precision, the impact of the built and natural environment on health, research does seem to consistently report that the majority of health outcomes are explained by factors other than healthcare. Public Health England published a report in 2017 '*Spatial Planning for Health: An evidence resource for planning and designing healthier places'* which examined the existing health and built environment evidence base, identifying relevant built environment topics, planning principles and characteristics that are associated, or thought to have an association with, health outcomes. The report highlighted the importance of planning in places and communities that encourage healthier choices.

3. The Local Plan and Health

Local Plan - Health Impact Assessment

3.1 One way to influence and promote health and wellbeing through new development is to ensure that the Local Plan is sufficiently robust to maximise health gains and mitigate any potential negative impacts. In 2016/17 a desktop Health Impact Assessment (HIA) was undertaken as part of the preparation of the Local Plan.

3.2 HIA is a process that can help to evaluate the health effects of a plan or project in recognition that where we live, how we travel, and how we gain access to green space or leisure activities can all have a significant impact on health and wellbeing. HIA provides an opportunity to ensure that the potential impacts on health and wellbeing, particularly where there may be inequalities in outcomes for marginalised or disadvantaged groups, are addressed from the outset and mitigated where possible.

3.3 Using the London Healthy Urban Development Unit (HUDU) HIA tool, the Local Plan and all of the underpinning policies were assessed according to the following eleven topics:

(i) Housing quality and design
(ii) Access to healthcare services and other social infrastructure
(iii) Access to open space and nature
(iv) Air quality, noise and neighbourhood amenity
(v) Accessibility and active travel
(vi) Crime reduction and community safety
(vii) Access to healthy food
(viii) Access to work and training
(ix) Social cohesion and lifetime neighbourhoods
(x) Minimising the use of resources

(xi) Climate change

3.4 Under each of the topics above, the HUDU tool poses a range of questions against which the draft Local Plan and supporting policies were considered, taking into account Havering's population profile and health needs.

3.5 In response to the findings and recommendations of the HIA revisions were made to the Local Plan. Some of the key actions taken were:

- Embedding health and wellbeing throughout the Local Plan, recognising that the health challenges of non-communicable diseases, health inequities and inequalities are hugely influenced by the environment
- Developing a specific Health and Wellbeing Policy to highlight the importance of health and wellbeing to those wishing to develop and invest in the borough
- Ensuring strong support for active travel options
- Strengthening policy support for independent living and adaptations to facilitate this.

Health Impact Assessments for Major Development Proposals

3.6 The HIA of the Local Plan has resulted in a new planning policy that will require all major development proposals (typically over 10 residential units or 1,000sqm of commercial floorspace) to be accompanied by a HIA when they are submitted to the Council for planning approval.

3.7 The purpose of this policy approach is to ensure that health and wellbeing is given full consideration as individual sites come forward for development and the potential health impacts of the proposed development are taken into account from the outset. It will build on the overarching position provided by the Local Plan and will give the Council more leverage in seeking improvements to the quality of development schemes from a health perspective.

3.8 In order to help developers and planners take this approach forward and to achieve maximum health benefits the Public Health Service will be developing detailed guidance for developers and will deliver training to the planning department.

Local Plan - Community Infrastructure

3.9 The Local Plan has a key role in facilitating the delivery of additional infrastructure which is needed to support the population and housing growth that is expected over the next 15 years. There is a clear recognition in the Plan of the importance of securing new infrastructure to support growth and tackle existing issues and to make sure that the community in Havering is well served by the facilities it requires.

3.10 The Council has prepared an Infrastructure Delivery Plan (IDP) which seeks to identify the infrastructure that will be needed in Havering. The IDP covers a wide range of infrastructure requirements including health and social care.

3.11 The Council has worked closely with the Havering Clinical Commission Group (CCG) to understand what healthcare facilities are required. Officers have been involved in the preparation of the CCG's Havering Primary Care Infrastructure Capacity Plan (2017) to ensure that health care requirements and the way in which the CCG is seeking to transform and deliver health services in future is fully reflected in the IDP and Local Plan.

3.12 As a result of infrastructure needs assessment and close working with the CCG, the Local Plan has been able to identify the need for new facilities and provides planning policy support for the provision of a new health hub in Romford, new health facilities in the south of the borough at Rainham, the north west of the borough and at the former St Georges Hospital site.

3.13 The Local Plan provides a platform from which to secure major infrastructure investment and will put the Council and CCG in a much stronger position to push for the improved infrastructure needed to support growth.

4. Next Steps

4.1 As mentioned in section 1.1 the Council is currently consulting on the Proposed Submission Havering Local Plan. The consultation is due to close on Friday 29th September. Following the consultation the Council will submit the Local Plan and any representations received to the Secretary of State for Communities and Local Government who will appoint an independent Planning Inspector to undertake an Examination in Public. Only once the Inspector has found that the Plan is acceptable can the Council then adopt the Local Plan. It is anticipated that adoption will be in Spring 2018.

Havering
LONDON BOROUGH

IMPLICATIONS AND RISKS

Financial implications and risks:

There are no financial implications arising from this report.

Legal implications and risks:

There are no legal implications arising from this report.

Human Resources implications and risks:

There are no HR implications arising directly as a result of this report.

Equalities implications and risks:

There are no equalities implications arising from this report.

BACKGROUND PAPERS

None

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Joint Commissioning Strategy
Board Lead:	Wendy-Brice Thompson
Report Author and contact details:	John Green (01708 433018; john.green@havering.gov.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

The Joint Commissioning Unit has been established to commission services on behalf of: Adults Social Care; Childrens Social Care and Public Health services. The strategy that has been developed covers these areas from a Havering council perspective but does not, at this point, include health commissioning apart from references to joint working within the document. These services support vulnerable people across communities and it is essential that the services we commission are of high quality and support people in the right way.

This commissioning strategy details, and seeks approval, for the approach to commissioning services and designing an effective system. There is a need to consult with a wide range of interested parties to ensure the strategy is understood and is compatible with wider objectives. Directors of relevant services have already been consulted and approved the content of the strategy in its current form.

The Joint Commissioning Strategy is intended to be in alignment with and a delivery mechanism for, the Health and Wellbeing strategy. As such comment is sought from

the Health and Wellbeing board as part of a consultation agenda prior to gaining Cabinet approval.

RECOMMENDATIONS

The Board is invited to comment on the strategy prior to seeking Cabinet approval.

REPORT DETAIL

The strategy is provided for Health and Wellbeing Board comment.

IMPLICATIONS AND RISKS

The Joint Commissioning Strategy sets the direction for the commissioning of services until 2020. If it is out of alignment with the aims of the Health and Wellbeing strategy then opportunity could be lost to design a system that will deliver against the themes and aspirations of the strategy.

BACKGROUND PAPERS

As detailed within the Joint Commissioning Strategy document

Havering
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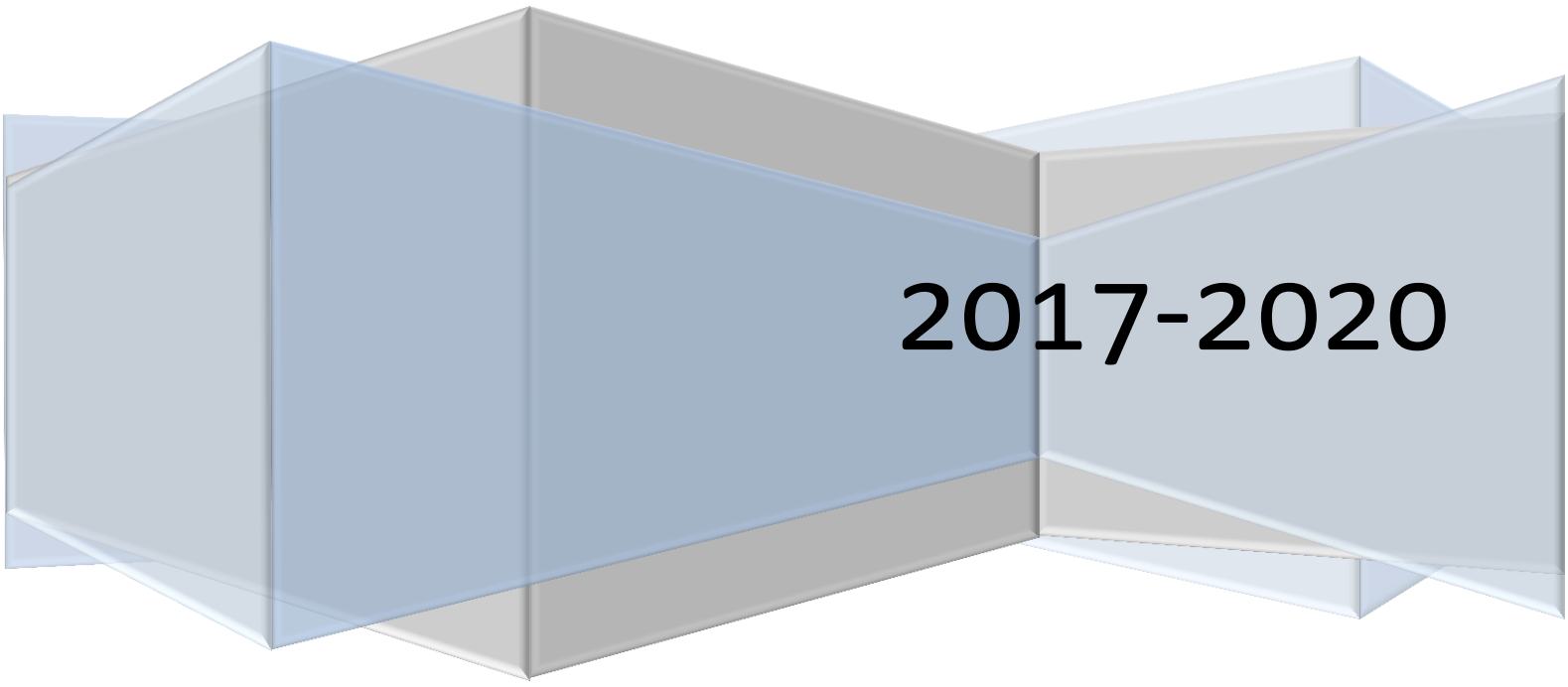
Joint Commissioning Strategy

Commissioning for Adults, Children and Public Health

John Green



Joint Commissioning Strategy

Introduction:

The Joint Commissioning Strategy, covering Adults, Children's and Public Health, is compatible with and supports the goals of the Havering Health and Well-being strategy.

After consultation it will be a statement for stakeholders as to priorities and strategic commitments, providing the basis for commissioners to deliver change and meet our strategic goals. Behaviour, approach and delivery will be compatible with the commitments made.

It needs to be read in conjunction with:

- The JSNA (Joint Strategic Needs Assessment), including 'This is Havering' – Havering's single point of truth regarding demography and population projections. There are no separate statistics in this document but references will be made where such data is important and relevant to points being made.
- 'Havering's Market Position Statement 2016' – this strategy is compatible with and will cross reference to the MPS
- Children Looked After Sufficiency Statement 2016 -2019
- 'Strategic Procurement Strategy 2016- 2018'

The strategy will specify:

- The high level strategic goals that we want to achieve
- A set of non-negotiable conditions
- A set of commissioning principles that will be observed in all that is done

The strategy establishes the right approaches to achieve higher level strategic objectives. This means managing conflicting agendas and priorities, managing a market of providers and working with and designing cross organisational systems that interact and influence each other. By achieving an effective system design we will look to save money whilst protecting or enhancing services and ensuring markets are sustainable and of high quality.

Executive Summary

There are three high level strategic goals which Havering commissioning will be working to deliver:

- Prevention - to maximise independence or maintain it for as long as possible
- Increasing the scope and scale of personalisation
- Delivering Integrated services and working in partnerships to achieve improved outcomes

In addition we will have specific programmes that address particular groups, but recognise the same strategic goals apply

- Adults with Disabilities
- Children and Younger People

The Havering commissioning strategy is fundamentally about **Prevention**, managing demand for services by improving the health and well-being of people in the community. This applies to vulnerable groups but also, at a public health level, to the population as a whole, providing services that prevent future demand. This requires the commissioning of universal services as well as taking the opportunity to prompt people at an early stage to consider and take responsibility for their own health, taking all available steps to mitigate demand. To achieve community level health and well-being a whole system design has to interact effectively, no small ask when there are multiple providers, agencies and organisations with their own ideas, initiatives and priorities.

The strategy recognises this complexity and the factors to be taken into account to get the best outcomes for end users. Thus **working toward integrated services and working in partnership** is identified as a strategic goal in itself. Without cross organisational engagement in developing end to end processes that work for the end user, silo based solutions will mean poor experiences for people. This is why, for the future, the region is looking to Accountable Care Organisation or System (ACO or ACS) models as the way forward. In the meantime the best has to be made of current organisational structures and ways devised of making systems work for the end user.

It is the person requiring care, however, who is best placed to understand responses required to meet needs. For this reason, another, complementary, strategic goal is to increase the scope and scale of **personalisation** in Havering.

There has been progress in reaching the current personalisation offer but there is an opportunity to strengthen what is available. Implicit in this is the need for a conversation between service user, carer and commissioner, and the voice of the user is integral to the strategy and will be embedded within practice.

The goals to **support people with disabilities to maximise independence** and to '**support Havering's children and families to lead happy, healthy lives and to reach their full potential'**[1] recognises there will be a specialised response to their needs. This will include those in need because of family circumstances, those with learning disabilities, with dementia, with autism, with mental health conditions or with physical and sensory disabilities. The overarching goals of Prevention, Integration and Personalisation will, however, still apply.

These objectives are interdependent. Prevention is going to be more successful if we are working in partnership successfully with other organisations or services, so communication and a wide understanding of initiatives taking place in each area is essential.

Structure and Approach

Organisational structure needs to be supportive of strategy. The Joint Commissioning Unit has been designed in alignment with the strategic objectives. Programme Managers, with teams of commissioners and project managers, will be responsible for each of the strategic objectives. In addition teams related to quality, placements, financial control and development of personalisation will ensure that all aspects of this strategy are addressed actively. Workforce development, culture and performance management will be aligned with achieving strategic objectives.

[1] Havering Children's vision

Choices about what activities to undertake, what to prioritise, ideas to implement, services to commission and along what timelines, will be made through appropriate programme and change management, service improvement and design methodologies and approaches. This approach will feed into corporate reporting mechanisms allowing for transparency at different levels of detail depending on the audience.

There are also external demands on the service, most obviously legislative ones. The observance of the statutory requirements and guidance relevant is interwoven with this strategy.

Similarly commissioning practice will be apparent from the commitments and aspirations within the document. However our practice commits fully to:

- Outcome Based Commissioning – Specifying the requirements of services that we commission in terms of outcomes. Understanding we need both input and impact and outcome measures. Working actively and intelligently with providers acknowledging that specifications and contracts can describe a service but in real world situations flexibility and design has to be an ongoing process that requires high quality communication and dialogue to achieve beneficial outcomes.
- Ensuring Return on Investment – Ongoing monitoring of impact by ensuring that measures are in place and working with providers through active contract management. Taking necessary action to protect the council's financial interests.
- Co-design and co-production of services – Working with providers and service users and their families and carers, to design shape and understand services that really meet needs.
- Innovation, Improvement and Change – A commitment to curiosity and experiment within the service so that outcomes for service users can be enhanced and the overall system improved. A continual outward look for creativity that can be applied and adapted to the Havering context. For example the successful application and implementation, over three years, of an Innovation bid for regional commissioning for children's residential care, based on the Narey Report[2].

The Strategic Goals

1. **Prevention**

Utilising all available assets is essential in ensuring that public services continue to support those most vulnerable in our communities. Almost every activity, engagement, communication and discussion between service users and their parents/ carers, potential service users and their parents/ carers and those who are part of the social care and health system should look to utilise and enhance available assets and abilities as, at least, an implicit aspect of the conversation. It is essential that front line social work, operational management, Public Health, council services like Housing and Culture and other partners work together to implement a preventative model based on conversations that encourage and promote independence. This is not a proxy for leaving people out

[2] 'Residential Care in England'. Report of Sir Martin Narey's independent review of children's residential care; July 2016

of a system who need it. It is about empowering and supporting people to use all they have to maintain a healthy and independent life.

Prevention has been categorised as primary, secondary and tertiary[3] depending at what point the intervention or 'nudge' to behaviour change takes place.

In regard to public health services primary prevention can include things like encouragement of breast feeding, improving health at the earliest of stages. Services will include Health Visiting and Sexual Health services, where behaviours can be influenced that prevent later demand.

Public Health statutory mandates include sexual health; health checks and health visiting. The NHS constitution applies to these services which mean a slightly different set of demands around commissioning and clinical governance, which is passed on to the provider. Commissioners need to be assured that services are of high quality and meet clinical standards.

Public Health services will be addressed and understood within the Prevention stream. It is recognised that these have a special intention and element to them which will be recognised in the treatment and commissioning of those services.

It is challenging to measure and monitor how successful preventative measures are and their direct impact on expenditure. As much as possible we will use data and establish systems that provide evidence to ensure an understanding of preventative models and to inform where future investment will be best placed. It is important that public health and commissioners work together where there are needs for data and evidence bases to support the delivery of improved health and well-being.

The prevention programme will look to improve our offer across a range of commissioned services. Whilst there are many different providers potentially delivering these services for different users (e.g. children looked after; children with disabilities; adults with learning disabilities, older frail adults, people with physical or sensory disabilities) the generic services include:

- Home Care – We have implemented the 'Active Homecare Framework', a dynamic purchasing system (not dependent on externally provided IT solutions) which enables providers to operate in Havering providing they meet quality criteria, which will be further developed over time. They will include service user feedback, leading to an outcomes based commissioning model. There is no price competition or payment by results, simply an understanding of outcomes and a commitment to continuous improvement. We are committed to ensuring home care workers benefit from a reasonable funding regime, not in pushing providers to the lowest possible cost model.
- Residential Care – The numbers of people going to residential and nursing care can be reflective of actions taken elsewhere in the system. If numbers of children going into residential care show disproportionate increases, for example, it may suggest there are opportunities for improvements in practice and preventative measures earlier in their pathway. The aim is to sustain people in the community where possible working closely with social care partners to understand models of care and response to need. It is important to share intelligence around trends, the market and expectations.

[3] Care Act guidance chapter 2: Preventing, reducing or delaying needs

Nationally the market for placements for children, both for looked after children and for those with special educational needs and disabilities (SEND) is recognised as difficult. This is in terms of availability and cost. We are therefore looking at a regional response by partnering with other Councils through the successful Innovation bid for funding of a three year programme of change. We are also beginning to investigate property options for finding placements within Havering.

For adults with learning disabilities we are looking at the possibility of working with providers to change residential models and introducing more personalised models of care through Individual Service Funds (ISF). However we will not move away from residential care to supported living unless it is the correct thing to do for the residents.

Our residential care market for older adults is a large one and we continue to work with our providers to understand the pressures on the market. However we acknowledge that there is a need to get a greater understanding of the market and we have committed to undertake a full review of all provisions in the coming year.

- Voluntary Sector services – The voluntary and community sector is an important part of the market. Extensive engagement with both commissioned and non-commissioned voluntary sector services co-produced a set of outcomes important in the Havering context. The required outcomes include:

    - High quality information and advice – for adults this is a directly commissioned service, Care point, that provides scope for face to face and telephone contact. In addition there is a 'Care Point' website that is being constantly updated with information and advice for adults' services. For children's services the 'Local Offer' is the statutorily required website and this will be developed and opportunities identified for joining up these services.
    - Ensuring people are supported in their journey from hospital to home; 'Help not Hospital'
    - Low level support in the community for vulnerable people that prevents escalation to statutory services; 'Here to Help'
    - Low level support in the home, providing and installing equipment to support independence; 'Havering Safe at Home service'.
    - Short breaks services - short breaks will contribute to the ongoing support of children and young people in their own homes as well as preparing young people for independence and adulthood. In particular, we are keen to work with providers to reduce reliance on centre-based services, and instead support young people to maintain friendships out in the community e.g. meeting friends for swimming or to go to the cinema or just to meet for a coffee, with the right support.

    However the process also identified three other outcomes that are particularly important in the Havering context:

    - Social inclusion – informed by the identification of social isolation as a major driver for demand in Havering. Further explored through a social inclusion project, producing recommendations for change that have informed both the need for

preventative services but also the idea of social reablement, integrating a social response to work with the support given from the new reablement service for older people. The approach to short breaks outlined above indicates the importance of building social cohesion and capacity at all ages.

- Carers, both young and old, supported in their role – informed by the demographic of Havering and the identification in the last census of 25000 carers within the borough. The Carers Strategy identifies more detailed outcomes for the voluntary sector to respond to.
- Development of self-sustaining peer support networks – responding to the need for the community to use all its assets to provide support to people.

A commissioning exercise has been launched for organisations to indicate what service design they propose to best deliver the outcome required. This will go live in 2018.

In regard to voluntary sector support for children with SEND, there is a need to ensure commissioned models meet the needs of service users. This will be addressed and the market developed to enable service users to access both commissioned services and other services through the use of direct payments. The Local Offer will be developed to reflect this choice allowing families to have more control over the services they choose.

Once commissioning exercises are complete we will work with providers to ensure outcomes are delivered. We will look to integrate the services with the wider system where necessary.

- Extra Care Housing – We have aligned our 3 Extra Housing schemes and will re-commission the services from 18/19. We will review the offer during 17/18, with a view to improving the service, maximising benefits and applying lessons to any new schemes identified. There is a case for potential increase in provision over coming years and these will be developed in partnership with Housing, using lessons learnt from our current provisions.
- Shared lives – we have introduced a new shared lives service and will develop this, making connections with the community and delivering cost efficiencies.
- Housing provision for young adults – looking to develop and improve our offer to assist young adults move from semi-independent provision to responsible and equipped members of the community
- Drug and Alcohol services – These are important in managing demand with implications across public services, for health, police, housing, childrens and adults services and community safety if drug and alcohol misuse escalates. We will continue to review impact through our current contract but understand wider implications with public health colleagues.

2. <u>Personalisation</u>

The definition of personalised service involves the concept of choice and control for those who require support. In some cases that is giving the ability, for those with capacity to do so, the choice of what they want to use the money that they need (as defined with social workers) in the way they want to, to meet that need. It is also a wider definition regarding all interactions with service users

and their parents/ carers and, potentially, their families that respects them as the best people to make choices about what is required to meet needs. Services need to recognise this and be able to respond and flex to individual need as far as possible – delivering a service around a child/ adult rather than expecting the service user to fit in with how the service is delivered.

Our strategy in Havering is committed to increasing the scope and scale of personalisation and the infrastructure that supports it. There are many issues to be understood, solutions identified and implemented through a programme of change in partnership with service users and their parents/ carers.

Measures will include numbers of particular types of personalised accounts (direct payments; managed accounts; ISFs) but success will be measured in the real change that is delivered to people's lives as a result of increasing choice and control. Measuring this is more complex but is the reason why we are looking to improve our offer.

To build a solid infrastructure for a sustainable system, the activities and approaches needed include:

- Engagement and inclusion of those who are current recipients of self-directed support so that they can shape the model moving forward
- Engagement with those who are potential recipients of self-directed support.
- Clear and specific commitment at a leadership level
- Engagement with the market – outlining the drive toward personalisation and the implications, which will include:
    - The opportunities for developing services designed to meet the needs of individual budget holders.
    - Micro commissioning and the need for growth in personal assistants and/or micro commissioned services that meet particular needs
    - Review of levels of payment to direct payment budget holders
    - Emphasis that once direct payments are in place that costs of services are a matter for the provider to communicate to the DP holders and not the Council
- A culture developed (within and outside the organisation) that understands and appreciates the power of personalisation, promoting the thinking that is needed to move from the perception of dependent service users and their parents/ carers to empowered ones
- Use of external information and learning to promote ways of developing personalised services
- Committing to making processes as easy as possible to access and purchase services
- A proportionate and explicit approach to risk around safeguarding and quality within the context of directly commissioned services
- Draw on cross borough initiatives where they are supportive of market development, quality etc.
- Develop the approach to support planning to ensure full alignment with the goals of personalisation
- Communicate and work with providers to develop the range of services and the support needed to respond to the demand generated for such services
- Have a clear and documented policy framework as the basis for design and decision making

- Clear set of outcome based measures ensuring movement towards increasingly personalised services for users
- Commissioning services to allow them to be flexible and responsive to individual and family needs

Once the programme of change establishes an infrastructure for personalisation the scope for more imaginative and innovative approaches will be possible.

The corollaries of personalised services, meeting holistic outcomes that support service users and their parents/ carers, are people and families more able to live independently, with reduced dependency.

3. Integration and Partnerships

In many cases integrating services for end users or ensuring that we utilise and align the capacity of partners to deliver strategic outcomes is beneficial. The existence of different priorities, agendas, budgets, contractual arrangements, management and governance structures as well as the reality of differing personal beliefs and agendas means that working in partnership, even across different departments let alone different organisations can be, in practice, difficult.

There is a commitment to take the opportunities available from closer partnership working and/ or integration for improving services. However this is not a passive process. We have to actively work on making partnerships work and change and adapt processes and wider systems to create the right environment.

Our commitment, from a commissioning perspective is to work effectively, where benefits for end users will accrue, with partners. There is a significant list of things that we want to develop and enhance that will be a key stream of work for commissioning as we move forward.

Some of the key partners, and an indication of things that we could work together on to enhance service user outcomes, are summarised below:

Social Care

Whilst this is a commissioning strategy it can only work if it is compatible with social care objectives, and vice versa. This is the crucial link to meeting the strategic objectives outlined.

It is essential that the objectives of this commissioning strategy are reflected in the day to day interactions between social workers and service users and their parent/ carers. This interaction will set the tone for expectations of the service users and their parent/ carers around the purpose of the service, the outcomes that are to be achieved and, where possible, the assets the individual can access to support themselves. Introducing and understanding of personalisation also depends on social workers' explanation and promotion of the concept, whilst recognising a supportive infrastructure, built by commissioners, also needs to be in place.

If the connection to commissioned services or financing mechanisms is through social workers identifying need, and understanding what is available and appropriate in the market to meet that need, it follows that commissioning and social care has to communicate effectively and continuously.

To get this right the relationship at senior levels and in the day to day operational interface between social workers and the various elements of commissioning has to be positive and of high quality. Processes need to be supportive of achieving a flow from social work into commissioned services that are effective, controlled properly (financially and in terms of quality of provision) and are proportionate to need.

This strategy commits fully to building and maintaining high quality communication and management of flow at all levels.

Public health

The relationship with public health needs to be coordinated and consistent with the aims of the council in place shaping. There is an opportunity to institute and apply the principles of 'Making every Contact Count' within the JCU, establishing the approach to behaviour change that utilises the many day to day interactions that we have with stakeholders, including front line services and providers, to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations.

The understanding of wider health and wellbeing aspirations will mean that contracts we commission will have embedded within them commitments to wider health and wellbeing objectives. For example, pushing the idea of flu vaccination to care providers, reducing impact on staff but also reducing the possibility of infection being passed on to service users.

The 'nudge' concept will be understood, to ensure that all engagements shift behaviours in the right way to create resilience in the community. Anything we can do to embed this across the service will build a network of 'right messages' and ensure that health and wellbeing value is maximised in all contracts we commission.

Integrated Care Partnership

The Joint Health and Wellbeing strategy and many organisational cross overs and governance groups indicate an already established partnership approach between the London Borough of Havering and Havering Clinical Commissioning Group (CCG). However this basic partnership is extending to incorporate local authority partners and to reflect the changes to CCG structures.

An Integrated Care Partnership has formed that involves CCGs and Local Authorities across the three boroughs, Havering, Barking and Dagenham and Redbridge. As part of the governance structure a Joint Commissioning Board has been formed to take opportunities for joint commissioning. Many initiatives and objectives are shared and delivered and the strategic goals of prevention, integration and partnerships and personalisation resonate across all organisations. The partnership has been in place in various forms over some time and, through lessons learned from the three authorities and through demographic and demand profiling, has developed a Localities Model for delivery of services.

The Localities Model

In Havering the localities have populations within them of a size that best suit population based initiatives. There are three such localities; North, Central and South, with largely equal populations though with potentially different needs. The approach is increasingly to look at population based solutions but this continues to be work in progress. Ultimately the move to a localities model has to be designed so that end users get better services. The concept means that the response to local needs will deliver more value for the residents in that area, because services are aligned with those local needs. Design and implementation of change will be a feature of the Integration and Partnerships agenda.

Better Care Fund

The Better Care Fund (BCF) continues to provide opportunities for joint working, ideas and initiatives in Adults Social Care and Health that will be delivered and developed until the local system graduates to a recognisably integrated service. A cross borough BCF, with Barking and Dagenham and Redbridge, will begin in 17/18 and be developed over the duration of the two year plan.

NELFT (community services provider)

The provider of community health services, commissioned largely by the CCG, is the North East London Foundation Trust. NELFT also provide public health commissioned services like Health Visiting, again operating in the community on a daily basis. It is therefore the case that whenever we want to integrate social services with health based community services it is often integration with NELFT that is the key to making services work on the ground. Where necessary then we will actively work with NELFT to ensure that service outcomes are achieved.

In relation to Adults services a Community Services Integration (CSI) programme (part of the overarching strategic objective of Integration and Partnerships) has been developed that is delivering changes to provision. There are three main streams to the programme:

1. Integration of Reablement and Rehabilitation
2. Integrated 'front door' to services
3. Integrated Localities

1. A local authority commissioned reablement service, provided through NELFT, will integrate as fully as possible with NELFT's rehabilitation service, commissioned by the CCG. The local authority commissioned service commenced on the 18th April 2017. Outcomes will be carefully monitored and the partnership fostered between commissioners and providers so that the service is continuously improved. This will provide a significant element of the hospital to community process (see below), a pivotal aspect of managing demand, where a window of opportunity exists to encourage and guide people back to independence, using all assets available to them, avoiding a slow regression to dependency. It is recognised that the wider intermediate care pathway, a range of services designed to prevent people going into hospital and reabling and rehabilitating them when they come out, could benefit from being more connected. Options to achieve this range from creating a single entity made up of several currently disparate services from different organisations, commissioned as a whole, to more informal cross sector communication facilitated by commissioners. In any case it is

acknowledged that this intermediate care pathway is important in preventing people from becoming dependent on care, where possible. This will be focused upon during 17/18 and is already part of the discussion at the Joint Commissioning Board (see above).

2. A redesign of the front door to Adults services is based on a set of principles. Fundamental to this is having expertise on the front line that is capable of understanding and responding to the queries that are brought to it. These will include trying to understand the issues presented as a whole and finding solutions rather than passing people on, providing increasing numbers of resolutions at first point of contact. Where failure of service is identified as a cause of the contact there will be a commitment to review and improve system conditions that reduce the quality of service to the customer. We will design against demand so that if queries are surfacing that cannot be answered appropriate skills or knowledge will be brought into the service to ensure that, increasingly, queries raised can be answered fully.

   To extend and enhance this offer, making it increasingly capable of responding in an holistic way to queries brought to it, there is a commitment to work with NELFT to ultimately join up and provide a single point of access for community health and social care information.

3. The third stream is to create integrated localities based on GP hubs, where ASC and NELFT staff, such as social workers, district nurses and therapists, are co-located so that productive joint working is facilitated. This may extend to other services if the interests of the customer are served by doing so. The development of cultural, strategic, operational and information alignment is required to enable the full benefits of integration to be delivered. However it is recognised that achieving this has levels of complexity and will be carefully managed and introduced incrementally, so that the service slowly shifts to a fully integrated service. In the longer term it remains a possibility that Accountable Care Organisation level integration, exploring capitated budgets across different organisational boundaries, is considered.

BHRUT - Hospital to community for older people

The interface between hospital and the community is vitally important in the relationship between health and social care, both for the individual and for the organisations concerned.

Going into hospital and coming out with a new or on-going need for support demands a quick and effective response, putting in place all the necessary support mechanisms that will reable and rehabilitate the person back to independent living as soon as possible. We are committed to the principles of 'Discharge to Assess', the idea of getting people out of the acute setting as soon as they are medically fit, ideally back home, where prompt assessment of needs leads to support in place quickly, in whatever form necessary, to enhance chances of rehabilitation and independence. There are a significant number of dependencies on this happening effectively.

- Understanding as soon as possible the point at which clinical need in an acute setting ends, so that the person is identified as ready to go home
- Once this point is understood the rapid transportation home of the person with required support in place (be that equipment or support from a therapist, care worker or an adjustment to the home environment)

- Getting the right assessment of need for the person, recognising that the assessment will be different if done:
    - At the point of crisis in hospital,
    - Immediately after the person gets home
    - After a period of reablement and/ or rehabilitation at home.
- Other influencing factors will be whether the assessment is a joint one, with multi-disciplinary input and whether there is a full understanding and application of the principles of personalisation, developing support plans that focus on outcomes.
- How quickly, from the point of return home, the application of high quality reablement and/ or rehabilitation is put in place
- The quality and intelligence applied in determining need for home care
- The messages that are given to the person concerned around dependency and the ability to get them back to independence
- The family response to the situation
- The ability of informal carers to take responsibility for meeting the needs of the person they are caring for
- The quality and appropriateness of the housing situation of the person concerned

All these dependencies, and others, play out in deciding whether or to what extent and how quickly the person might be capable of being fully independent. If the services do not coordinate, the likelihood of recovery being sustainable for the person concerned will be diminished.

Where commissioned services are part of this they need to be enabled to play their part in contributing to the desired outcome. This needs to be considered in the design of such services, ensuring that integration is designed as an end to end process and not as an individual, segregated service. Commissioners and providers from different organisations need to join up where possible to design across the end to end process, with the benefit to the end user in mind, and not in silos with the achievement of narrow targets as the measure of success. It is, for example, quite possible to achieve targets in getting people out of hospital quickly (thereby achieving success if seen as a worthwhile target in itself), whilst providing a poor service to the service user and building on-going problems if the required support at home is not in place as it should be.

The complexity in getting the process right consistently across organisations and on a day to day basis is considerable but, as a prerequisite of success, requires a joint commitment to making things work to the benefit of the service user. Our design will align with the High Impact Change model[4], ensuring people get home with all the support necessary to maintain independent lives.

Our strategic approach will look to approach things from this perspective and our system design will actively avoid the development of solutions in isolation of partners crucial to the design of an effective end to end process.

Housing and property

[4] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model

Housing, designed to meet needs of individuals and their parents/ carers will delay and prevent the need for care. It is essential, therefore, that the dialogue between Housing and commissioning is an active one to ensure provision is responsive to community needs.

Supported Living[5] is a feature of how the needs of vulnerable people are being met, but with growing demand from the groups of people who may need such support in future, there needs to be a joined up strategic response that understands both the housing need and the care that is attached to it.

Social care for various groups requires a property element that is, however, more diverse than general housing. The designs vary depending on what service is being provided. A residential care home for children will differ from a supported living facility for people with learning disabilities and this will differ again from a residential home for older people. It is often the case that the market will provide properties and have care linked to the property that they own. Whilst this has advantages it also means it is difficult to change providers if similar property is not available. In other cases property is owned by different agencies from the care provider, creating complications with compatible timelines and strategic objectives of different organisations. Over a period of time, if the Council has none of these properties and do not control where they are based, it can cause problems with finding provisions and costs can escalate.

Where this has happened, or is happening, the issue will be articulated and possibilities around providing Council owned properties or working with other providers to ascertain interests in providing property assets needs to be brought to decision makers attention, jointly from Housing and Social Care.

Property as a means of responding to people's needs, with social care attached in some form, means the two are inextricably linked. This needs a joined up response formulated that both protects the financial interest of the council but also means people are in the right places and localities to meet their needs.

Culture and Leisure

The occupation of people in cultural or leisure activities is a powerful preventative measure against physical and mental deterioration. The initiatives in culture and leisure are therefore significant for the agendas outlined in this strategy and dialogue should ensure that opportunities are taken and impact is maximised where it makes sense to do so.

Other Councils

Partnership working between councils can yield significant benefits, particularly where similar issues are faced and where services that address those issues can be commissioned jointly. There are some significant examples where the weight of alliances has drawn significant benefits compared to local commissioning at much smaller scale. The strategic commitment is to identify those areas where this approach yields benefits and to work more actively with regional partners to deliver benefits.

[5] Supported Living is the umbrella term for Housing that is designed with a particular use in mind, normally accompanied by some kind of housing related support and/ or care provision potentially commissioned separately.

The Joint Commissioning Board (with Barking and Dagenham, Redbridge and Havering) mentioned above will be the forum where commissioning opportunities across boroughs will be identified, along with possibilities around integrating commissioning functions.

Where specific opportunities for improvement arise, such as looking for a regional response to the need for an improved market for children's' residential placements, we will actively look to build partnerships of mutual interest.

Placements & Providers

When vulnerable people need support it is often the case that there is an urgent need to find a place for them to reside, either in the short term or for longer periods, sometimes for life. This means that a good quality placement is essential to protect the interests of the individual. This might be a childrens home providing semi-independent support, or a nursing home designed for older people or a supported housing scheme for people with learning disabilities. Where it is possible to plan for the eventuality then social work and placements teams in commissioning should be prepared to work with the market in advance.

Planning is not always possible when there is an urgent need for a placement. Where the market is limited, choice becomes a problem and costs escalate.

It is the aim of this strategy therefore to ensure that the relationships between social work, placements teams and providers enable the smoothest possible flow from identification of need to high quality, value for money, placement. The issue arises across a range of service user groups, including children in need, children with special educational needs and disabilities, older people coming from hospital needing home care or residential care, people with mental health issues, with learning disabilities etc. In practise this means commissioning will:

- Understand and build a market wherever there is need
- Manage relationships
- Understand flow in designing end to end processes
- Identify and resolve issues that will inevitably arise in such a multi stakeholder, cross organisational process.

At the end of these processes providers, on a day to day basis, provide services to vulnerable people. For the most part these services are provided with consideration and sensitivity, ensuring that the quality of service is sufficient to meet the needs of service users and their parents/ carers. The challenge in supporting people who have social, physical or mental health issues is significant and, as commissioners, we respect the work done. Supporting providers to deliver means clarity in commissioning, listening to issues and working together to resolve situations that arise. Financial challenges are well known by commissioners and providers alike but they can only be met where there is dialogue and appreciation of the limitations each other face.

This commissioning strategy commits overtly to a partnership approach where dialogue is valued and trust is built. There is not always an easy answer to problems faced but it will not be found in an adversarial situation, where each side becomes entrenched in negative assumptions and generalisations based on individual cases where things have not worked effectively.

We will actively work to identify issues and record the response we have to those issues, even where the identified problem cannot be resolved in the way that commissioners and providers would like.

We have established forums for dialogue and will welcome provider participation in those forums.

The interactions with different parts of the commissioning service will be consistent. They will be based on mutual respect and an initial assumption that we are both here to provide the best possible services to end users whilst looking to provide value for money. Where this assumption is proven not to be the case we will deal with such issues openly and understand them as individual cases not as representative of a wider provider market.

Our contract management will be based on the need to continually improve services and we will look to be flexible where possible and where it achieves positive outcomes.

Required conditions

There is an understanding that there are certain conditions, constraints or imperatives that need to be observed in what we do. They are not necessarily strategic objectives but do need to be recognised and accommodated within the strategy. They include:

- Saving money whilst protecting services
- Ensuring quality and safety for service users and their carers
- Ensuring a sustainable market

These conditions can set up conflicting priorities, thereby creating challenges that need to be constantly reviewed.

Saving Money whilst protecting services

Commissioning of services in the Social care and Health arena needs to look at the whole system and be generous in understanding that parochial interests can be detrimental to the whole. This parochial interest can be driven where budgets are separate or targets are established, so that success can be seen very narrowly in protecting that budget or hitting that target.

Examples of this can be seen in many parts of the social care and health system. It is the strategic aim, therefore, to avoid, where possible, the consequences of this narrow, ultimately detrimental approach, on service users and their parents/ carers and on Council return on investment.

Although this may seem to be self-evident there are areas where it is challenging to acknowledge that targets achieved (sometimes from established practice or long term pieces of work) have not impacted beneficially on service users and their parents/ carers.

The drive will be to continually have integrity in wanting to improve services to end users and deliver savings as a result of successfully re-designing systems. This will be in preference to shunting cost or undermining long term sustainability for short term savings against a particular set of cost centres when the knock on effects are more detrimental to other budgets.

The approach that we will put in place will, therefore, be based on an understanding of the whole system and on-going dialogue with stakeholders who can help inform the proposals and designs that

we come up with in future. An openness and ability to listen will be fundamental to this, as well as a developed approach to thinking and consideration around end goals.

There are improvements to be made to the current system that will have immediate budgetary impacts as well as less direct and measurable impacts on expenditure through management of demand. It is for commissioning to identify these opportunities and take all necessary actions, paying due regard to legalities and regulations, to make those improvements. Procuring services in that context is a means of getting to where you want to be, and ultimately secures a competitive, fair and quality protected market. However it is quite possible to be compliant with procurement requirements and regulations whilst building a dysfunctional system that does not work very well for stakeholders to that system. Doing the wrong things right is one way of putting it. It is for commissioners to influence a whole system design that interacts effectively and provides increasingly positive outcomes to service users and their carers whilst providing value for money.

In practice commissioning will work to a set of Medium Term Financial Savings (MTFS) opportunities and will monitor and manage the delivery of those savings carefully. There will be on-going consideration of opportunities for savings coming from the continuous improvement of system design. These will be added to the savings opportunities once they are clear and can be committed to. In this way corporate savings targets will be addressed whilst services to end users are protected or enhanced as much as possible.

It will also be the case that we will look for economies by working with local partners. The joint commissioning of sexual health services are an example of how opportunities to work with boroughs local to us and/or whole London solutions provide benefits in costs.

Improving Quality

The assessment of need for service users and their carers is delivered by social work teams employed by the LBH. The quality of these services is managed and regulated by operational management teams reporting to a Corporate Director.

Need for those not eligible for services is defined and responded to from within the community. Judgements are made by individuals sometimes influenced by their families, or through advice from a range of other sources.

Once need is assessed the large part of Havering's services are delivered through external providers. The responsibility for ensuring that services provided are safe and meet expectations around quality sits with the Council and, more particularly, within commissioning.

The means to do this sits with a dedicated team of quality officers who actively monitor the quality of provision within the borough.

The providers we have can vary in type:

- Voluntary sector providers (commissioned and non-commissioned) ranging from very small, one person offers, to very large organisations employing thousands of people
- Independent providers across a range of disciplines

The services also vary and can be building based or based in the community, for example:

- Residential care for older people, people with learning disabilities, people with mental health conditions and people with some or all three and/ or other conditions like dementia.
- Supported Housing for a range of service needs, similar to those above
- Services that deliver particular outcomes, like befriending, support home from hospital, care navigation, information and advice.
- Short breaks services
- Home care and reablement services that take place in people's homes

The services are sometimes differentiated as being 'registered' (subject to scrutiny by the Care Quality Commission or Ofsted) or unregistered. Either way the Quality team has to play a role in ensuring these services meet quality standards.

The vast range of services means that they cannot all be subject to a detailed visit or analysis.

Our strategy is therefore to take a proportionate approach which can vary from light touch, desk based analysis to intensive visits and detailed reports. Visibility of our approach will be crucial for those who may be held accountable for any deficiencies in quality and it will therefore be necessary to have what we are doing documented and approved.

The approach will to some extent be based around compliance with a set of standards and expectations about the care provided in buildings or at home. This is hugely important in relation to the quality of care provided and safety of service users and their carers.

However if the perceived quality of a service is prescribed by inputs the monitoring of quality can start to impinge on the outcomes of the service and the experience of service users and their parents/ carers. This can also be frustrating for providers. Our strategic approach is to move as far as possible (whilst we recognise that in most cases inputs need to be measured and reported upon) towards outcome based quality monitoring to support outcomes based commissioning.

In practice this means evaluating what service users and their parents/ carers report in terms of their experience rather than providing rules for providers based on numbers, targets around numbers or prescribed times. It should not be under estimated, however, how carefully these approaches need to be managed and introduced. For many of the commissioned services the regime in place at the moment is based on measuring inputs as a mean of ensuring a basic level of service. Our strategy is to retain these aspects where they are essential in ensuring quality but, where appropriate, to develop models where quality is defined by service users and their parents/ carers. The challenge for the Quality agenda in LBH commissioning is to design systems that facilitate this and to ensure that improved service user experience is the key measure and driver for what we commission.

There will also be an understanding and engagement with advice and guidance available from organisations like the Care Quality Commission; the National Institute for Health and Care Excellence; the Social Care Institute for Excellence and other organisations with specific input around quality and best practice. This is of particular relevance when high quality clinical care is required for health services commissioned through public health.

Ensuring sustainable markets

As stated above there is a wide and diverse market that is commissioned to provide services. Our duty is to ensure this market is sustainable. However there are currently many conflicting forces at play that limit the ways that markets behave as you would normally expect in relation to the laws of supply and demand.

In normal circumstances the lack of a commodity in terms of supply would mean that the cost of that commodity would rise.

Demand for services is predicted to continue to rise across almost all conditions and service user groups[6]

Demand for services (even though demand management initiatives will be introduced as much as possible – see section on Prevention) is therefore likely to rise. Care services are largely people based and it therefore follows that the number of people we will need to provide care in future is likely to increase. This is already manifesting itself in markets like the home care market where across the country the deficit in recruitment is causing shortages in provision. This has had a direct knock on effect on transfers of care from hospital and the challenges around ensuring quality of service. Normally this shortage would increase the cost of the commodity, in this case the rates of pay for professional carers, but because Council budgets are being constrained this modifying effect is not happening as it would in a true market. This is an example of the impact of treating different parts of an inter related system differently, apparently cutting costs in one area of the system but in fact making the whole, wider system less sustainable and raising costs overall. Recently the government has identified extra funding, through various mechanisms, to mitigate some of these risks.

Havering commissioning is responding to this by trying to ensure that investment in the system is targeted where it can make most impact. Savings will be delivered in the ways outlined above, by taking opportunities to re-design the overall system.

There are of course other aspects to maintaining a sustainable market. Dialogue with providers is a key element of the strategic approach in this area. The dialogue, through provider forums, through a web portal and through co-production exercises, will be a key factor in the overall strategic approach. It is not only engagement but the tenor of the discussions that are had that is important.

The commitment is to operate from an assumption that the Council and providers have a shared objective; to provide high quality services to vulnerable people in a cost effective way.

This will shape the dialogue as a positive one, with the idea that together we can identify and work on issues that are faced, to the benefits of the end user. If, in the event, it is clear that intentions or practice of providers is incompatible with this assumption the Council will deal with that as required with that particular provider as an exception.

Commissioning principles

To set a basis for understanding of expectations when we embark on commissioning exercises, programmes or projects we have identified a set of principles. These will be used as guides and tests

[6] Havering Market Position Statement 2016

to ensure that the pieces of work we are undertaking and the approaches we are using are compatible with the strategy above. Whilst there is work to do to ensure these principles are fully embedded there is already a commitment to these principles that is shaping Havering's commissioned services and our approach to them. The initial set of principles includes:

1. We will operate an evidence-based, 'intelligent commissioner' approach
2. We will develop and publish clear strategies, consistent with the Council's vision and service plans, for achieving our ambitions.
3. We will enable the purposeful involvement of stakeholders in all aspects of commissioning activity. We will ensure that citizens are part of governance arrangements where possible and engage in a variety of other ways to influence and feedback on the decisions we make and the delivery of the services we commission.
4. Commissioning activity will always be subject to rigorous yet proportionate governance arrangements.
5. Transformation will be a specific and planned part of commissioning practice. Project work arising from this will be robustly managed using established principles and practice.
6. Services will be designed using the principles of normalisation, enablement, reablement and the maximisation of support from natural networks and community resources. The broader principles of individual and community wellbeing will underpin all of our commissioning decisions.
7. Where services need to be procured, we will maximise the choice and control of the person using them and provide both choice and challenges to people to take responsibility for themselves and others.
8. To encourage and sign post residents as early as possible, for example through public health commissioned services, to take healthier choices leading to self-management, self-care and an understanding of the need to plan for the future.
9. All commissioned activity will be subject to positive and robust safeguarding practice and scrutiny, and ensure that safety and well-being are of paramount importance in the delivery of services.
10. Services will be commissioned to deliver outcomes.
11. Our commissioning activity will promote health and wellbeing, social value, equality and diversity.
12. We will design services against demand so that they are responsive to current and real need.
13. We will treat all providers equally. If new provider forms, such as Alliance and Accountable Lead Provider models, Consortia, Social Enterprises, Mutuals and User Led Organisations support better outcomes we will actively encourage the development of these.

14. We seek a diverse range of services and will encourage and support the development of niche providers to help fulfil this.

15. We will base decisions about cost effectiveness on the longer-term costs and outcomes of a service and work with providers to drive out costs and improve efficiencies.

Practical Implementation

This strategy represents high level goals, excluding detailed implementation plans. These sit as part of the programmes we have established that are aligned with the goals detailed. Within each of those programmes sit projects and commissioning exercises and benefit measures that will deliver continuous improvement to the system. The detail within each programme is available if required, from overall programme definition to project initiation and specific plans. In all cases we will endeavour to make them compatible with the commissioning principles, strategic goals and the system conditions described above.

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HEALTH & WELLBEING BOARD

Subject Heading:	BHR Transforming Care Partnership Plan update
Board Lead:	Wendy Brice Thompson
Report Author and contact details:	Lee Salmon Ext 4414

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 is a report updating the board on the developments of the BHR Transforming Care Partnership Plan.

The BHR Transforming Care Partnership comprises of the CCGs and Local Authorities for Barking and Dagenham, Havering and Redbridge, NHSE London specialist commissioning and the North East London Foundation Trust (NELFT). This TCP is referred to as the Outer North East London (ONEL) area by the National TCP Programme.

Each of the 7 commissioning organisations is represented at the BHR Transforming Care Programme Board, which is chaired by the BHR CCGs Programme Director Mental Health and Learning Disabilities (Senior Responsible Officer) working closely with the Director for Adult Social Care London Borough of Havering (Deputy Chair).

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In October 2015, NHS England (NHSE), the Association of Directors of Adult Social Services (ADASS) and the Local Government Association announced a national plan called *'Building the Right Support'*. The programme was an extension of the Winterbourne View programme and aims to ensure that more people are supported in the community rather than in placements in institutional settings, namely Assessment and Treatment Units (ATUs), within the next 4 years.

BHR TCP submitted its vision and work plan on 11 April 2016 following consultation with stakeholders and approval of the vision and plan by all of the relevant Health & Wellbeing Boards (HWBB) across Barking and Dagenham, Havering and Redbridge.

Following the first year of delivery the National TCP Programme has now asked all TCP areas to refresh, strengthen and summarise their plans.

In May 2017 BHR TCP board undertook a stocktake exercise in preparation for the refresh and to look at performance against year one of our plan.

This process brings together learning from the first year of TCP delivery, and a number of strands of work TCPs have been undertaking in recent months.

TCPs have been asked to set out a narrative summary of their plans and to provide a summary of their finance and capacity plans and comment on how we will ensure that there is a Clear Plan of How Services Will Change.

RECOMMENDATIONS

- Review stocktake summary and note the current performance and progress that has been made in developing the BHR Transforming Care Partnership vision to date.
- Review the revised plan for BHR TCP.

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REPORT DETAIL

1.1 Highlights from Barking Havering and Redbridge Transforming Care Partnership NHSE Stocktake 12 May 2017 – **please refer to the attached document.**

1.2 Members of the Partnership Board and operational leads in the partnership organisations have all contributed to the stocktake exercise, taking into account the learning from year 1, the transformation requirements and inpatient trajectory for year 2 and the system challenges.

1.3 The requirement from NHS England's National Programme to refresh our plan asks local TCP boards to describe how services will change in order to deliver the continued ambition of *Building the Right Support*.

1.4 This has translated into BHR's stating the high level outcomes of reducing inpatient numbers and reducing bed capacity. The revised plan aims to;

- **Reduce the number of inpatient beds commissioned from 26 in March 2016 to 14 in March 2019**.
- **Decommission out of area beds as long stay patients are discharged into the community.**
- **Reduce the number of beds commissioned under the block contract with NELFT**
- **Strengthen community services**
- **Specialised Commissioning**
- **Clarity on cost pressures/savings**
- **Understanding and being ready for the housing need**
- **Workforce development**

1.5 Governance and Implementation of the revised plan will be monitored via a milestone action plan which is reviewed at each TCP Board meeting.

1.6 The TCP Board will receive reports on progress against TCP plan at each Board meeting along with a performance dashboard. Work is organised into a number of work streams each led by a partner organisation. A regular report on milestones made to NHSE regional team and reviewed at London TCP leads meetings.

1.7 There are links to shared children's work across BHR to ensure in particular transition arrangements work for young people likely to experience crisis as young adults.

1.8 This work is supported by a range of additional meetings to support key elements of delivery:

- Regular meetings with NHSE and specialist commissioning to plan discharges and transition.
- Regular commissioner meetings to support discharge.

1.9 The BHR feeds into the NEL STP through the SRO role – which leads both the BHR TCP programme but also the NEL STP programme.

BACKGROUND PAPERS

None.

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LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Havering CAMHS Update
Board Lead:	Jacqui Van Rossum, Executive Integrated Care Director, North East London NHS Foundation Trust (NELFT)
Report Author and contact details:	Jacqui Van Rossum, Executive Integrated Care Director, North East London NHS Foundation Trust (NELFT)

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
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- ☒ Theme 4: Quality of services and user experience

SUMMARY

A summary of recent CAMHS developments that are supporting the outcomes for CYP in the Borough of Havering. It will also update in progress CAMHS transformation.

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RECOMMENDATIONS

That the Health and Wellbeing Board note the updates.

REPORT DETAIL

Please see attached presentation.

IMPLICATIONS AND RISKS

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

BACKGROUND PAPERS

None

NELFT NHS
NHS Foundation Trust

HAVERING CAMHS UPDATE

NELFT NHS
NHS Foundation Trust

CHILD & ADOLESCENT MENTAL HEALTH SERVICES

SERVICE UPDATE

Integrated Children's services at Acorn Centre, London Rd, Romford

NELFT NHS
NHS Foundation Trust

CURRENT POSITION

6 staff who have attended the Children and Young People's Improved Access to Psychological Therapies Training. (CYP- IAPT), more staff attending this year.

Total co-location to the Acorn Centre (Integrated Children's Servcie) by February 2017.

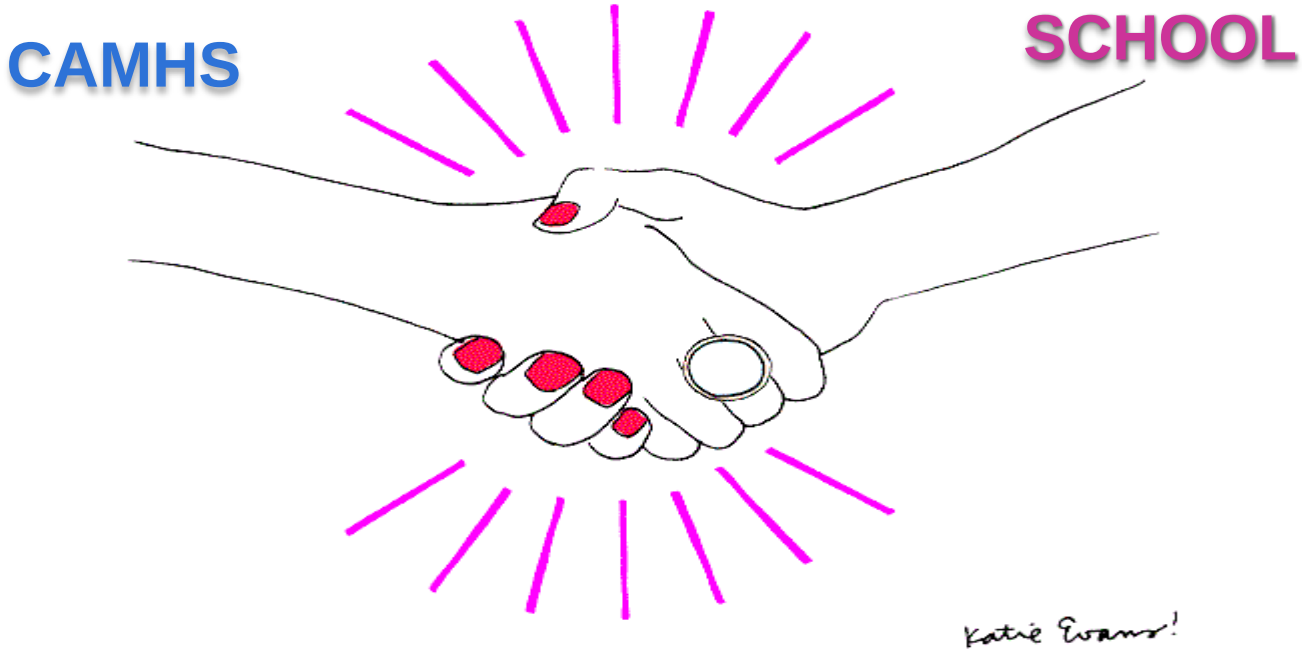
"Thrive" model to be introduced at Havering CAMHS.

Young peoples Home Treatment Team/Crisis Team created in Havering.

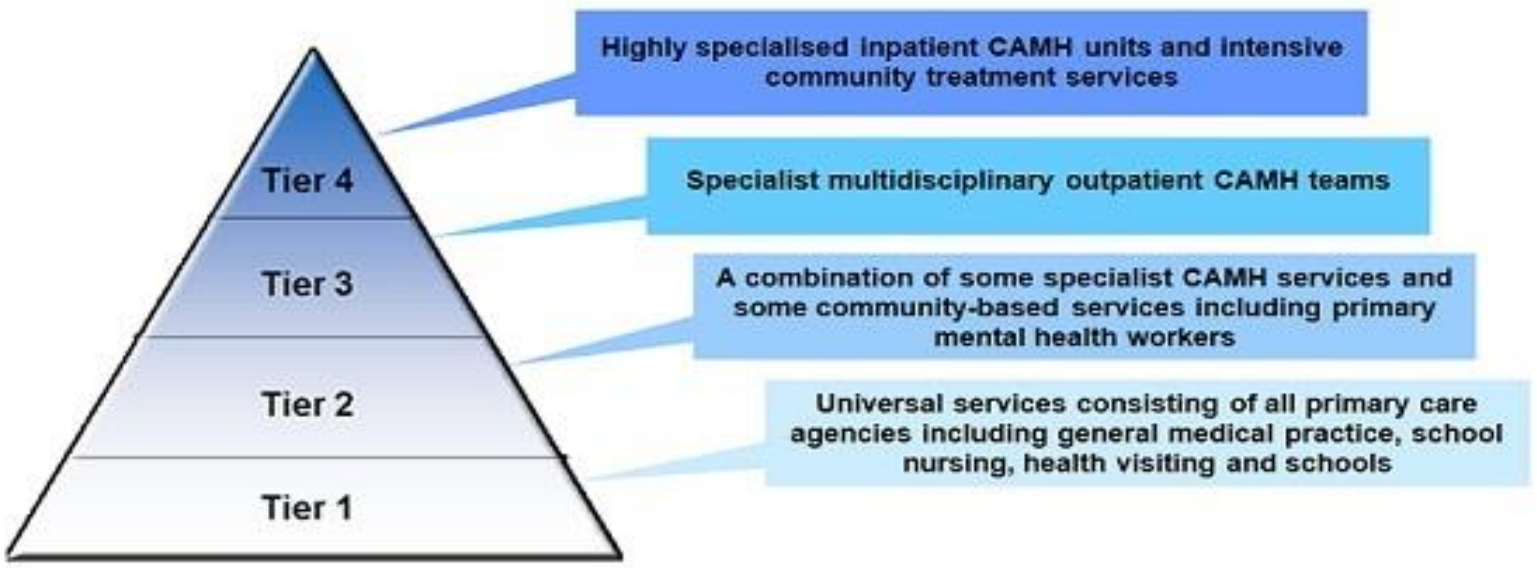
CURRENT POSITION continued……

- **Service Transformation**
- **Working in partnership with Children and Young People**
- **CYP IAPT evidence based therapies**
- **Routine Outcome Monitoring**

New School's Link Worker Role



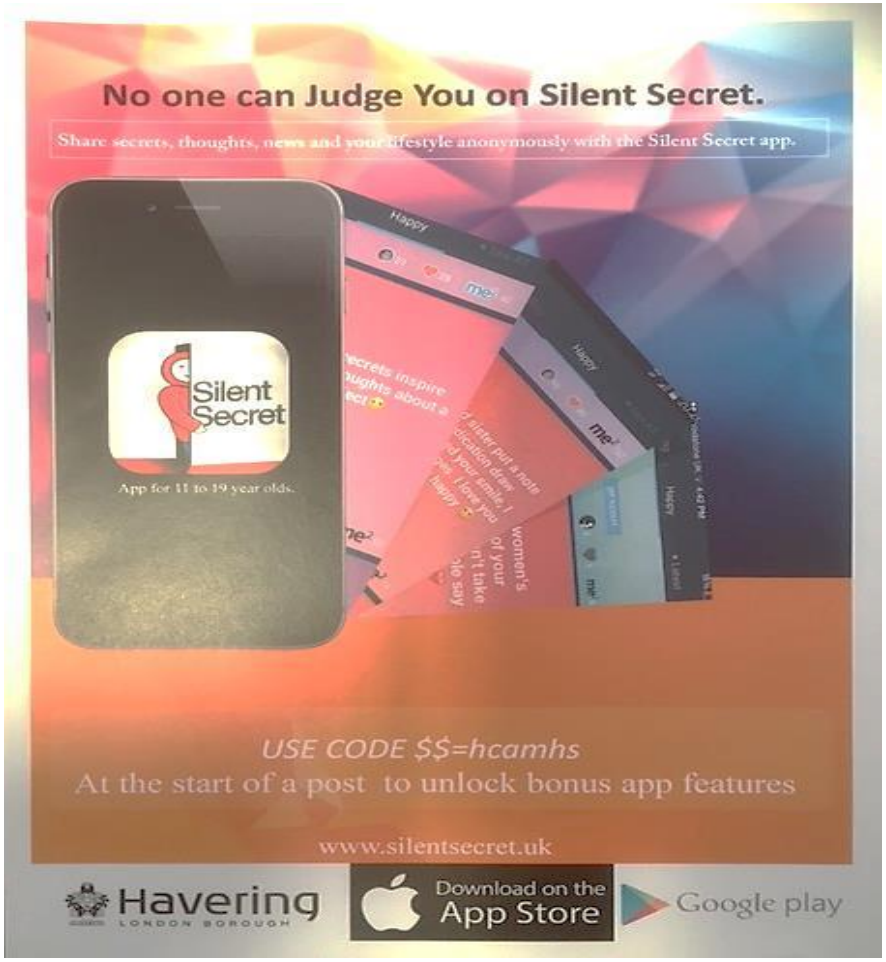
Current CAMHS structure



NELFT NHS
NHS Foundation Trust

I-Thrive

Silent Secret App



NELFT NHS
NHS Foundation Trust

NELFT ‘My Mind’ PHONE APP

https://youtu.be/fz3pmn0ys10

NELFT NHS
NHS Foundation Trust

Crisis Provision in Havering

NELFT NHS
NHS Foundation Trust

Self-Harm figures July 2016-July 2017

Total amount of Self Harm referrals = 55% :

45% of self-harm referrals are Girls.

10% of self-harm referrals are Boys .

Age range of CYP who are referred with self-harming behaviours:

5-12 yrs 5%	**girls 4.5% boys 0.5%**
13-15 yrs 35%	**girls 30% boys 0.5%**
16-18 yrs 10%	**girls 7% boys 3%**

NELFT NHS
NHS Foundation Trust

Benefits to Young People and Their Families

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HEALTH & WELLBEING BOARD

Subject Heading:	Healthwatch Havering: Annual Report, 2016/17
Board Lead:	Anne-Marie Dean, Chairman, Healthwatch Havering
Report Author and contact details:	Healthwatch Havering

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 is the Annual Report of Health watch Havering for 2016/17

RECOMMENDATIONS

That the report be noted.

Havering
LONDON BOROUGH

REPORT DETAIL

The Annual Report of Healthwatch Havering is presented for the Board's information, in accordance with the requirements of the Local Government and Public Involvement in Health Act 2007 as amended.

IMPLICATIONS AND RISKS

There are no implications or risks for the Council.

BACKGROUND PAPERS

None.

healthwatch Havering

ANNUAL REPORT, 2016/17

Still making a difference…

Presented in accordance with
"The Matters to be Addressed in Local Healthwatch Annual Reports Directions, 2013"

What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organization, established by the Health and Social Care Act 2012, and can employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff and several volunteers, both health and social care professionals and people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforces the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organization which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organization, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution will be vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'

Winston Churchill

CONTENTS

We will be sending copies of this Annual Report to the statutory recipients (including the British Library) and circulating it to local health and social care organisations. In the interests of the environment and economy, we are not producing printed copies this year but the report is available for downloading from our website www.healthwatchhavering.co.uk and a hardcopy can be supplied on request.

The electronic version of this report contains hyperlinks to the relevant sections and to external URLs Healthwatch Havering is not responsible for the content of external websites.

Foreword

Anne-Marie Dean, Chairman of Healthwatch Havering

Welcome to our fourth report. This has been a busy and interesting year. There are national initiatives that are beginning to develop into local plans, with the London Borough of Havering (LBH) and the Clinical Commissioning Group (CCG) designing more integrated and accessible care, patient groups becoming more involved in shaping their local GP and other services and timely progress on the work across the borough to improve services for people with learning disabilities. Some of our highlights are:

- ✓ The excellent work undertaken by our volunteer members has continued unabated with more Enter and View visits to Residential and Care homes, Barking, Havering and Redbridge University Hospitals Trust, North East London Foundation Trust and, this year, with a focus on developing our knowledge and expertise about GP premises.

- ✓ The joint review between Healthwatch Havering and Havering Council's Health Overview and Scrutiny Committee regarding the very significant delays in the referrals to treatment. The report is expected to be published at the end of June.
- ✓ Partnership working across the borough with CCG sub-groups, Accident & Emergency Board, Locality Design Planning group, Care Point, Patient Reference Groups, Havering Over Fifty Forum (HOFF), Havering Volunteer Centre, Positive Parents, and other organisations and individuals committed to improving services for people living with Dementia, Learning Disabilities, Sight Problems or nearing the End of Life.
- ✓ Our purpose is to help to ensure that these groups develop and embrace the need to involve the people of Havering, carers and patients in the design, delivery and assessment of care as a natural part of the way we all work together.

We would like to thank you for finding the time to read this report, and our volunteers, residents and colleagues for their hard work

THIS YEAR AT A GLANCE

ENTER AND VIEW

Question: So why do we think Enter and View visits are so important?

Answer: These visits provide a unique perspective on the provision of care and services in the borough and shared openly with our residents. Havering has one of the largest numbers of care homes in London, an acute hospital trust that is just emerging from "special measures" and nearly 50% of the GP practices have been rated as Inadequate or Requiring Improvement (with several now in "special measures"). By carrying out Enter and View visits, we can assess what these facilities are like and by chatting with staff, service users and their friends and relatives, we can find out – and report – what they think of them.

✓ Nursing and Care Homes

The residents of our Nursing and Care homes are an important part of our society in Havering. Many residents have the benefit of regular family and friends to visit them, but some may not, for many reasons. So we take pro-active measures to visit homes and assess the environment and care these people receive. We carried out:

Enter and View visits to Nursing and Care Homes	14

Follow up visits to Care Homes to see how they have fared since our most recent visit	4

✓ Hospital Services

We undertook 2 visits to Queen's Hospital. This included a series of semi-announced visits undertaken to the wards at meal times.

✓ Mental Health and Community Services

We undertook 3 visits: to the Community Rehabilitation wards at King George Hospital, Goodmayes; to the Mental Health Street Triage Scheme at Goodmayes Hospital; and to the Long-Term Conditions Centre at Harold Wood.

✓ GP Practices

We undertook 17 visits across the borough. This year the CQC completed its inspection of almost all GP practices in the borough. While some practices have been rated 'Good', too many practices have been rated Inadequate or Requires Improvement and a few have been placed in "special measures". We visited a range of practices to learn about the state of general practice in the borough.

Among the issues we raise during these visits is the relationship between the practice and its Patient Participation Group and how best use is made of the strength of input these volunteers have to the work of every practice.

Quote: "I take this opportunity to thank the team members for their visit and feedback. I must acknowledge the fact that they conducted the inspection without any disruption to the practice and were very pleasant and courteous."

✓ Other health and social care facilities

We also visited:

- Two pharmacies (associated with GP practices)
- A private Day Care facility for people with learning disabilities
- A drug and alcohol advisory service
- A dental practice

The reports of all of our visits are available on our website

www.healthwatchhavering.co.uk/enter-and-view-visits

WORKING IN PARTNERSHIP

CCG and BHRUT – working on urgent and emergency care

This year has seen us working with the Clinical Commissioning Sub-Groups and the Accident and Emergency Board, addressing issues such as the high attendances at the Queen's Hospital A & E (Emergency) Department, exploring a wider role for NHS 111 and working with the London Ambulance Service to design new pathways.

We also regularly attended the BHRUT Assurance and Surveillance Group, overseeing the transition of BHRUT and its hospitals from special measures.

Havering Health and Wellbeing Board

We take our statutory membership of Havering's Health and Wellbeing Board very seriously and our Chairman, Anne-Marie Dean, has been assiduous in attending its meetings.

Highlights from the board include Local Children's Safeguarding and Adult Safeguarding, the Dementia Strategy, the development of Integrated Care Pathway boundaries matching those of the Primary Care Networks to support better locality planning, the development of the East London Health Care Partnership which is being launched on 3rd July with the Partnership Community Groups launching on 4th July. The importance of attracting staff and providing an environment which is stimulating and supportive to staff, this included discussion about an Academy for staff and the importance of providing more key worker housing such as the opportunity which the St. Georges hospital site could offer.

Havering Locality Development Planning Group – a partnership with LBH and CCG

This newly formed group is part of the wider work being undertaken by the Accountable Care System/Integrated Care Partnership board as a

contribution to the development of the East London Health and Care Partnership [1]. This group is working to achieve a better integration of services in the primary, community and social care teams and a service that is most response and accessible. The group is at an embryonic stage of development as they begin to tackle how to innovate and design sustainable solutions for integrated health and social care services across North East London.

We have continued working with the CCG and other stakeholders on the future development of the former St George's Hospital site in Hornchurch.

Voluntary Organisations and Patient Forums

Our team has also been working with a range of local organisations such as Care Point, Patient Experience Reference Forums, the Havering Over Fifties Forum (HOFF) and Havering Volunteer Centre aimed at improving the standard and range of health and social care services across the borough from a patient and carer perspective.

All of these organisations, together with ourselves, have the key aim of ensuring that we all use our best assets, experience and wisdom and involve our communities to ensure that we have a health and social care service which is safe, dependable and sustainable for the long-term future.

[1] The East London Health and Care Partnership is taking forward the Sustainability and Transformation Plan (STP) for the North East London "footprint"

Learning Disabilities

We continue to work with some outstanding families, friends and organisations as we work together to improve the facilities and services from people with learning disabilities across the borough. Through listening to the experiences of individuals and families, we have shared these experiences with the CCG.

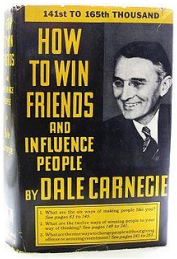
The CCG are supporting an initiative that will ensure that all GP practices in Havering are provided with access to a Toolkit for GPs – A Step by Step Guide for GP Practices for people with Learning disabilities www.rcgp.org.uk/learningdisabilities

Working with our Healthwatch colleagues

With our Healthwatch colleagues from Barking & Dagenham and Redbridge, we meet regularly with our CCG and BHRUT colleagues, enabling us to be fully informed of key issues in primary care.

This year we have worked together on a bid won by Healthwatch Barking & Dagenham to deliver training sessions to key 'front of house' health service teams who work directly with patients and carers

Across North East London the Healthwatches are working together to design information and consultation sessions that support the work of the STP and the East London Health and Care Partnership.



Influencing others

Our relationship with the range of partners that we work with gives us the opportunity to influence their thinking and their operational activity.

For example, after our attention was drawn to an unpleasant odour permeating parts of Queen's Hospital, we were able to ensure that the hospital's management team looked into the matter and took action to get rid of the odour.

Quote: "What an excellent result, which is down to your persistence in pursuing this matter. I doubt I would have had such a successful outcome without your input. So I'm sure I speak on behalf of all the staff and patients who have and still do attend these clinics, a very big thank you from us all, especially me."

REPORTS AND CONSULTATIONS

The Delayed Referrals to Treatment report

We formed a Joint Topic Group with Havering Council's Health Overview and Scrutiny committee. Its purpose was to give Healthwatch volunteer members and Councillors the opportunity to explore the issues regarding the very significant delays in the care of the patients at Queens Hospital ad King George Hospital.

Using the values of the NHS – Accountability, Probity and Openness – a total of 9 Volunteer Members and 7 Councillors met with, in all, 10 representatives from BHRUT, the BHR CCGs, NELFT and the NHS Improvement Authority.

The problem had begun in December 2013 when the Trust migrated data from one computer database to another, which exposed a discrepancy: up to 93,000 referrals from GPs for treatment had somehow been missed. The size of tackling this discrepancy had been daunting. A total of 9,000 extra appointments would be needed, a further 20,000 to cope with the additional demand on the Trust's services, 760 operations would reduce the backlog, with a further 800 needed to cope with the additional demand. The trust had the most long-waiting patients in the country, with around 850 patients waiting more than 52 weeks for treatment. By the end of March 2017, local GPs had redirected a total of 26,000

patients into alternative services, helping ease pressure on the BHRUT waiting list.

The review was not intended to apportion blame for the delays but to examine why they occurred, and to be satisfied that, so far as possible and practicable, appropriate steps had been taken to avoid their recurrence.

The report is to be published in June 2017 and we would like to express our appreciation for the assistance given by all the individuals and organisations involved, which enabled an open and transparent review to take place.

Enter and View reports and their findings

From the beginning of Healthwatch, we have taken the view that a robust programme of Enter and View visits was the best way that we could ensure that we examined on the ground how patients' and residents' needs were being met.

To that end, we have established a robust method for identifying premises that should be visited, with a monthly meeting of staff and volunteers at which the programme is managed, visits arranged and the findings of recent visits reviewed. In 2016/17, we carried out 42 visits (with a small number of premises visited more than once), including, for the first time, several GP practices, several pharmacies and a dental practice. The full list appears in Appendix 1.

Our visiting teams were generally made welcome and managers and proprietors were very co-operative in facilitating the visits. The team members were made to feel welcome by staff, residents and residents' relatives and friends alike.

Few major problems were identified and mentioned in our teams' reports of their visits. Where we did make recommendations, we have been, or will be, following up to see what effect they have had.

All reports of our visits have been published on our website www.healthwatchhavering.co.uk/enter-and-view-visits and shared with the home, GPs or hospital, the Care Quality Commission, the Clinical Commissioning Group, Havering Council and other relevant agencies. Owing to the thorough nature of pre-publication checks, not all reports of the visits during the past year had been published at the date this report was prepared.

Spending Money Wisely Consultation

The CCG together with the GP Clinical Directors for Havering, Barking and Dagenham and Redbridge have sought to consult local people's opinion on a range of treatments and prescribing. These are treatments or prescribing where there is no evidence of clinical value and to limit other

treatments and prescribing to much closer scrutiny always allowing for clinical decision making where appropriate.

The planning for this exercise began in March 2016 and we have worked closely with the CCG in designing the process ensuring that the information was clear and easy to read and that there were sufficient opportunities for local people to attend events. The consultation process completes in mid-May.

Means of consultation

We did not carry out any formal consultation exercises this year. We have continued to receive, and act on, contacts from the public about health and social care matters through a variety of sources, including personal contacts, telephone calls, email, letters and our Tell Us What You Think Cards[2].

We also consulted a range of local commissioners and providers of health and social care services about a range of services. None refused to co-operate with us or to provide information.

[2] These are pre-paid postage postcards available from various locations that enable the public to let us have information – good or bad – about health and social care facilities.

GOVERNANCE

Our decision making

How we focus our time and energy is influenced by our volunteer members, the people who live and work in Havering and local organisations.

The board, which consists of directors, staff and volunteer members, establishes our priorities which are set out below in 'Our Plans for 2017/2018' and our programme of 'Enter and View' visits is set by our volunteer members at the monthly Panel Meeting.

Our policies and procedures are discussed and agreed in public board meetings and our board minutes are accessible on our website. The governance documents ensure that we operate efficiently and fairly in accordance with our statutory and legal requirements.

As part of our governance this year we reviewed the document 'A guide to the legislation affecting Healthwatch Havering'.

Because we have considerably widened the range and the complexity of the issues we now address as part of the 'Enter and View' programme, we have reviewed and widened the pro-forma of questions that volunteer members ask when undertaking visits.

We have bi-annual Away Days with all our members, to which we invite outside speakers to talk to us about their services and challenges. Our speakers help us to align our plan with critical issues happening in our borough. This year our speakers addressed the following subjects

- Irvine Muronzi and Wellington Makala of NELFT, about how to approach patients receiving hospital care for mental health issues
- Dr Sanomi – Local GP Clinical Director – 'Spending Money Wisely' consultation and the challenges facing Primary Care
- Ben Campbell and Sandy Foskett, of the Commissioning Team from the London Borough of Havering – talking about the commissioning of Domiciliary Care Services for the Boroughs older and vulnerable community.
- Patrick Farrell, Consultant Paramedic, Darzi Fellow in clinical decision making, attached to Queens and King George Hospital Accident and Emergency Department.

Healthwatch Havering is, in legal terms, a company limited by guarantee called Havering Healthwatch Limited. As a company limited by guarantee, it has no shareholders and is prohibited by law from distributing any financial surplus (or profit). Registration particulars and other contact details appear at the end of this report.

Our volunteers

Although Healthwatch has statutory powers and is established by law, it relies for the exercise of its functions mainly on the efforts of its volunteer members. The majority of the volunteers who work in Healthwatch Havering have a professional background within the health and social care sector or have many years' familiarity with health and social care needs. This gives them valuable insight into the work that they do and enables them to report authoritatively on the Enter & View visits that they carry out.

Our volunteers give unstintingly of their time – something that is appreciated not only by Healthwatch but also by the wider community. We are delighted to report that, in June 2017, a number of Healthwatch volunteers received awards from the Havering Volunteer Centre in recognition of their efforts.

Healthwatch Havering Volunteers receive their awards, 9 June 2017

Left to right:
Shelley Hart of Havering Volunteer Centre; Dianne Old; Ron Wright;
Deputy Mayor of Havering, Cllr Dilip Patel; Diane Meid; Dawn Ladbrook; Jenny Gregory; Carol Dennis;
and Emma Lexton
(photo: Harvey Lexton)

Financial Report

Funding

Havering Council provided grant in 2016/17 to fund our activities at the same level as pertained for the financial years 2013/14 to 2015/16, £117,359.

Allowing for use of reserves, Corporation Tax adjustments, interest received and other miscellaneous income, the amount carried forward at the end of 2016/17 was £3,533.

A summary of the detailed accounts is set out in Appendix 2. The full audited accounts are available on our website at http://www.healthwatchhavering.co.uk/our-activities

Staff

Staff remained unchanged during 2016/17 from those in post at the end of March 2016. There are three directors – two who are engaged in executive roles as Chairman and Company Secretary respectively for 21 hours per week, while the third undertakes a non-executive role – and two part-time employees.

Our Plans for 2017/18

In April, we had an Away Day to choose our priorities for 2017/18. These are

1) To develop our relationship with the Strategic Transformation Board, the Accountable Care System/Integrated Care Partnership for BHR and the Locality Development to ensure that we can understand, influence and support the engagement and consultation process for our residents.
2) Patient Empowerment will continue to be developed continuing to support people and families with Learning Disabilities and services with the Primary Care setting.
3) To work with the Commissioning team in the Borough on the recently procured Domiciliary Care Services to learn more about the services and the opportunities for resident's feedback. These services are provided to residents many of whom are among the most vulnerable in our community
4) To work with Queens Hospital and the Public Health team to design a process to engage patients and visitors to be more aware of the importance of 'No Smoking' in the hospital environment.
5) Continue with the Enter and View programme and to begin to explore the opportunity of creating a learning opportunity between the organisations using the knowledge gained by our E & V visits.

In all of this, we will be following the national guidance in the Healthwatch England Business Plan for 2017/18 – to bring the public's views to the heart of local decisions

The "Healthwatch" logo and trademark

Havering Healthwatch Limited has a licence agreement with Healthwatch England governing use of the Healthwatch logo and trademark.

The Healthwatch logo is used widely for Healthwatch Havering activity. It is used on:

- The Healthwatch Havering website
- This Annual Report
- Publications such as reports of public consultation events and Enter & View visits
- Reports to official bodies, such as the Health & Wellbeing Board and Overview & Scrutiny Committees
- Official stationery, including letterheads and business cards
- Members' identity cards
- Newspaper advertisements and flyers for events

Appendix 1 Enter and View visits.

In addition to having one of the largest residential and care home sectors in Greater London, Havering has the largest number of GP practices in London rated by the CQC as Inadequate or Requiring Improvement, a major hospital Trust (BHRUT) that is only now emerging from Special Measures following a 2013 inspection that found it Inadequate, a community health services Trust (NELFT) rated as Requiring Improvement, and a CCG that is under immense financial pressure and subject to Directions by NHS England. Moreover, the local health economy generally is under considerable strain because of the demands of urgent care needs, residential and domiciliary care needs and the imminence of the retirement of a number of GPs working single-handedly or in small partnerships.

From the beginning of Healthwatch, we have taken the view that a robust programme of Enter and View visits was the best way that we could ensure that we examined on the ground how patients' and residents' needs were being met.

To that end, we have established a robust method for identifying premises that should be visited, with a monthly meeting of staff and

volunteers at which the programme is managed, visits arranged and the findings of recent visits reviewed. In 2016/17, we carried out 42 visits (with a small number of premises visited more than once), including for the first time a number of GP practices, several pharmacies and a dental practice. The full list appears below.

Our visiting teams were generally made welcome and managers and proprietors were very co-operative in facilitating the visits. The team members were made to feel welcome by staff, residents and residents' relatives and friends alike.

Few major problems were identified and mentioned in our teams' reports of their visits. Where we did make recommendations, we have been, or will be, following up to see what effect they have had.

All reports of our visits have been published on our website www.healthwatchhavering.co.uk/enter-and-view-visits and shared with the home, GPs or hospital, the Care Quality Commission, the Clinical Commissioning Group, Havering Council and other relevant agencies. Owing to the thorough nature of pre-publication checks, not all of the reports had been published at the date this report was prepared.

We did not exercise Enter and View powers at an ophthalmology practice during this year.

The powers of Healthwatch to carry out Enter and View visits are set out in legislation[3] and most visits were carried out in exercise of them. On 8 occasions however, noted in the table that follows, visits were carried out at the invitation of the establishment's owners/managers and there was no need for the exercise of our statutory powers; but that has not affected how we have reported on such visits.

[3] The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013

We did not find it necessary to make recommendations to Healthwatch England on special reviews etc.

Date of visit	Establishment visited		Reasons for visit
	Name	Type	
		2016	
12 April	Cranham Court	Nursing Home	To observe the home in normal operation following CQC rating of Good
12 April	Little Gaynes	Residential Care Home	To observe the home in normal operation following CQC rating of Requires Improvement
26 April	Alton House	Residential Care Home	To observe the home in normal operation following CQC rating of Requires Improvement
1 May	Foxglove Ward and Japonica Ward, King George Hospital	Community Rehabilitation Wards	By invitation of NELFT; joint visit with Health Overview & Scrutiny Committee members
16 May	Rosewood Surgery as Hub practice	GP practice	As part of review of operation of GP Hub service
17 May	King's Park Well Pharmacy pre-6.30pm	Pharmacy	As part of review of operation of GP Hub service
17 May	King's Park GP pre-6.30pm	GP practice	As part of review of operation of GP Hub service
17 May	Rosewood Surgery	GP practice	As part of review of operation of GP Hub service
19 May	King's Park GP after 6.30pm	GP practice	As part of review of operation of GP Hub service

Date of visit	Establishment visited		Reasons for visit
	Name	Type	
		2016	
19 May	King's Park Well Pharmacy after 6.30pm	Pharmacy	As part of review of operation of GP Hub service
24 May	Petersfield GP Practice	GP practice	As part of review of operation of GP Hub service
25 May	North Street GP Practice	GP practice	As part of review of operation of GP Hub service
23 July	North Street GP Practice as Hub practice	GP practice	As part of review of operation of GP Hub service
28 July	Moreland House	Residential Care Home	To observe the home in normal operation following CQC rating of Requires Improvement
13 September	Havering Court	Residential Care Home	To observe the home in normal operation
27 September	Arran Manor	Residential Care Home	To observe the home in normal operation following CQC rating of Good
6 October	Queens Hospital: In-patient meals	Acute Hospital	Following expressions of concern about the standard and serving of meals in certain wards
11 October	WDP Havering	Drug and alcohol advisory service	By invitation in advance of CQC inspection

Date of visit	Establishment visited		Reasons for visit
	Name	Type	
		2016	
27 October	Maylands Health Centre (GP Practice)	GP practice	By invitation, following catastrophic flooding of premises in June
27 October	Maylands Health Centre (Pharmacy)	Pharmacy	By invitation, following catastrophic flooding of premises in June
27 October	Maylands Health Centre (Parkview Dental Practice)	Dental practice	By invitation, following catastrophic flooding of premises in June
1 November	Straight Road GP Practice	GP practice	To observe the practice in normal operation, following CQC rating of Requires Improvement
7 November	Greenwood GP Practice	GP practice	To observe the practice in normal operation, following CQC rating of Requires Improvement
14 November	High Street (Hornchurch) GP Practice	GP practice	To observe the practice in normal operation, following CQC rating of Requires Improvement
15 November	Ravenscourt	Residential Care Home	To observe the home in normal operation following CQC rating of Good (qualified by "Well Led" Requires Improvement)
18 November	Berwick Surgery GP Practice	GP practice	To observe the practice in normal operation, following CQC rating of Inadequate

Date of visit	Establishment visited		Reasons for visit
	Name	Type	
		2016	
21 November	Mawney Road GP Practice	GP practice	To observe the practice in normal operation, following CQC rating of Inadequate
23 November	Mental Health Street Triage Service	Community Health Service	By invitation of NELFT to learn about the service
5 December	Long Term Conditions Centre, Harold Wood	Community Health Service	By invitation of NELFT to learn about the service
8 December	Suttons Avenue GP Practice	GP practice	To observe the practice in normal operation, following CQC rating of Inadequate
		2017	
17 January	Beech Court	Residential Care Home	To observe the home in normal operation following CQC rating of Requires Improvement
23 January	Mungo Park GP Practice	GP practice	To observe the practice in normal operation, following CQC rating of Requires Improvement
2 February	Lilliputs Centre (Second visit)	Complex of Residential Care Units for people with learning disabilities	To observe the home in normal operation following CQC ratings of Requires Improvement of certain units within the complex

Date of visit	Establishment visited		Reasons for visit
	Name	Type	
		2017	
6 March	The Oaks	Residential Care Home	To observe the home in normal operation following CQC rating of Good
16 March	Modern Medical Centre GP Practice	GP practice	To observe the practice in normal operation, following CQC rating of Requires Improvement
21 March	Sarnett House	Residential Care Home for people with learning disabilities	To observe the home in normal operation following CQC rating of Requires Improvement
29 March	Barleycroft	Residential Care Home	To observe the home in normal operation following CQC ratings of Requires Improvement (current and previous)

Future programme

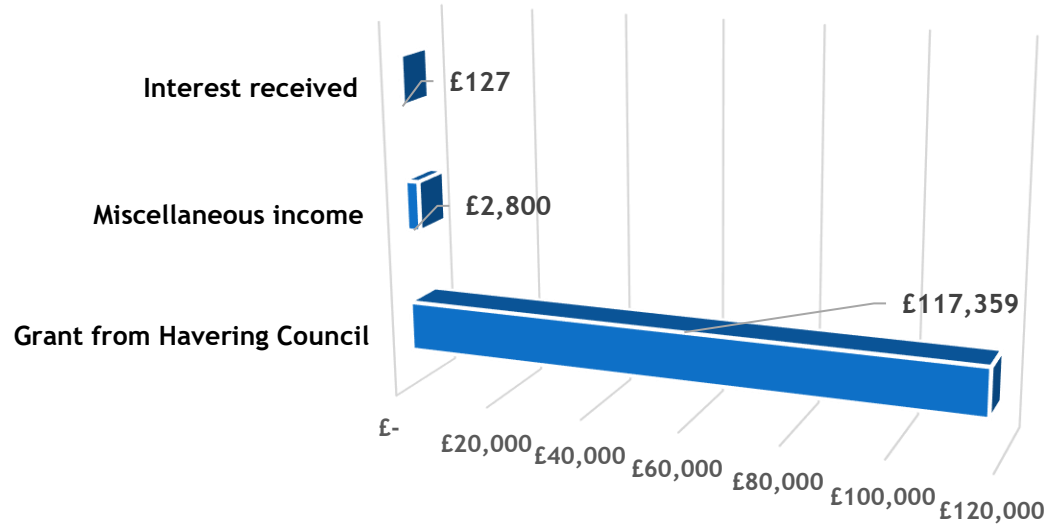
Our future Enter and View visit programme will continue to be informed by CQC reports on establishments, by information gathered through meetings with local regulatory agencies and by complaints (and compliments, should we receive any) from service users.

We have already identified a number of establishments that we plan to visit during the course of 2017/18.

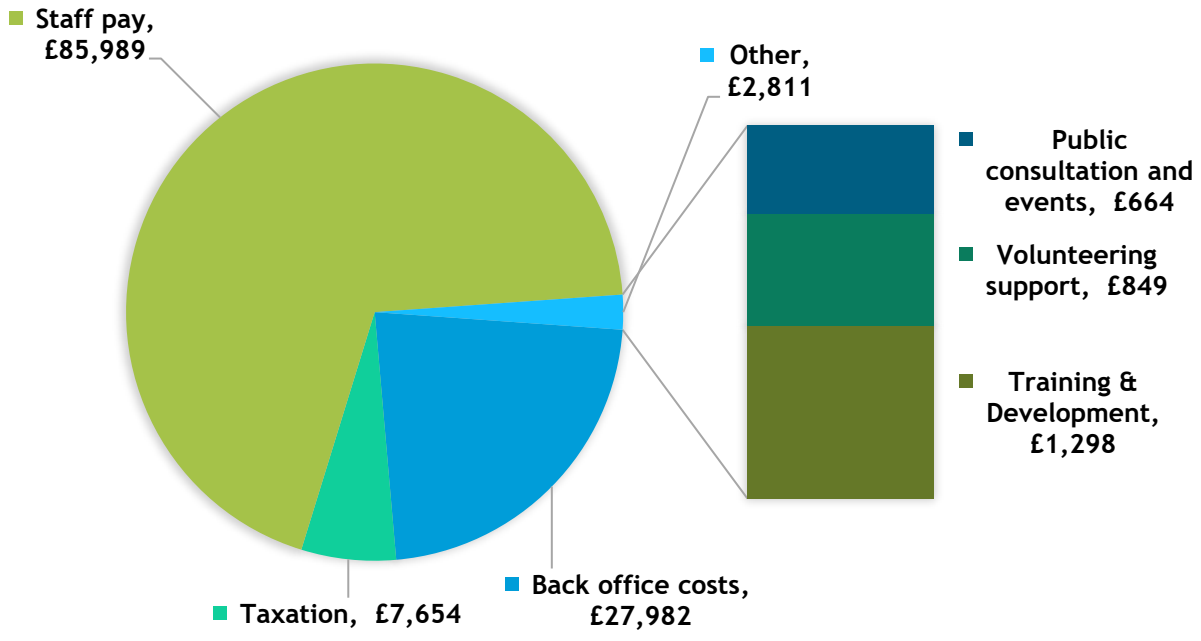
Appendix 2 Summary statement of Income and Expenditure

For more detail, please refer to the annual accounts available on our website at http://www.healthwatchhavering.co.uk/our-activities

INCOME SUMMARY



EXPENDITURE SUMMARY



Participation in Healthwatch Havering

Local people who have time to spare are welcome to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering, to allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

We are looking for:

Members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

Some Members may wish to become **Specialists**, developing and using expertise in a particular area of social care or health services.

Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and social services.

Interested? Want to know more?

Call us on **01708 303 300**; or email
enquiries@healthwatchhavering.co.uk

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
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No. 08416383

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Twitter feed: @HWHavering

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	SEND Executive Board Update
Board Lead:	Tim Aldridge – Director of Children's Services
Report Author and contact details:	Caroline Penfold – Head of Children's and Adults with Disabilities. 01708 431743

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

As previously reported, the borough is committed to the implementation of the reforms to support for children with Special Educational Needs and Disabilities, (SEND) as outlined in the Children and Families Act (2014) In Havering we have made significant progress in implementing new processes, establishing positive working relationships with our local partners and improving outcomes for children and young people with SEND. There is a program of joint inspections from Ofsted and the Care Quality Commission and Havering can expect an inspection at any point in the next 3 years. The inspection will assess how we have implemented the reforms for children and young people, provide us with valuable feedback on where they see our strengths and where we have more work to do. In Havering we have established a SEND Executive Board which oversees the implantation of the reforms, works to establish priorities and monitors progress.

This report provides an update on the key areas of progress.

Havering
LONDON BOROUGH

RECOMMENDATIONS

The Board is invited to receive an update at the meeting, outlining the progress made since the previous update to the Board in May 2017 and note areas for action over the coming months.

REPORT SUMMARY

The Update to the board will cover:

- The status of the High Needs Review and Strategy, with the full strategy being presented to the board in November
- The Local Area Self-Evaluation progress to date, with the full document being presented at a later board
- The work undertaken to date in preparation for an inspection
- The Education, Health and Care Panel review and refresh
- The Education, Health and Care process improvements, including the EHC hub developments
- The engagements already taken place and scheduled in with schools

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.

Havering
LONDON BOROUGH

Health and Well-being Board SEND Update

The SEND Executive Board

The SEND Executive Board has been established with representation across the authority, CCG, NELFT, Schools and Parents. The Board is chaired by Tim Aldridge (DCS)The Board has been overseeing the review and development of work to ensure the expected reforms to the area of Special Educational Needs and Disabilities (SEND) is targeted, making progress and is delivering the expected outcomes of the Children and Families Act. There is a programme of work the board is undertaking, and an update on each of the areas can be found below:

High Needs Review and Strategy

Last year, the government announced proposals to consult on how funding is given to local authorities and schools to support children and young people with SEND. As part of this, local authorities were required to refresh their SEND Strategy to ensure that it is up to date, reflects current and predicted trends, and provides clarity on how the authority expects different levels of needs to be met and where its current and future gaps in provision are. There is also an expectation that local authorities are making sure provision is effective and that high needs funding is invested appropriately to gain maximum benefit for its local population.

Linked to this work was the announcement in March 2017 that a new SEND capital grant will be available for three years commencing 18/19 of which Havering's allocation is £2.5m in total. To enable the borough to draw this down we need to demonstrate how we intend to use this, in line with an evidenced needs analysis and published strategy.

The LA have been working with schools and academies, post-16 institutions, local authority staff, as well as children, young people and parents to ensure that the range and quality of provision reflects the needs and aspirations of children and young people in the area.

Emerging priorities for provision for SEND and those requiring alternative provision are:

- Re-designating special schools where possible/ necessary to better reflect their intake
- Expanding provision in our special schools where necessary
- Develop the new free school for children and young people with Autism and SEMH (social, emotional and mental health difficulties). This would be for pupils aged from 3 – 16 years, and who are at the more complex end of need.
- Reviewing how alternative provision is provided, in line with government guidance regarding schools' responsibilities for educating excluded pupils

- Developing sufficient, high quality Additionally Resourced Provision (ARP) (particularly important if special schools are re-designated)
- Investing in workforce training to ensure staff across all schools, mainstream, ARP and special, feel confident in supporting pupils with additional needs to achieve.

Emerging priorities for funding are:

- Ensuring schools and academies have sufficient funding in their delegated budget to enable them to support pupils' SEND where required.
- Funding to schools that recognises those that take in disproportionately high numbers of children with SEN.
- Realistic and consistent funding levels for schools with ARPs, both SEN and Emotional and Behavioural (SEMH).
- A review of special school funding to include matrix levels
- Funding to address high needs in early years
- Monitoring of increasing costs of residential and independent school placements
- Development of local provision that will lead to a reduction in the costs of external provision
- A review of post 16 SEN costs up to 25.

A final draft of the refreshed SEND Strategy will be published and formally consulted on in the autumn, and a full update will be bought to the next board meeting for sign off.

Education, Health and Care Panel (EHCP)

The Education, Health and Care Panel, formally known as SEN Panel, was introduced in 2014 to support the legislative changes to the SEN Code of Practice. To meet the Local Authority's statutory duty to ensure consistency, transparency and timely decision making the EHCP Multi-Agency Panel needs to be supported by representation from key decision makers with budgetary responsibility across Education, Health and Social Care.

Feedback on the functioning of the panel indicated that the panel wasn't always making decisions in a timely way and was spending a long time considering all levels of request and issues. This led to the agreement to review the processes and composition of the panel. The review highlighted two areas to be improved upon to support a more efficient, focussed and professional decision making forum that supports the ethos of the legislation introduced.

These are:

1. Panel to be targeted and focussed on Complex or Multi-Agency resourced cases, cases that require group funding or decisions. Cases that are complex and present risk to the authority if not dealt with in a timely manner.

    a. Panel will be moved to fortnightly and management decisions taken on lower level issues between

    b. Panel will be relaunched and new guidance will be published

2. Changes in processes to support the improved efficiency of Panel.

    a, clarity around attendance

    b, effective panel preparation and recording of decisions.

Children and Adults Service (CAD) Business Process Improvements

The business processes within the CAD team do not mirror those used in the rest of Children's Social Care, meaning that the child's record cannot be shared across the service and other teams easily and performance information is hard to collate. CAD have worked with the Innovation and Service improvement team to modify CCM, the Child record system, to allow the recording of all CAD children. The staff are currently being trained to use the system and a program of migrating case records will be commencing this autumn.

Specifically in the area of the EHC assessment and planning, the service has been investigating the use of an interactive system involving schools parents and young people. Following a demonstration of a new web based system called EHCP hub, which can offer a platform to stream line communication and EHCP development in a multi-agency interactive way involving parents and schools, a decision has been taken to implement the hub and work will commence on this in October 2017. The benefits to using this platform are greater efficiency and transparency regarding the EHC assessment and planning process involving all our partners.

Local Offer

The Children and Families Act (March 2014) requires Local Authorities to publish a local offer, setting out in one place information about provision they expect to be available for children and young people in their area who have special educational needs.

The Local Offer has two key purposes:

- To provide clear, comprehensive, accessible and up to date information about the available provision and how to access it

- To make provision more responsive to local needs and aspirations by directly involving disabled children and those with SEN and their parents, and disabled young people and those with SEN, and service providers in its development and review.

Havering's Local Offer was moved to a new more accessible online platform, in March 2017.

This has enabled the Local Offer steering group, made up of representation from Education, Health, Social Care, Leisure, Providers, Positive Parents and the Parent Forum, to co-produce and improve the content of the local offer. There is more work to be done on expanding and updating the content and resources have been identified to work on this further.

SEND Local Area Inspection Preparation

As highlighted earlier in this report Harvering can expect an inspection of its SEND provision within the next three years. We have started to prepare for this by collating all key documentation relevant to the inspection, outlining roles and responsibilities in advance and during the inspection through a logistics planner. Other work that has been undertaken to date in preparation for an inspection are:

Self-Evaluation

A selection of audit tools for the Local Authority, CCG and Local Area have been released by the Council for Disabled Children (CDC) The Local Authority tool has been populated and is currently circulated within the council for consultation. The CCG Audit tool has been populated and has been passed over to the local authority who will merge the two together to form the Local Area audit and in turn will be served as our self-evaluation for the inspection.

The SEND Executive Board will receive a copy of the Local Area Audit at their September meeting, where it is envisioned that it will be agreed to send out wider for consultation, which will include schools and parents. Upon the closure of the consultation the final version will be submitted to the HWBB in November for their information and agreement.

Communication

Some information has already been provided to head teachers, parents and schools upon the launch of the SEND Local Area Inspection. However this was some time ago so a more detailed communications plan has been drawn up.

At the end of the last school term a briefing note and accompanying letter was sent to all Head Teachers of all schools within the borough. It was asked that the briefing note be disseminated to all staff and SENCO's.

A presentation, on the Local Area inspection and what will be expected from schools, will be provided to the Headteachers' Consultative Forum in October. This will be the time that any questions the head teachers have, will be able to be asked.

Tri-Borough Meetings

A Tri-borough meeting between Havering, Redbridge and Barking &Dagenham has been set up. This meeting allows for senior managers at each local authority to discuss any issues they have encountered, share good practice examples and following the B&D inspection, guidance on what is expected.

During the first meeting, which took place in May 2017, Health, better working arrangements, and placements were identified as priority areas across all three boroughs. The schedule of

the meetings are yet to be agreed but will be discussed at the next meeting and Terms of Reference will be drawn up for all parties to agree.

Conclusion

The borough remains committed to the ongoing delivery and development of high quality support to children and young people with SEND in Havering. We are embedding a practice of strong leadership and a culture of co-production in all that we do.

It is acknowledged that there have been improvements in the way that support is delivered and recognition of areas that still need to be improved.

We are planning for an inspection that will hopefully endorse the measures we have and continue to take. The inspection will give us an external objective feedback on our ability to understand the needs of our children and young people and our ability to plan to meet their needs now and in the future.

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Progress with development of a joint suicide prevention strategy between Havering and Barking & Dagenham
Board Lead:	Mark Ansell
Report Author and contact details:	Elaine Greenway Elaine.greenway@havering.gov.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

More than 6,000 people in the UK took their own lives in 2014 which equates to one suicide related death every two hours. In Barking and Dagenham, and Havering there were 80 lives lost to suicide in 2013-15. Every life lost to suicide is a tragedy and many suicides are preventable. Therefore, local authorities are required to have a local strategy and action plan for suicide prevention by the end of 2017. In Havering, prevention of suicide and self-harm is one of the themes of Havering's Mental Health Partnership Board.

Havering Council's public health service and Barking & Dagenham's public health service are collaborating on leading the development of a joint suicide prevention strategy and action plan.

A steering group was formed in June 2017 which is responsible for developing the draft strategy and action plan. The group is chaired by the LBH Director of Public

Health, with the BHR CCG mental health lead as Vice Chair. It is attended by partners that include BHRUT, NELFT, Police, drug and alcohol treatment service, adult social care, safeguarding leads, Crossrail, etc.

A workshop for wider engagement is planned for October to further develop the draft strategy and action plan.

It is proposed that the final draft strategy and action plan be presented to the November meeting of the Health and Wellbeing Board for consideration and comment.

RECOMMENDATIONS

The Health and Wellbeing Board is asked

- to note that that there is a joint strategy in development
- to receive and comment on the final draft strategy and action plan in November
- that, in order to meet the deadline that plans be produced by end 2017, the Chairman may subsequently take action to approve final versions of the strategy and action plan
- to confirm that, for Havering, the governance of the Suicide Prevention Strategy will be to the Mental Health Partnership Board (the governance of the MHPB is to the HWB)

REPORT DETAIL

No further detail

IMPLICATIONS AND RISKS

As this is a joint strategy and action plan, there is a risk that B&D HWB and Havering HWB may have differing views about the strategy and thus the strategy may not be agreed within the timescale required (i.e. by end 2017).

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LONDON BOROUGH

BACKGROUND PAPERS

Health and Wellbeing Board members may wish to consider the document “Suicide Prevention: A guide for local authorities” available at https://www.local.gov.uk/sites/default/files/documents/1.37_Suicide%20prevention%20WEB.pdf

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HEALTH & WELLBEING BOARD 20 September 2017

Subject Heading:	**Update on East London Health & Care Partnership and NEL 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, East London Health & Care Partnership 07879 335180** ian.tompkins@eastlondonhcp.nhs.uk

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- ☒ 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 provides a further update to the Board on the development of the East London Health & Care Partnership and the Sustainability and Transformation Plan, particularly in relation to finance, the governance arrangements and public engagement.

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.eastlondonhcp.nhs.uk or email: enquiries@eastlondonhcp.nhs.uk

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RECOMMENDATIONS

The Health and Wellbeing Board is recommended to:

Note the report.

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). The STP for East London is being developed by the East London Health & Care Partnership. The plan is known as the NEL STP because the NHS has divided London into five areas: north east; north central; north west; south west; and south east.

1.2 For Havering, the work to develop the detail underpinning the NEL 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 See Appendix 1

3. Engagement

3.1 We recognise the involvement of local people is crucial to the development of the NEL 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. A series of public engagement events and activity is planned for the summer of 2017 onwards (See Appendix 1). Local Healthwatch organisations and others are also helping 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 East London Health & Care Partnership 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.eastlondonhcp.nhs.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 East London 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.

Havering
LONDON BOROUGH

Appendices

Appendix 1: General update on the East London Health & Care Partnership April 2017

Appendix 2: East London Health & Care Partnership transformation priorities

Appendix 3: What East London Health & Care Partnership is doing and what it means for local people

Appendix 4: East London Health & Care Partnership governance structure

IMPLICATIONS AND RISKS

None

BACKGROUND PAPERS

None.

Appendix 1: General update September 2017

Index

1. Background and context (our public narrative)

As more and more people choose to live and work in east London, and more of us are living longer, the demand on health and social care services is at an all-time high.

Our doctors, nurses, paramedics and other health and care professionals are looking after record numbers of people every day as our population grows faster than in any other part of the country.

Despite immense pressures, local hospitals are continuing to treat A&E patients as fast and effectively as any major western country.

Our GP, mental health and community services are among the very best in the country, and local councils are providing vital care to the most vulnerable.

It's thanks to the dedication and hard work of the professionals involved, and the support of many thousands of voluntary carers, community and charity organisations across the area that we are getting the care we need.

But change must be allowed to happen, and things improved, if we are to protect the health and care services we value so much, not just for now but for future generations.

The NHS has constantly adapted and must continue to do so as our community and our health needs also change.

It is now able to treat people with new drugs and clinical care that weren't available in the past. With this comes an increase in life expectancy, but also a rise in the ailments of old age. More people now have conditions including heart disease, arthritis and Type 2 diabetes.

There are big opportunities to improve care by making common-sense changes to how the NHS has historically worked and bring it closer to the social care services run by local councils.

This a chance to deliver improvements that matter:

- to make it easier to see a GP;
- to speed up cancer diagnosis;
- to offer better support in the community for people with mental health conditions;
- to provide care for people closer to their home.

If we do nothing and carry on providing and using services in the way we do now, without any changes, we will not only miss out on these improvements, we will fail to keep up with the growing demand and simply won't have enough money to keep services going as now.

In the east London area alone, there will be a £580m shortfall in funding within four years, by 2021. Services and facilities may have to close and standards of care will suffer if not addressed urgently.

Change is required, and fast, to help keep us healthy and well in the future and to receive care when we need it.

We all have a part to play in this – all of those providing the services, and all of us using them. We can all do our bit.

It's why neighbouring NHS hospitals, community and mental health trusts, family doctors, pharmacies, local councils and others have come together to plan for the future and redesign local health and care services to benefit us all – now and in the years ahead.

Working as the East London Health & Care Partnership, and backed by the leaders of all the organisations involved, they are combining their expertise and resources to develop ways of giving our nurses, doctors and care staff the best chance of success to look after us when we need them to.

The organisations behind the Partnership are:

NHS

Clinical Commissioning Groups

Barking & Dagenham; City & Hackney; Havering; Newham; Redbridge; Tower Hamlets; Waltham Forest

'Provider' Trusts

Barking, Havering and Redbridge University Hospitals Trust; Barts Health

NHS Trust; The Homerton University Hospital NHS Foundation Trust; East London NHS; Foundation Trust; North East London NHS Foundation Trust

Councils

Barking & Dagenham; City of London Corporation; Hackney; Havering; Newham; Redbridge; Tower Hamlets; Waltham Forest

With a shared goal to help people live healthy and independent lives, the Partnership's mission is to protect vital services and provide better treatment and care built around the needs of local people, safely and conveniently, closer to home.

A top priority is to reduce the pressures on our hospitals and accident and emergency departments. A&E is all too often used as the only door into health and care services, when ideally people should be supported by NHS 111 staff, GPs, community staff and resources in their own homes.

The Partnership also wants better outcomes for cancer patients, people with diagnosed with diabetes and improvements to mental health services, and to help people become independent with access to care at home.

Reshaping services to provide them in the right place, where people need them most, supported by the right team of staff from across health and social care, with the right resources, is a key and urgent requirement.

The response to the demand on services needs to offer better alternatives that help prevent people's health deteriorating. This isn't just to make the most efficient use of the resources and money available, but to provide a better quality of care and services in the community, where local people have told us they want them.

Attempting to improve the hundreds of health and care services for the two million people of east London – a population expected to grow by around 30,000 more people in 2017 alone – is a daunting and complex task, but many of the most beneficial changes can be made quite simply.

Significant improvements are already being made by joining services up and people are starting to feel the benefit. The area now has some of the best care provision and facilities in the country, but there's still much to do.

Although they operate safely, some our hospitals aren't fully equipped to meet the needs of modern healthcare. Waiting times for appointments and treatments must be reduced. And more has to be done to safeguard our most vulnerable people, such as the elderly, disabled and those with mental health difficulties.

'Barrier busters'

The East London Health & Care Partnership isn't afraid to tackle these challenges. It will build on the successes achieved so far and bring health and social care providers even closer together, breaking down any barriers between them as necessary.

The good work already being done to meet more localised needs will continue. The Partnership is not there to undo what works, slash budgets or act secretly behind closed doors. Instead, it will drive forward wider benefits that can only be achieved by everyone working together, coming up with new ideas and better ways of working that can put a stop to duplication and unnecessary expense.

The Partnership's main priorities are:

- To help local people live healthy and independent lives
- To improve local health and care services and outcomes
- To have the right staff in the right place with the right resources to meet the community's needs
- To be a well-run, efficient and open Partnership

It's NEL Sustainability and Transformation Plan (STP) sets out how these priorities, and those of the wider health and care sector, will be turned into reality.

The plan describes how the Partnership will meet the health and wellbeing needs of east London by improving and maintaining the consistency and quality of care, and plugging the shortfall in funding of services.

It proposes improvements that can benefit the whole area. This includes the availability and quality of specialist clinical treatments, a better use of buildings and facilities and the introduction of digital technology to improve services for local people.

The STP is not the only thing the Partnership is doing to help local people live healthy and independent lives.

The involvement of councils is enabling the provision of health and care services to be aligned with the development of housing, employment and education, all of which can have a big influence.

But the biggest single factor in the long term is to prevent ill health and in particular deaths caused by the effects of lifestyle choices such as diet, lack of exercise and smoking.

This is something we can all play a part in – everyone living and working in east London. It's not just down to the authorities. It's up to all of us to do those little things each day that help us stay healthy and fit.

And it's not just about watching what we eat and drink, or being more active. It's about using services in the right way.

Rather than immediately going to the doctor or calling for an ambulance when we don't need to, we can go to the pharmacist and get advice from telephone and online services first.

We can all do our bit. If we do this, and get behind the work of the East London Health & Care Partnership, the prize is being able to lead healthy and independent lives, and get the care we can trust and rely on when we need it.

2. The NEL STP in detail

The *NEL Sustainability and Transformation Plan (NEL STP)* sets out how local health and care services will transform and become sustainable over the next five years, building and strengthening local relationships and ultimately delivering the vision of the NHS Five Year Forward View.

Forty four such plans have been developed throughout England. They are geographically set around 'footprints' that have been locally defined, based on natural communities, existing working relationships, patient flows and taking into account the scale needed to deliver the services, transformation and public health programmes required.

The NEL STP has been defined as one for north east London by NHS England, because it has divided the capital into five 'footprints': north east; north west; south east; south west; and north central.

Originally drawn up in June 2016, and then redrafted following engagement with key stakeholders, the NEL STP was submitted to NHS England and NHS Improvement on 21 October 2016.

The plan is currently only a 'draft'. It will continue to evolve as the organisations concerned develop it further, agree shared solutions, and as we receive feedback from stakeholders.

The NEL STP describes how the organisations involved in the partnership will:

- Meet the health and wellbeing needs of its population
- Improve and maintain the consistency and quality of care for our population
- Close the financial gap.

All of the organisations involved in the NEL STP face common challenges, including a growing population, a rapid increase in demand for services and scarce resources. By working together they will be best placed to drive change and make sure health and care services in north east London are sustainable by 2021.

The NEL STP builds on existing local transformation programmes and supports their implementation including:

- Barking and Dagenham, Havering & Redbridge (BHR)
- City and Hackney
- Newham, Tower Hamlets and Waltham Forest: Transforming Services Together programme
- The improvement programmes of our local hospitals, which include supporting Barts Health NHS Trust out of special measures.
- Vanguard projects eg Tower Hamlets Together

The organisations behind the NEL STP are actively seeking to collaborate where it makes sense to do so, sharing learning from the devolution pilots and transformation programmes.

2.1 NEL STP vision and priorities

The vision of the NEL STP is to:

- Measurably improve health and wellbeing outcomes for the people of east London and ensure sustainable health and social care services, built around the needs of local people.
- Develop new models of care to achieve better outcomes for all, focused on prevention and out-of-hospital care.
- Work in partnership to commission, contract and deliver services efficiently and safely.

To achieve this vision, we have identified a number of key transformation priorities:

- The right services in the right place: Matching demand with appropriate capacity in east London
- Encourage self-care, offer care close to home and make sure secondary care is high quality
- Secure the future of our health and social care providers. Many face challenging financial circumstances
- Improve specialised care by working together
- Create a system-wide decision making model that enables place-based care and clearly involves key partner agencies
- Using our infrastructure better

These priorities have now been categorised under four headings:

- Healthy and independent local people
- Improving services
- Right staff, right place, right tools
- A well-run partnership

More information on this is given in Appendix 2

To deliver the NEL STP we are building on existing local programmes and setting up eight work streams to deliver the priorities.

The work streams are cross-cutting east London-wide programmes, where there are benefits and economies of scale in consolidating a number of system level changes into a single programme.

The work streams are:

- Promote prevention and personal and psychological wellbeing in all we do
- Promote independence and enable access to care close to home
- Ensure accessible quality acute services
- Productivity
- Infrastructure
- Specialised commissioning
- Workforce
- Digital enablement

Each delivery plan sets out the milestones and timeframes for implementation.

The full STP, and eight delivery plans, can be found on our website www.eastlondonhcp.nhs.uk

The delivery plans are currently being refreshed. Updated versions are due to published in the autumn.

A summary of what the Partnership is planning to do across services, such as urgent and emergency care, primary care and mental health, and what it means for local people, is given in Appendix 3.

2.2 Partnership governance

The launch of the Sustainability and Transformation Plan (STP) process signalled the move towards working in larger geographical areas and the need to develop governance arrangements to support strategy development and change at a system level. To achieve this, 20 organisations in East London have been working together to develop the East London Health and Care Partnership (ELHCP).

The Partnership governance structure is attached as Appendix 4.

Progress has been made in bringing the governance groups together.

- ELHCP Community Group – A group of local people, voluntary sector, and other key stakeholders to promote system wide engagement and assurance.

  A wide range of organisations and people (around 300 in total) from across east London have been invited to co-create the group.

  An initial meeting was held on 4 July and attended by nearly 100 people and work to develop the group is ongoing. More information is given in section 4 on page 10 below.

- ELHCP Mayors and Leaders Advisory Group - To provide a forum for political engagement and advice to the ELHCP STP

  Cabinet members (health) from the eight east London councils have held three meetings to date to discuss how this Group could develop. See section 3 on page 9 below.

- ELHCP Social Care & Public Health Group – Directors of Children's and Adult Services and Directors of Public Health

  The directors of adult services are setting up a working group to look at the current and future challenges relating to the social care workforce across east London, including recruitment and key worker accommodation

- ELHCP Assurance Group – An independent group of audit chairs and local authority scrutiny members to provide assurance and scrutiny

  This Group is due to hold its first meeting soon. Borough scrutiny committees are being invited to nominate members to join the Group.

- ELHCP Finance Strategy Group -To provide oversight and assurance of the consolidated east London financial strategy and plans to ensure financial sustainability of the system.

  This group is now meeting regularly. It includes council and NHS chief finance officers among its members.

The arrangements are underpinned by a Partnership Agreement (see Appendix 4) which, while not legally binding, intends to ensure a common understanding and commitment between the partner organisations of:

- The scope and objectives of the ELHCP STP governance arrangements
- The principles and processes that would underpin the ELHCP STP governance arrangements
- The governance framework / structure that would support the development and implementation of the ELHCP STP

The Partnership Agreement has now been circulated to the member organisations of the ELHCP for signature.

3. Engagement with Local Authorities

The ELHCP is engaging widely with stakeholders to shape its governance arrangements. Engagement with local authorities has been paramount and is being achieved through various forums.

There are now three local authority representatives on the Partnership board:

- Tim Shields, LB Hackney (for City and Hackney)
- Kim Bromley-Derry, LB Newham (for Newham, Tower Hamlets and Waltham Forest)
- Andrew Blake-Herbert, LB Havering (for Barking & Dagenham, Havering and Redbridge)

Cabinet members (health) from the eight east London councils have held three meetings to date to discuss how the Mayors and Leaders Advisory Group could develop.

At the most recent meeting, on 23 June, the cabinet members expressed a strong desire to be more involved in the work of the Partnership, and the shaping of ideas, especially in the development of proposals around accountable care systems and a single accountable officer role. A similar request for more involvement has come from the various Health & Wellbeing boards and some scrutiny committees.

The Partnership chair, Rob Whiteman, and exec lead, Jane Milligan, are now exploring ways of doing this. This includes having political representation on the Partnership board and in the development of transformation programmes.

The cabinet members have also been asked to nominate fellow members to join the Community Group (referred to in 2.2 on page 7 above).

Scrutiny members are being asked to join the Assurance Group. The INEL and ONEL JHOSCs have been invited to nominate members from each to join this Group, but this may end up happening on an individual borough basis.

The Partnership is also actively encouraging local authority officers to be involved in the transformation work streams listed on page 7 above.

4. Involving local people and communications/engagement generally

STPs have been widely criticised for being put together too hastily with little consultation.

The timescale set by NHS England to produce the initial plans was tight. As a consequence, there was only a limited time for engagement. Some key stakeholders felt disengaged from the process, as did patient representatives. Also, much of the detail behind the plans was initially kept under wraps giving rise to accusations of secrecy and the STPs being seen as no more than 'hit lists' and cuts to services.

NHS England acknowledges this criticism, but it caused significant reputational damage to what is a genuine and necessary attempt to deal with very real challenges.

The immediate priority of our communications and engagement strategy has therefore been to repair that damage.

Most, if not all, of our key stakeholders recognise and understand the challenge. We want to rebuild their trust and confidence and engage with them in a more positive way so they are involved in developing shared solutions.

A starting point has been to talk about a partnership rather than a plan. It is why we changed our name to the East London Health & Care Partnership.

The STP itself is still being referred to as such, but it is just one of many things the organisations involved can do together to protect and improve health and care services for the people of east London. Our plans to explore the link between health and housing, starting with a conference on 18 October, is one example

It was also felt east London was a more appropriate and familiar way of describing the area as a whole rather than north east London – the name used by the health service to denote the area.

Next is to communicate in an open and honest way; unravel the jargon, speak in plain and simple language and be accessible and transparent. Most importantly, we must listen to what people have to say.

Relevance is also important. Our communications will reflect a knowledge and understanding of the many different audiences we want to reach and be targeted to suit each group. What does it all mean for them? How are their interests being taken into account? What part can they play?

Local relevance and insight is particularly important. We will work closely with our communications and engagement colleagues in the partner organisations at borough level to make full use of their knowledge and networks.

An online Briefing Room has been set up as a central source of information and materials for members of the Partnership to adapt and use in local communications and engagement activities. This includes narratives around the NEL STP (what it is and what it isn't); the various transformation plans and programmes (as they emerge); facts and figures; presentations (tailored for specific audience); information videos; and case studies.

At the heart of our stakeholder engagement will be the Community Group – a subgroup of the East London Health and Care Partnership.

Part of the Partnership's governance structure, the Community Group's principal purpose is to act as a reference group to support the development of the Partnership's strategies, plans and activities and recommend the most effective ways for it to communicate and engage with its many different audiences.

Nearly 100 representatives from the voluntary, business, education, health and care sectors attended an event on 4 July for stakeholders and partners that could form our Community Group.

It is in effect a 'group of groups', made up of a range of people from professional organisations, the education and business sector to voluntary organisations, local councillors, Healthwatch and other patient and public groups.

How such a wide and diverse group comes together and gets involved, and how the Community Group develops, is still 'work-in-progress'. A working group of some of those that attended the event on 4 July is helping plan the next steps.

In the meantime, some of the organisations and public and patient representatives are being invited to take part in the Partnership's activities, such as improvements to the signposting of services.

A determined effort is also being made to involve young people in the Community Group. This is currently being progressed through local councils, NHS organisations, colleges and universities.

Another key audience is, of course, frontline staff – not just those in the NHS, but in councils too. Their buy-in is key and we have started engaging with them to create understanding about what the Partnership, and the STP, means to them.

We very much want staff to be involved in shaping services and our internal communications will reflect this. They will recognise the contribution everyone has to make, encouraging and valuing people's achievements, opinions and ideas.

If we are to give staff the effective help and support they need it's vital we listen to what they have to say, and demonstrate what we do as a result.

While staff and the other key stakeholders in the Community Group are taking precedence in the immediate future, we eventually want to reach out and engage with as many people as possible, including the wider public.

The Partnership's website has been rebuilt, with an improved design. (www.eastlondonhcp@nhs.uk)

An easy guide to what the Partnership plans to do and what it means for local people is to be published on the website in September. Printed copies will be made available for people that don't have access to the internet, with extracts placed in local publications.

Social media and YouTube are also being used to raise awareness of the challenges to health and care in east London, promote service improvements and run prevention campaigns.

The Partnership is also planning to hold a series of public engagement events across east London during the late autumn and winter.

Designed in collaboration with local councils and NHS organisations, with at least one major event in each borough, the events will be used to create awareness and understanding of what the Partnership is doing and what it means for local people. The larger events will feature a 'Question Time' session, and current and planned improvements to services will be showcased in a mini expo.

The Partnership communications and engagement team are working closely with their 300 plus colleagues in the member organisations to create shared opportunities to increase audience reach and give consistent messaging. They are also forging links with wider comms networks across London, including those in other boroughs, the Met Police, London Fire Brigade, TfL, professional organisations, eg Royal College of Nursing, and national charities. The Partnership's comms and engagement is seen as leading in the STP field.

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Appendix Two

East London Health & Care Partnership

Transformation Priorities

Four big issues and four Priorities

1	2	3	4
Poor health, growing population & more demand	Variable access and quality of services	Lack of workforce, poor technology and buildings	Unaffordable health & social care system
Healthy & independent local people	**Improving services**	**Right team, right place, right resources**	**Well run partnership**
•Preventing ill health and lose of independence •Tackling inequalities •Good mental well-being	• More services out of hospital and integrated in primary, mental, social & community care • Improved priority services: maternity, mental health, cancer, urgent & emergency care • Strong hospital & specialist services	•Healthy work places •Skills & career development, recruitment & retention •Housing for key workers •Digital & online services •Better buildings	• Partnerships • Productivity – value for money • Better organised - new organisations bringing together providers & commissioners • Living within our means

Our story

The transformation agenda for health and social care across East London is significant and exciting. We are challenging ourselves to be clear that more of the same isn't enough, or will provide fit for purpose health and care going forward. These are the four big challenges the ELHCP want to tackle:

1. Healthy and independent local people

- We have one of the largest and fastest **population** growth rates in the country - 18% over the next five to ten years
- This is both growth of a younger population and also the older population
- East London also has a transient population and areas of intense **health inequalities** and deprivation
- People want their **whole health and social care needs** considered as one and we too often treat and manage people in parts, in particular not making sure that people's mental as well as physical health are treated equally. We have also traditionally focused more on resourcing physical health needs than mental and well-being needs.

2. Improving services

- **Resources** (capacity) are not necessarily in the right part of the system, often still tied up in acute hospitals rather than in the **community,** where people tell us they want them.
- Access is too often through A&E, at a point of crisis. The front door to the system should be people's own front doors with care provided by multi-disciplinary teams across health and social care, supported by the voluntary sector and our strong local communities.
- The problem with accessing care in a crisis through A&E means our solutions tend to be too much about providing care around a few hundred hospital beds, rather than care around the one and half million beds in people's own homes.
- This support should be centred in the home, and using digital technology and more self-care support to prevent crisis and maintain independence.
- It's not only about demand and capacity not lining up, the **quality** of some of our services and the outcomes people get are variable –and we want the best standard for everyone across East London
- Access to primary care is **variable** and the Care Quality Commission has highlighted services, **quality** and **outcomes** across our providers that need to improve
- Some services are not as **resilient** as they could be, for example primary care and urgent and emergency care services
- We have a long history of innovation through working with patients and clinicians to co-design individual components of care, but this hasn't been easy to spread more widely.

Our story

3. Right team, right place, right resources

- We have the opportunity to innovate training, roles and ways of working. It's about the right care, at the right time, in the right place and most importantly – the right team.
- Community–based working often gives more autonomy to staff and releases them to innovate and provide whole person care- and this is important, as not only is capacity not always in the right part of the system, but we need new types of roles, development opportunities and ways of working as finding and keeping the **workforce** these days is challenging, especially with the cost of living and housing in London.
- We also have serious challenges our estates and technology. We have some of the best buildings, but also others that are not fit for purpose, such as Whipps Cross Hospital. We also have estate with old hospital buildings that could be re-purposed used for new integrated health and social care facilities, creating health campuses
- People live their lives on their smart phones now and there is an urgent need for health and social care services to become more **digital friendly**

4. Well run partnership

- Ultimately all our challenges above mean that the **financial** as well as service and quality sustainability of our health and care system is impacted. There is scope to be more productive and if we do not seize the opportunity our financial challenges and sustainability will continue and service stability will be affected.
- In recent years the system has become **fragmented**: causing duplication, not always working to the best advantage for the patient or local people and putting artificial barriers between professionals and organisations across health and local government services. We need to make sure we are organised well and working in partnership.
- Individual institutions will not address the financial or quality goals we have, and in order to get the best of our collective resources we need to transform how we work together using a **partnership** approach, rather than working with an individual organisation focus.

East London Health & Care Partnership

Urgent & Emergency Care

What are we doing?

- Providing better information to the public on where to get the most appropriate healthcare.
- Launching a new, improved NHS 111 Integrated Urgent Care (111 and Clinical Advice Service) and working towards improved links with other health services eg Mental Health, GPs, Pharmacists, Urgent Treatment Centres, ambulance services and community health professionals.
- Improving access to weekend and evening GP appointments as well as introducing the chance to be seen not just in person, but on the phone or online.
- Creating Local HealthCare Hubs bringing community nurses, GPs, mental health staff and other NHS specialists under one roof in community settings.
- Creating consistent Urgent Treatment Centres, so people understand what treatment can be given there
- Creating special areas in the hospital for specific emergency conditions so that people do not need to stay overnight in a hospital bed when there is no medical need for this.

What does it mean local people?

- You will be able to understand the range of local healthcare services available and how to access them.
- By calling or contacting NHS 111 Integrated Urgent Care (111 and Clinical Advice Service) you will be able to access the most appropriate clinical advice on where your health needs will best be treated as close to your home as possible.
- You will be able to book GP appointments more easily and these will be also be available in person during evenings and the weekends as well as over the phone and online. You will be able to be seen by a range of healthcare professionals in your community in new Local HealthCare Hubs more quickly.
- Wherever you live in east London, you will be able to be seen at our Urgent Treatment Centres for the treatment of minor injuries, including broken bones and minor burns.
- You are likely to be satisfied with your experience as a patient because we will be reducing the time you need to spend in hospital.

East London Health & Care Partnership

Primary Care

What are we doing?

- Improving access to weekend and evening GP appointments as well as introducing the chance to be seen not just in person, but on the phone or online.
- Creating Local HealthCare Hubs bringing community nurses, GPs, mental health staff and other NHS specialists under one roof in community settings.

Quality improvement

- Helping practices improve the experience of their patients
- Helping practices improve services for people with long term conditions
- Helping practices become a better place to work and remove administrative headaches
- Training staff in proven improvement techniques
- Sharing solutions that work across east London
- Established an east London Primary Care Partnership for Quality improvement Board which will enable acceleration of quality improvement approaches, learning and case studies across the whole area.

Provider development

- Helping GP federations develop to improve care, reduce overheads and give primary care a stronger future
- We are bringing GP federations and networks together to share learning and experience, and solve common challenges - we have recently set up an east London Primary Care Provider Forum.
- Establishing a range of online resources that GP federations and practices can use to take forwards quality improvement

Workforce development

- Working out what mix and number of staff will be needed going forwards and how to find and train them
- Working together to retain current staff for longer, making east London an attractive place to work for new recruits

What does it mean local people?

- More time with GPs to avoid rushed appointments and increased accurate diagnosis.
- Patients being able to book appointments quickly, within a reasonable timeframe and a pre-booked one if they wish.
- Patients being able to see a preferred clinician if they wish to wait longer for an appointment.
- Patient access to reliable information about the practice so that they can make their own decisions
- Patients not only being able to book appointments via telephone but by other means, such as through the internet website, emails, digital TV or by text.
- Increased access to a range of health professionals to provide care best suited to individual needs
- Better support and information to enable the public to take better control of their own health.
- A service that treats patients as people not numbers.

East London Health & Care Partnership

Digital

What are we doing?

- Enabling GP appointments to be booked online.
- Allowing people to view their own health and care records.
- Putting more services, such as some GP consultations and mental health services, online.
- ·Improving information systems and sharing records to allow health and care professionals to work closer together.

What does it mean local people?

- You will be able access health and care services more quickly and easily.
- You will be able to book GP appointments or talk to your GP online.
- Doctors and other care professionals will be better placed, with the right information, to help prevent illness and give you better care, should you need it.
- You will be able to get care closer to home, or in your home.
- You will have better information on how to stay healthy and well.

East London Health & Care Partnership

Mental Health

What are we doing?

- Working with partners to address the wider determinants of mental health eg access to accommodation, education and employment.
- Supporting the roll out of digital self-management tools such as the London Digital Mental Wellbeing Service (www.digitalwellbeing.london).
- Developing an east London-wide suicide prevention strategy.
- Supporting employers to improve staff mental health and emotional wellbeing via programmes such as Mental Health First Aid.
- Developing our talking therapies services so they are more appointments with reduced waiting times.
- Integrating mental health services into GP surgeries, A&E and General Hospitals.
- Developing perinatal mental health services for expectant mums and mums of new babies.
- Improving services for people experiencing a crisis by ensuring everyone in crisis can access mental crisis support 24/7.
- Delivering mental health treatment at home.
- Delivering specialist mental health services for children and young people closer to home.
- Developing a new Child and Adolescent Mental Health Psychiatric Intensive Care Unit here in East London.

What does it mean local people?

- Improved access to and shorter waiting times for psychological therapies.
- A wider range of mental health services to be accessible via your GP
- Your mental and physical health and social care needs treated as one, wherever and whenever necessary.
- Enhanced support to access the right education, employment and accommodation opportunities for people with mental health issues.
- People in east London will have access to the same range of mental health services wherever they live.

East London Health & Care Partnership

Cancer

What are we doing?

- Ensuring that we are seeing all patients who need an urgent appointment within 2 weeks.
- Making sure that patients are receiving their tests and diagnostics on time to enhance early diagnosis and treatment and improve cancer survival.
- Educating GPs and other professionals to improve better communication with hospital consultants.
- Encouraging patients in east London to take up their screening.
- Improving IT and administrative processes to make sure the cancer referral pathway is effective and patients' care is integrated.
- Listening to patients and carers to ensure that we keep improving their care with all our partners.
- Working with Public Health services to improve prevention and lifestyle choices.

What does it mean local people?

- If you are referred urgently by your GP or another health care professional you will get seen within two weeks.
- If you have a cancer diagnosis, you will receive treatment quickly in order to improve your chances of survival.
- A number of health and social care professionals will be involved in your care to ensure your care is integrated.
- Your experience of care will be positive because we are listening and making improvements.
- If you take up screening when you get an appointment, you are likely to receive early detection and treatment.
- If we in east London improve our lifestyle choices, fewer of us will develop cancer.

East London Health & Care Partnership

Maternity

What are we doing?

- Working with and listening to local women in East London to understand their needs and design care based on those needs.
- Working to ensure that unbiased information regarding choice of place of birth is available for women.
- Ensuring the workforce is sustainable in the next 5 - 10 years to cope with the level of births in East London.
- Ensuring safe and high quality care for all mothers and babies.
- Working together to ensure each woman receives continuity of care with the same staff members throughout her pregnancy and birth

What does it mean local people?

- You will be able to see one or two midwives throughout your pregnancy to ensure continuity of care.
- If you have a long-term condition such as diabetes, or you are having twins or other multiples, you will be seen by your midwife and obstetrician regularly and may be referred to a specialist
- You will be able to use a website or app to give you more information about the places available to you to give birth in East London.
- The plan for care during your pregnancy will be developed and agreed between you and your midwife or obstetrician.
- Your overall experience of care during and after your pregnancy will be positive and of high quality.

East London Health & Care Partnership

Medication

What are we doing?

- Following national recommendations from NHS England we will review the prescribing of certain medicines, where there is either limited evidence for their effectiveness or for which there are safer alternatives. This will ultimately save money for NHS reinvestment.
- Buying specific medicines (biosimilars such as anti-inflammatory medicines infliximab and etanercept) from alternative better value suppliers, which saves money for re-investment.
- Reducing medicines waste may involve the empowerment of patients, encouraging them to take charge of their overall health. This could lead to better outcomes e.g. medication reviews with pharmacists that identify medications that are no longer needed.
- Decreasing antibiotics resistance by reducing the amount and type prescribed and educating patients and prescribers on the importance of completing courses of anti-biotics in the instances where they are necessary.
- A review of the pharmacy workforce; analysing the benefits of increasing the presence of clinical pharmacists within GP practices and/ or clinics in order to help ensure the right medicines, at the right time for the right patients.

What does it mean local people?

- You will be able to get professional medical advice for all minor ailments in all pharmacies, including out of hours pharmacies.
- Pharmacists will also give you consistent advice on the nature of medicines available to buy over the counter and available on prescription and point you in the correct direction for your symptoms.
- You will not be prescribed anti-biotics unless they are essential.
- You will be less likely to be kept in hospital waiting for medicines to be prescribed.
- The cost of prescribing medicines to you as a tax-payer will be less, meaning funds can be allocated to other parts of the health and care service.

East London Health & Care Partnership

Prevention

What are we doing?

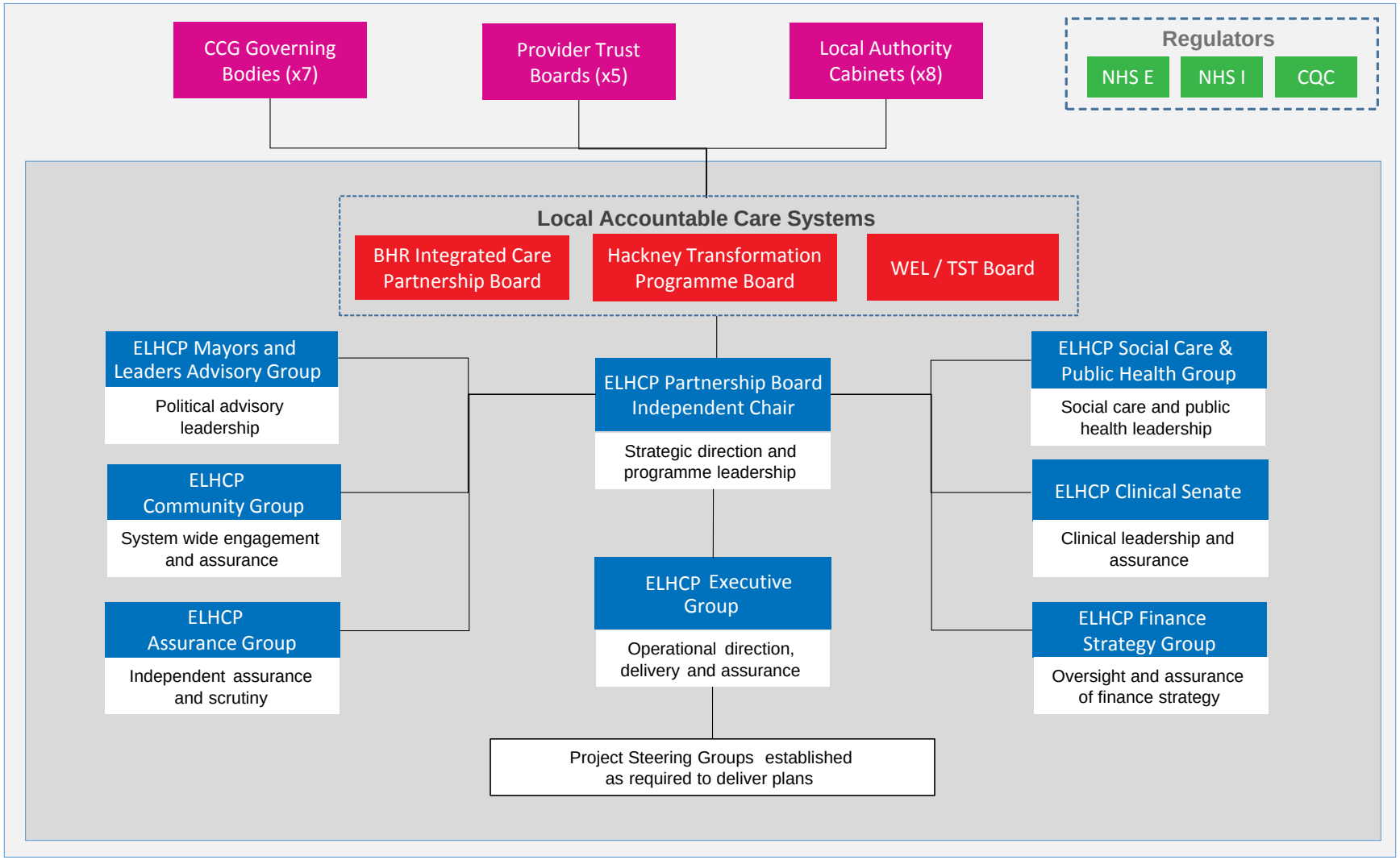
- Building better support into our hospitals, mental and community health services to help smokers quit.
- Improving workplace health across east London, starting with the NHS. Because happier, healthier NHS staff means better healthcare for patients.
- Improving screening processes to better identify those at risk of contracting Type 2 diabetes, and offering courses to help those people change their lifestyles.
- Standardising care for people with Type 1 and Type 2 diabetes in GP surgeries and hospitals across east London.
- Empowering people, through flexible self-care course, to better look after their diabetes and avoid unnecessary hospital trips.
- Working with local schools, education institutions, local employers, libraries and voluntary services, to provide better support for young people with diabetes, taking into account their social and economic context.

What does it mean local people?

- Better support to quit smoking, with help and advice available at many health and care centres, workplaces and online.
- Better screening, treatment and support for diabetes.
- New services to help young people, and pregnant women, manage diabetes better.
- Better opportunities and more support to stay healthy at work.
- Greater consistency of healthcare opportunities and support across east London.

East London Health & Care Partnership

Governance structure



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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 15 November 2017. Deadline for papers **27 October.** To be held in CR2	
East London Health and Care Partnership Update	Ian Tompkins
High Needs Funding Review and SEND Strategy	Tim Aldridge
Integrated Care Partnership adult service pilot communications plan (deferred from July)	Keith Cheesman
Forward Plan	
HWB Meeting 31 January 2018. Deadline for papers **12 January 2018.**To be held in CR3A	
East London Health and Care Partnership Update	Ian Tompkins
Forward Plan	
HWB Meeting 14 March 2018. Deadline for papers **23 February 2018.**To be held in CR3A	
Update on East London Health and Care Partnership	Ian Tompkins
Health Protection Forum Report	
Obesity Strategy	Mark Ansell
Report from End of Life Steering Group	

Havering Health and Wellbeing Board - Forward Plan 2017/18

Forward Plan	

Previous Board meetings and topics covered

HWB Meeting 10 May 2017. Deadline for papers **28 April 2017**. To be held in CR3B	
Update on Referral to treatment delays	Sarah Tedford / Louise Mitchell
Update on STP	Ian Tompkins
Integrated Care Partnership	Barbara Nicholls/ Alan Steward
Dementia Strategy- for sign off	Andrew Rixom, on behalf of CCG
Health and Wellbeing Strategy: extension to June 2019	Mark Ansell
Refreshed Health and Wellbeing Board Strategy Dashboard/indicator Update	Mark Ansell
Forward Plan	
HWB Meeting 19 July 2017. Deadline for papers **6 July 2017**. To be held in CR3A	
CCG System Delivery Plan (originally scheduled for May Meeting)	Alan Steward
CCG - Consultation on Service Restriction	Alan Steward

Havering Health and Wellbeing Board - Forward Plan 2017/18

Havering End of Life Care Annual Report 2016/17	Gurdev Sani
Better Care Fund Planning for 2017-19	Keith Cheesman / Caroline May
Integrated Care Partnership Progress Report	Keith Cheesman
Drugs and Alcohol Strategy Update	Elaine Greenway
East London Health and Care Partnership Update	Ian Tompkins
Forward Plan	
HWB Meeting 20 September 2017. Deadline for papers **1 September 2017**.To be held in CR2	
Update on Referral to Treatment Delays	Sarah Tedford / Louise Mitchell
Healthwatch Havering Annual Report	Anne-Marie Dean
East London Health and Care Partnership Update	Ian Tompkins
Local Plan Development	Neil Stubbings
SEND Executive Board Update	Tim Aldridge

Havering Health and Wellbeing Board - Forward Plan 2017/18

BHR Transforming Care Partnership Plan update ((originally scheduled for May Meeting)	Lee Salmon
Havering CAMHS Update (originally scheduled for July Meeting)	Jacqui Van Rossum
Joint Commissioning Strategy	John Green
The development of a joint Havering and Barking & Dagenham Suicide Prevention Strategy	Elaine Greenway
Forward Plan	

Groups to provide papers to HWB board

- JSNA Steering Group
- Care Transformation Board
- SEND Executive Group
- Mental Health Partnership Board
- CAMHS Transformation Partnership Board
- CYP Commissioning Forum
- Adults Commissioning Forum
- End of Life Partnership Board

Health and Wellbeing Board Indicator Set: September 2017

The following high-level indicator set reflects the priorities and themes of the Health and Wellbeing Board Strategy. The first 10 core indicators provide an overview of the health of residents and the quality of care services available to them. Below the core indicators are additional indicators covering those topics of current and special interest to the Board which will change over time.

#	Indicator	What is *Good*?	Trend	Havering		Comparators						Period	Update status
				Count	Rate (%)	London	RAG	England	RAG	Target	RAG		
1	Healthy life expectancy, male	High	-	66	-	64		63		-		2013-15	Unchanged
2	Healthy life expectancy, female	High	-	65	-	64		64		-		2013-15	Unchanged
3	Physically active adults	High	-	-	55	58		57		-		2015	Unchanged
4	Overweight (including) obese children, Year 6	Low	↑	993	37	38		34		-		2015/16	Unchanged
5	Achieving a good (or better) level of development at age 5 (EYFSP)	High	-	-	71	71		69		73		2016/17	Unchanged
6	Good blood sugar control in people with diabetes	High	-	-	52	58		60		-		2015/16	Unchanged
7	A&E attendees discharged with no investigation and no significant treatment; (the figure for the previous year 2015/16 was 18,331)	Low	↓	16,585	-	-		-		-		2016/17	**Updated***
8	NHS friends and family recommendation of NHS Havering GPs	High	-	298	88	87		89		-		Jun-17	**Updated**
9	Satisfaction with Adult Social Care services	High	-	-	62	60		64		-		2015/16	Unchanged
10	Mortality attributable to air pollution	Low	-	-	5.1	5.6		4.7		-		2015	Unchanged
11	Prescribed Long acting reversible contraception (LARC) excluding injections	High	-	1,350	2.8	3.6		4.8		-		2015	Unchanged
12	Referral to treatment	High	↑		92					92		June 2017	**Updated**

Trend rating: ↑ Increasing / better; ↓ Decreasing / better; ↑ Increasing / worse; ↓ Decreasing / worse

RAG rating: Significantly better than comparator; Significantly worse than comparator; Similar to comparator; Comparison not made

There are nearly 250K Havering residents. An increase of 10% in the last 10 years, with similar growth projected for the coming decade. Havering has the oldest population in London (46K residents aged 65 and older, 14K aged 80 or older) but the number of births each year has increased by 33% in the last 10 years to nearly 3.3k. Havering is gradually becoming more ethnically diverse, but 83% of residents are White British; a higher proportion than both London (45%) and England (80%). Havering is relatively affluent, but 10K children and young people aged <20 live in low income families and there are pockets of significant deprivation to the north and south of the borough. Average life expectancy is better than the national average with a significant gap berween the least deprived and deprived areas. Most residents enjoy good health but 18% of working age people have a disability or long term illness.

#	Indicator	Description
1	Healthy life expectancy, male	The average number of years a male newborn would expect to live in good health based on mortality rates and self-reported good health
2	Healthy life expectancy, female	The average number of years a female newborn would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health
3	Physically active adults	Percentage of adults achieving at least 150 minutes of physical activity per week in accordance with UK Chief Medical Officer recommended guidelines
4	Overweight (including) obese children, Year 6	Proportion of children aged 10-11 classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex
5	Achieving a good (or better) level of development at age 5 (EYFSP)	Percentage of pupils achieving at least the expected level in the Early Learning Goals within the three prime areas of learning and within literacy and mathematics; this is classed as having a good level of development
6	Good blood sugar control in people with diabetes	The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol (equivalent to HbA1c of 7.5% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 12 months
7	A&E attendees discharged with no investigation and no significant treatment	Havering GP-registered patients who attend BHRUT A&E who are discharged without an investigation and with no significant treatment; this suggest that attendance at A&E was not appropriate. *Please note that there was an error on the indicator set provided to the Health and Wellbeing Board in July 2017. This should have read 16,585 not 8,568
8	NHS friends and family recommendation of NHS Havering GPs	The Friends and Family Test asks patients how likely, on a scale ranging from extremely unlikely to extremely likely, they are to recommend the service to their friends and family if they needed similar care or treatment
9	Satisfaction with Adult Social Care services	The percentage of adult social care survey respondents who expressed strong satisfaction with the care and support services they received
10	Mortality attributable to air pollution	Percentage of annual all-cause adult mortality attributable to human-made particulate air pollution (measured as fine particulate matter <2.5µm)
11	Prescribed Long acting reversible contraception (LARC) excluding injections	Percentage of LARC excluding injections prescribed by GP and Sexual and Reproductive Health Services per 100 resident females aged 15-44 years; a high figure suggests that there is access to a choice of contraceptive methods
12	Referral to treatment	Percentage of Havering GP-registered patients referred to BHRUT, treated within the expected timescales.

See **This is Havering** for further key geographic and socio-economic facts and figures https://www.havering.gov.uk/info/20073/public_health/405/haverings_health