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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD
AGENDA

1.00 pm	Wednesday, 24 February 2021	Virtual Meeting

Members: 16, Quorum: 6

BOARD MEMBERS:

Elected Members:	Cllr Robert Benham Cllr Jason Frost (Chairman) Cllr Damian White Cllr Nisha Patel
Officers of the Council:	Andrew Blake-Herbert, Chief Executive 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) Ceri Jacob, BHR CCG
Other Organisations:	Anne-Marie Dean, Healthwatch Havering Jacqui Van Rossum, NELFT Fiona Peskett, BHRUT

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

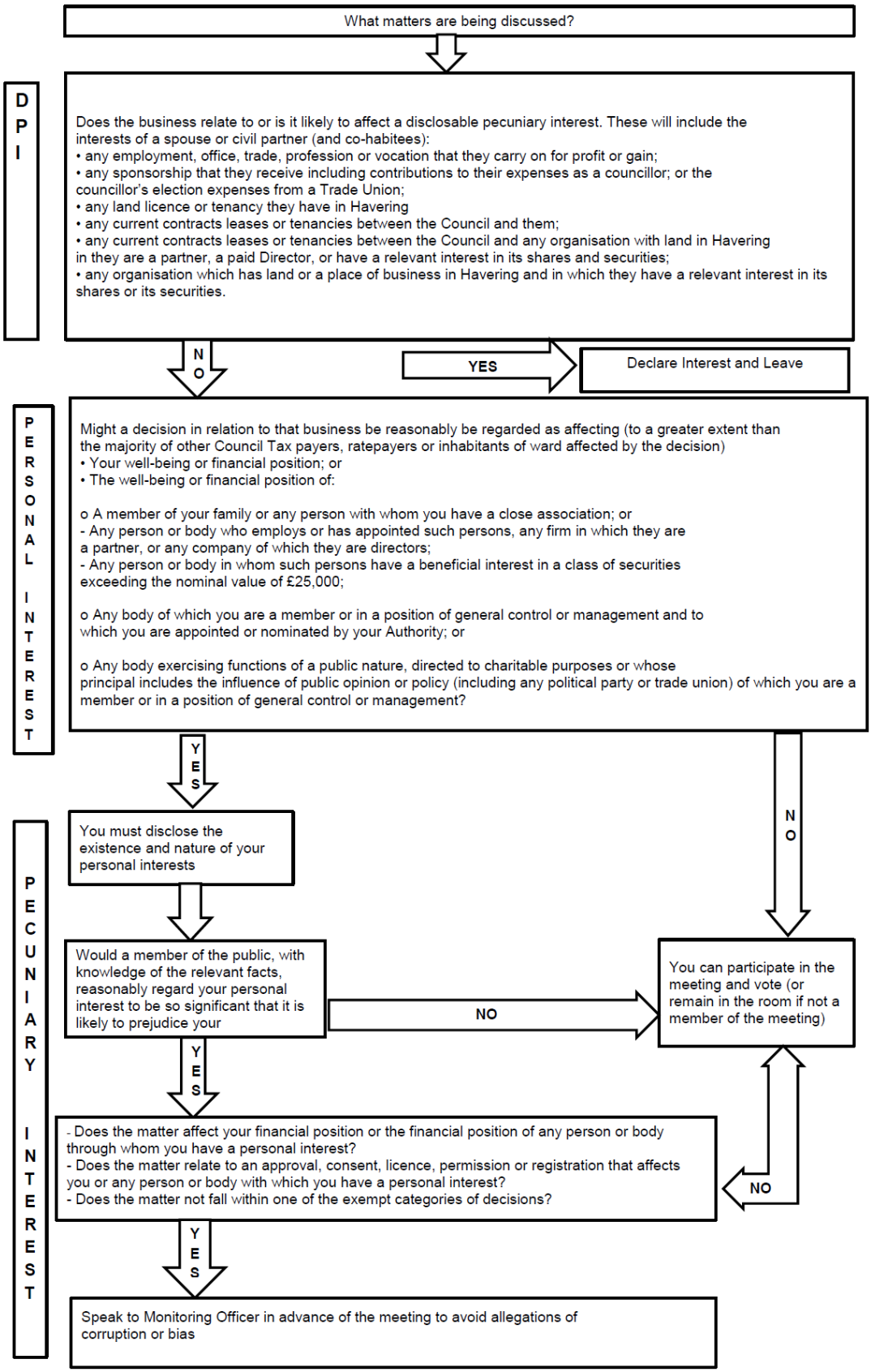
Havering's Health and Wellbeing Board (HWB) is a Committee of the Council on which both the Council and local NHS and other bodies are represented. The Board works towards ensuring people in Havering have services of the highest quality which promote their health and wellbeing and to narrow inequalities 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

DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF



AGENDA ITEMS

1 CHAIRMAN'S ANNOUNCEMENTS

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

2 APOLOGIES FOR ABSENCE

(If any) – receive

3 DISCLOSURE OF 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 (Pages 1 - 4)

To approve as a correct record the minutes of the Committee held on 27th January 2021 and to authorise the Chairman to sign them.

5 MATTERS ARISING

To consider the Board's Action Log

6 LBH PARTNERSHIP DESIGN GROUP

Verbal update to be given

7 LOCAL AREA COORDINATION (Pages 5 - 16)

Report attached

8 HEALTH AND SOCIAL CARE WHITE PAPER (Pages 17 - 20)

Report attached

9 COVID-19 UPDATE

Verbal update to be given

10 ANY OTHER BUSINESS

11 DATE OF NEXT MEETING

The next meeting of the Health and Wellbeing Board is to be held on 31st march 2021 at 1pm via Zoom.

MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD
Virtual Meeting
27 January 2021 (1.00 - 3.00 pm)

Present:

Elected Members: Councillors Robert Benham, Jason Frost (Chairman) and Nisha Patel

Officers of the Council: Andrew Blake-Herbert (Chief Executive), Mark Ansell (Director of Public Health), Ian Elliot (Children & Families Transformation) as a representative for Robert South (Director of Children's Services) and John Green (Head of Joint Commissioning Unit) as a representative for Barbara Nicholls (Director of Adult Services)

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

Healthwatch: Anne-Marie Dean (Healthwatch Havering)

BHRUT: Fiona Peskett

All decisions were taken with no votes against.

28 **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman reminded Members of the action to be taken in an emergency.

29 **APOLOGIES FOR ABSENCE**

Apologies were received for the absence of Cllr Damian White

30 **DISCLOSURE OF INTERESTS**

There were no disclosures of interest.

31 **MINUTES**

The minutes of the meeting of the Committee held on 25 November 2020 were agreed as a correct record and, due to COVID-19, will be signed by the Chairman at a later date.

32 **MATTERS ARISING**

There were no matters arising from the previous meeting.

33 ANY OTHER BUSINESS

There was no other business.

34 UPDATE ON DEVELOPING GOVERNANCE ARRANGEMENTS FOR INTEGRATED CARE SYSTEM

The Board members were presented with updated governance arrangements for the North East London (NEL) Integrated Care System (ICS).

Members were informed that borough partnerships were being established in each of the BHR boroughs. Each borough had been offered £25,000 to resource the development of a roadmap outlining development to April 2022 and beyond. Members were advised that the Health and Wellbeing Board (HWB) would be asked to sign off the roadmaps in March 2021.

It was noted that the Havering CCG would dissolve, and the NEL CCG would come into effect on the 1st of April 2021. Board members commented on the Integrated Care Partnership Board (ICPB) Terms of Reference (ToR). Members noted the suggestion of 1 Healthwatch representative on behalf of the 3 Boroughs. The Board noted that the ToR in reference to procurement and competition would need to be reviewed due to emerging legislation. Members raised concerns regarding the procedure for managing conflicts of interest and resolving disagreements in decision-making. The Board asked for consideration to be placed on an independent Chair and Vice-Chair to ensure varied representation and authority. In view of COVID-19, the Board asked that electronic means of engagement i.e., virtual meetings, be considered as part of the 'business as usual' model.

In conclusion the Board suggested 3 changes to wording in the Terms of Reference:

1. Regarding the EU regulations to include the word 'relevant'
2. Regarding the balance and roles of the Chair and Vice-Chair
3. Regarding the wording relating to virtual working

Otherwise, the Board agreed the Terms of Reference.

35 COVID-19 UPDATE

The Board was updated on the Borough's position regarding COVID-19.

Members were informed that collectively, rates in the South East of England were high. Members were informed that the incidence rate in Havering peaked in mid-December at 1,200 cases per 100,000 individuals due the emergence of a new, dominant, and more transmissible variant. While acknowledge the current reduction in cases, it was felt that the current rate (448/100,000), was unacceptably higher when compared to the national average (382/100,000). It was pointed out that rates remained higher among working adults (600/100,000) due to a large proportion of people

unable to work from home, whilst cases in children had driven down due to school closures. Members were informed that the positivity testing rate (20%) was far beyond the 7.5% limit recommended by Public Health England (PHE).
It was noted that on 26 January 2021, the UK passed the milestone of 100,000 deaths. It was noted that Havering had the highest mortality rate (273/100,000) nationally, which was attributed to the borough's generally older population and high community prevalence. It was noted that deaths in the borough were 18% higher compared to previous years.

NELFT

The Board received an update on the current NHS situation.

Members were informed that the phlebotomy backlog was cleared. The Board members noted an increase in the number of referrals to child and adult mental health services resulting from lockdown and isolation. Members were made aware of increased end-of-life care in learning disability settings. Members were advised that partners were looking at local options for crisis management and that additional bed capacity had been created across BHR hospitals. Members commented on developments to support public mental health (PMH) including work of the Mental Health Transformation Board. Members highlighted the potential for joint working between community and voluntary (CAV) sector partners and the local authority to support PMH.

BARKING, HAVERING AND REDBRIDGE UNIVERISITY TRUST (BHRUT)

Members received an update on BHRUT.

Members noted a gradual decrease in the number of hospital inpatients with COVID-19 diagnosis from a peak of 520 down to 350 at present. The frailty unit at Queen's hospital was transformed into a high flow oxygen unit to support high oxygen demand for patients with respiratory COVID-19. Members were informed that critical care units were operating at "super surge levels of expansion" in order to provide mutual aid to other intensive care providers. Members were advised that leave suspensions for staff were due to be lifted in February. Members were cognisant of staffs' health and mental wellbeing due to the pressures of working under increased demand.

CORONAVIRUS VACCINATION PROGRAMME

The Board was given an update on the progress of the coronavirus vaccination programme.

It was noted that BHR was on target to vaccinate the first four Joint Committee on Vaccination and Immunisation (JCVI) priority groups by mid-February 2021. The Board were informed that majority of care homes had now been vaccinated and that home visits were now taking place.

Members were given an update on outreach work. In accordance with historical flu vaccination trends, uptake for the vaccine was lowest in Black African and Bangladesh communities. Members queried the provisions for asylum seekers and were concerned that many might not be identified by typical databases i.e., GP registration records. Members suggested that the Community Leaders Forum could offer some relevant engagement and that 'vaccine champions' could be useful in influencing uptake in vaccine hesitant cohorts. Members were also informed that work was underway to increase vaccine uptake through CAV sector partners.

Members were advised that work was underway with NHS England to determine if and when coverage data at borough level would be made available to the public.

LOCAL TESTING STRATEGY

Members were given an update on the development of the Borough's testing strategy.
Members were advised that the current priority was to ensure good access to testing for the asymptomatic working population. Members noted that people unable to work from home would be able to test twice weekly using rapid lateral flow tests (LFTs). It was noted by the Board that 2 more community testing sites were to open at Gidea Park and South Hornchurch Libraries from the 1st February 2021, bringing the total to 5. It was noted by the Board that Havering in the weeks leading up to Christmas 2020, had the highest testing uptake and volume of tests made available to the community. Members thanked the Public Health team for their efforts and perseverance in setting up testing sites.

36 **DATE OF NEXT MEETING**

The next meeting of the Board would be held on Wednesday 24 February 2021 at 1.00 pm.

Chairman

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HEALTH & WELLBEING BOARD

Subject Heading:	Local Area Coordination Update
Board Lead:	Councillor Jason Frost Project Joint SRO: Patrick Odling-Smee and Barbara Nicolls
Report Author and contact details:	John Green Head of Joint Commissioning Unit john.green@havering.gov.uk

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

☐	The wider determinants of health • Increase employment of people with health problems or disabilities • Develop the Council and NHS Trusts as anchor institutions that consciously seek to maximise the health and wellbeing benefit to residents of everything they do. • Prevent homelessness and minimise the harm caused to those affected, particularly rough sleepers and consequent impacts on the health and social care system.
☐	Lifestyles and behaviours • The prevention of obesity • Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups • Strengthen early years providers, schools and colleges as health improving settings
☒	The communities and places we live in • Realising the benefits of regeneration for the health of local residents and the health and social care services available to them • Targeted multidisciplinary working with people who, because of their life experiences, currently make frequent contact with a range of statutory services that are unable to fully resolve their underlying problem.
☐	Local health and social care services • Development of integrated health, housing and social care services at locality level.
☐	BHR Integrated Care Partnership Board Transformation Board • Older people and frailty and end of life • Long term conditions • Children and young people • Mental health • Planned Care Cancer Primary Care Accident and Emergency Delivery Board Transforming Care Programme Board

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SUMMARY

1.1 This project originated as one of the transformation concept cases approved by Cabinet in July 2018, two 'test and learn' sites in Havering were set up; Harold Hill and Rainham / South Hornchurch with 6 Local Area Coordinators and on manager. A multi-agency Leadership Group guides the work seeing it would be beneficial to pilot this approach rather than undertake a feasibility study to understand the impact it could have in Havering. The Leadership group will evaluate the approach and what it has achieved across specific communities at the end of 2021. Funding was agreed with contributions from partners and a business case for transformation funding approved in February 2020. Funding was agreed for 2 years. The aspiration is that Local Area Coordination, if successful is rolled out across the borough. Achieving this aspiration will reply on funding from partners.

1.2 Local Area Coordination originates from Western Australia and is a model that follows a defined developmental approach. It is a community development approach rooted in community building and is developed from the ground up, work is undertaken within the community to engage them and empower them as community leaders to define how Local Area Coordination would work for them. The starting point in any site where Local Area Coordination is being considered is work that is undertaken in the community to focus on the strengths and assets within the community, the people and places that support a local area.

1.3 Interviews were held in January 2020 and two of the three Local Area Coordinator posts were appointed to for Harold Hill by the Local Area Coordination Community Steering Group. The appointment of the Local Area Coordinators for Harold Hill was then delayed by the first COVID-19 national lockdown and the two Local Area Coordinator's started at the end of July 2020 and were operational and taking introductions from late August 2020.

1.4 In October 2020 work began with the community to develop the Community Steering Group for Rainham and South Hornchurch. This work was completed in early November and recruitment began for 4 Local Area Coordinators. Interviews took place in January 2021 (one for Harold Hill and three for Rainham and South Hornchurch). 4 people were appointed and this completed the set-up of the Local Area Coordination Pilot. New Coordinators are scheduled to start in early March.

1.5 This paper sets out the progress made with the development of the service, what the service has achieved for people in Harold Hill so far, with case studies of our work, walking alongside people included throughout this document.

RECOMMENDATIONS

1.6 Receive the update on progress with the development of the Local Area Coordination team in Havering and discuss the opportunities to further connect this service to ensure the pilot is as effective as possible across all services.

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REPORT DETAIL

2. Progress report: Local Area Coordination

2.1 What is Local Area Coordination?

2.2 Local Area Coordination is a strengths based approach to working with people in the community. The approach is defined by 10 core principles (set out below) and these guide the work Local Area Coordinators do, "walking alongside" people to help them develop the skills they need to achieve their vision of a good life. Local Area Coordination seeks to connect people into their community, to make that community a welcoming and supportive place where people seek support to solve their own problems, reducing the need for traditional service interventions. Local Area Coordinators work on the basis of introductions, these can come from anywhere and there is no referral process or threshold to meet. If a person wants to make changes to live a better life, an introduction to a Local Area Coordinator can be made. The Coordinators listen to what people want to achieve and help them think about how they can get there, accessing support and making connections in the community to build the life they want. Many of the people that have been supported by Local Area Coordination to date have complex issues that they want to change and a Local Area Coordinator will work with them for as long as they need to, to achieve change. Local Area Coordinators work in a community covering an area of around 8000-12,000 population. They become part of the community and it is this way of working that is powerful in building trust with the local population.

10 core principles of Local Area Coordination:

3 Why Local Area Coordination?

3.1 There are 12 Local Authorities using this model across the country and there are several evaluation reports that show the benefits of Local Area Coordination, I have set out key points from some of these below:

Stories from Local Area Coordination…..
D is 45 and has learning difficulties. D had always been supported by his mum, but she died in 2019 and now he struggles. D had extensive rent and council tax arears and had a letter with a scheduled eviction date. He didn't understand what that meant and took the letter to the Salvation Army for help. That is where he met Trish, a Local Area Coordinator in Harold Hill. D's home was in a poor state. He had no food in the cupboard. He didn't have a cooker or washing machine. He didn't know how to cook and his personal hygiene was also poor. D's is a functioning alcoholic.

What are we doing for D?
Working with Peabody to undertake a benefits check and ensure that he is in receipt of the right benefits. This has culminated in adjustments made to his benefits retrospectively and the eviction notice has been rescinded and his arrears wiped.
Trish secured a stove and a microwave from the community and a washing machine through a local charity. Age UK plumbed the washing machine in for him. Trish taught him how to cook basic food and he now has food in his cupboard, which he was proud to show us. D has opened up about the loss of his brother and this being linked to his use of alcohol. He has agreed to attend a 1:1 meeting at the Westminster drug and alcohol project. We have supplied D with some new clothes and items for the winter from donations from the community.

D's brother in law met with Trish and was very grateful for what Local Area Coordination had done for him, he said he didn't know what to do for him and had been so worried about his impending eviction, he said he would not have coped with being homeless. He said he had a van and if we ever needed some help for someone else to call him as he would be happy to help us as we had helped him.

D's brother in law has also since introduced a friend of his to Trish who wants her help.

Benefits in working with D through Local area Coordination
D had not met the threshold for support from social care previously but it is likely that his situation would have continued to deteriorate until he was at crisis point. Costs avoided through this way of working could include:

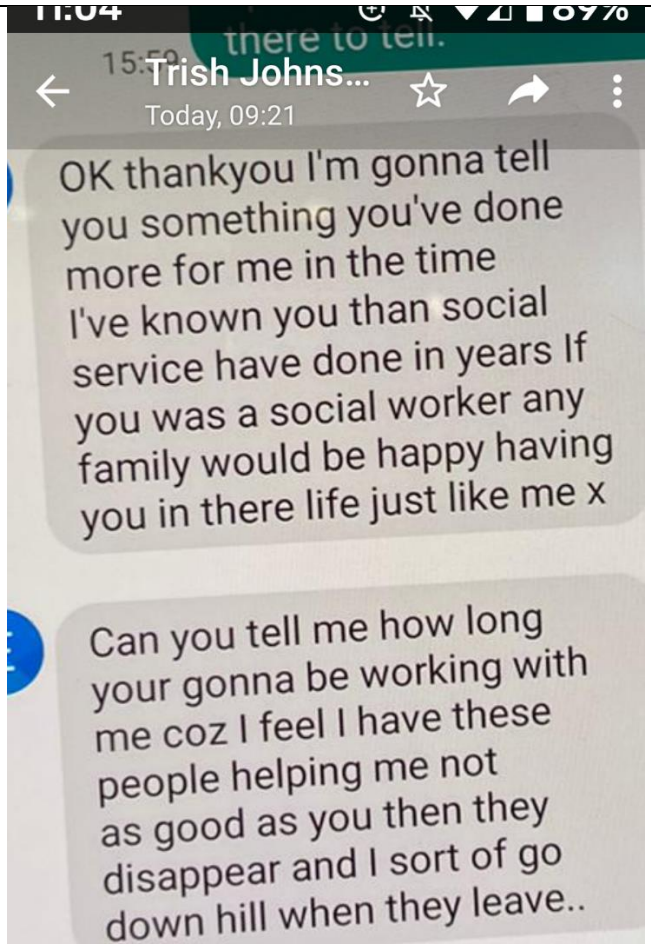
Health and care needs:	
Without support from Local Area Coordination D would have needed, at least in the short term, support to live in the community as his situation deteriorates: Average weekly cost of home care package for local authority in-house provision, England	£153
Housing:	
Homelessness advice and support - cost of a homelessness prevention or housing options scheme that leads to successful prevention of homelessness	£747
Average cost of a repossession to a complex eviction	£803-£7770

The cost matrix sets out an annual cost for adults living with severe and multiple disadvantages (SMD) - involvement in homelessness, substance misuse and criminal justice. Without intervention some of these costs would apply in this case.	£24,500

Local area Coordination also supports various legislative and policy intentions:

- In relation to the requirements of the 'Care Act 2014', with a duty on Local Authorities to promote health and wellbeing with the prevention duty focussing on 'prevent, reduce and delay'.
- 'The Homelessness Reduction Act' so that everyone who is homeless or at risk of homelessness will have access to meaningful help.
- NHS place-based care and greater collaboration and integration of health and social care services.
- Key to meeting these requirements and addressing the strategic and financial challenges is building community social capital and resilience to increase self-support and self-management and economic and social wellbeing. It will meet council objectives of enabling greater self-sufficiency in community and family networks; and in particular meet needs for care and support before crisis point.

3.2 The stories of the people open to Local Area Coordination in the first five months of operating in Harold Hill has shown us that people face many challenges. Accessing different services for their specific issues, but there isn't one support option that can help look at what is going on in their life, to look at them holistically and help them navigate each element. As a result people fall through the gaps between services or their needs aren't great enough to access them and their situation worsens until we need to respond at a crisis point. Whether that is managing mental health, addressing a housing or living concern, managing a long term condition, being connected into the community to tackle loneliness and isolation, some of the people we are working with have been known to statutory services and they have had periods of support when their needs have become concerning and they have met the threshold for statutory services, but the issues that got them there haven't been resolved and support is withdrawn when they are no longer of concern to that service and their particular threshold or remit.



3.3 Local Area Coordination can work with someone to achieve change over a longer period, change takes time. If we are serious about prevention and enabling people to be experts in their own lives then we need to structure our support to achieve this aim. We need to make a further shift to looking at how we keep people well rather than waiting for people to need services. It puts people at the centre, allowing communities to lead and public services to respond only when they're needed.

Stories from Local Area Coordination…..
N has type 1 diabetes, he has not managed this well and is now almost blind. N has always been very active, and had a promising career. His deteriorating health conditions means that he has lost his job and his relationship has broken down. His career was sport related and he spent a lot of time outdoors. N feels he has lost everything and is very depressed, he thinks he is a burden. N tried to apply for housing and had been refused, he said that when this happened he went and stood on a train platform for 2 hours as he wanted to kill himself. N has been to his GP but has not received a referral for mental health support. N is very keen to live independently from his parents where he currently lives with his nephew. He doesn't meet the criteria for housing. N was introduced to Local Area Coordination through a family member of someone else we are walking alongside.

What are we doing for N?
Local Area Coordinators are planning next steps for N to improve his mental health and to support him to advocate for himself and explore how he could be

independent. N understands that if he doesn't achieve independence whilst young enough to want to do so and has the confidence to build a life for himself on his own, he may need support later, especially if his support network is not there to support him in the longer term. N is only 30 years old and has his whole life ahead of him. Local Area Coordinators will help him build a new life, with his disability and help him realise he has the opportunity to build a good life.

Benefits of working with N through Local Area Coordination
Local Area Coordinators will walk alongside him to achieve an independent life and find a new path, where he values himself and looks positively to the future.

Mental Health and potential for Support:	
Average cost of service provision for adults suffering from depression and/or anxiety disorders, per person per year	£4741

There could be long term costs for N, he is currently supported by his parents. If they were no longer able to support him, he would need support as he doesn't currently have the skills to live independently.

3.4 Local Area Coordination is a way to drive system change, Local Area Coordinators can build a good understanding of the areas where statutory services are not meeting people's needs and engage in finding different solutions, working with the community and existing services to co-deign the right solutions to meet the needs of the community.

Stories from Local Area Coordination….
S is a single mum of three children. Her 16 year old son has Cerebral Palsy and caring for him has been her life. S is very protective of him and manages his care alone, often not letting others in, the social worker felt that her approach is preventing progress with her son and his mobility has decreased as a result. Our complex needs service introduced S to a Local Area Coordinator as they were struggling to engage S in planning and supporting her son.

What are we doing for S?
Tracy asked S what her view of a better life would be? She found that S is new to the area and doesn't have many connections locally but she wants to build her own life and make connections, building a life for herself was important to her. She said she felt isolated and her mental health is suffering. In building her own life, she felt that would enable her to engage better with services in planning to support her son, because she would have more of a purpose for herself. S told Tracy that she has a child that is transgender and in the process of transitioning. S has health issues of her own that she is managing. Local Area Coordination is walking alongside another mum with a child who is transgender and going through the process of transitioning and they have said they would like to meet when restrictions allow.

Benefits of working with S through Local Area Coordination

We can see that S needs to build local connections, for her own mental health and wellbeing but also to allow services to work with her to build her sons independence.

Supporting a child with complex needs:	
S: Is not engaging with the complex care team, her son's independence is limited because of her insistence to care for him in a certain way. His care needs in the longer term could be expensive if the service cannot work with her and build his independence and S is unable to care for him, she is managing long-term health conditions of her own.	Havering costs for residential care are £3-8000 per week depending on the needs of the child. (Havering cost from Complex Care team). Annual cost at £3000 per week is £156,000 Annual cost at £8000 per week is £416,000

4. Evidence of impact

4.1 There have been several evaluations of the effectiveness of Local Area Coordination from other Local Authorities, some outcomes achieved are listed below:

4.2 Local Area Coordination Evaluation in Swansea:

- In line with the finding from previous studies and building upon their approaches, this review found Local Area Coordination was tackling a broad range of social and personal issues.
- The data demonstrated a positive return on investment across the portfolio of 267 individuals supported and reviewed for financial benefit.
- The cost per supported individual were on average £980, though trending to circa £600 per individual as set-up costs were absorbed.
- High levels of complexity within the portfolio, with positive outcomes, this suggest that Coordinators are adding value across a range of public service pressures.
- Local Area Coordination implementation, as reviewed, involved costs of circa £400k with benefits in the range of £800k-£1.2m. This represents a benefit/cost ratio of between 2:1 and 3:1 using the core range assumptions, whilst continuing to provide return even under the most conservative parameters.

4.3 Local Area Coordination evaluation in Derby

- A Social Return on Investment Analysis (SROI) was undertaken to understand the wider impact of the service and inform continual improvement. This first forecast analysis demonstrated that over the three year forecast period with 10 Local Area Coordinators, Local Area Coordination would deliver significant social value with up to £4 of value for every £1 invested. Social return on investment is a principles-based method for measuring extra-financial value (such as environmental or social value) not currently reflected in financial account.

4.4. Local Area Coordination in York

- York have carried out work on cost divergence and cost avoidance and have an academic partnership with the University of York, who have completed an evaluation of their work over the first three years. It showed that 77-96% of cases have actively diverted people away from formal services.

5. Who are the people Local Area Coordination are working with?

5.1 Two Local Area Coordinators have been operational in Harold Hill since late August 2020. We currently have 23 people open to the service.

Prevalent issues we are supporting:

- Housing and living environment concerns (2 people with eviction dates with eviction avoided)
- Debt (council tax, rent arrears)
- Depression and mental health concerns
- Helplessness (I am a burden, not worth going on….)
- Health concerns and managing long term health conditions
- Feeling isolated
- Dealing with bereavement
- Alcohol misuse
- Struggling to maintain independence, manage themselves at home (hoarding, lack of life skills)

5.2 Generally we can see that more than one of these issues is a concern for the person we are working with. In many cases one issue such as a change in a person's health has led to other issues such as anxiety and depression and isolation or housing and debt problems.

5.3 The success of the pilot of the Local Area Coordination service will be dependent on how well the service integrates with other services across Havering and how well it is linked into transformation and change and development plans for services. The team meet regularly with the reconnections service and the social prescribing link worker to ensure we connect around people effectively to help them achieve what they want. The service is part of the planning and the development of the community hubs, contributing our experience of what we are seeing in the community and the support people are seeking. Local Area Coordination will be a key service within the localities programme, working as part of the network of professionals that will work to support people in a different way. To effectively support the people we are walking alongside we need to be connected, to and have an understanding of services and support available across the community to do this we need the continued support of professionals across all services.

Stories from Local Area Coordination….
T is 71, she fell down the stairs and went into hospital. Social Care supported when she was discharged from hospital, they suggested a blitz clean for her home, but T refused. She doesn't like people in her home. T now has a cleaner. When she fell, the police had to break in to her home when the ambulance was called and it was when T approached the local PCSO about the damage to her door, he introduced her to Tracy.

T is a hoarder, she has no heating in her home, and the only water supply was through her bath taps. She has ulcerated legs due to diabetes. T has had many welfare visits from social care in the past.

What are we doing for T?
Tracy has helped her to complete DFG and housing repair grant forms and arranged for Age UK to replace her stair rails. T is lonely, she was very independent and worked when she was younger, and she had a full and busy life, but is struggling with her current situation. Tracy is trying to connect her with social groups to get her reconnected to people in the community. We anticipate walking alongside T for some time to support her with the hoarding, address the state of her home and to reconnect her to the community. Tracy is helping T to purchase a new fridge freezer. T is looking to make some improvements to her home but this needs to be at her own pace. T had a fall over Christmas and there is reluctance to send her home due to the state of disrepair in her home, she has no heating. T wants to go home so Tracy is seeking information for her to have her heating system updated via a HA grant, if the issues with her home can be resolved then she will be discharged with some support in her home.

Benefits of working with T through Local Area Coordination
T has had numerous safeguarding concerns and welfare visits over the last few years and several hospital admissions. If she doesn't mange the ulceration to her legs, this could lead to more serious problems that could have a hugely detrimental impact on her mobility. Practical support to manage her home and connecting her to the community will hopefully have a longer term impact on her life. We are looking to connect her with another person we are walking alongside to help her manage and access her garden.

Health and support needs:	
Without support from Local Area Coordination T will need support to live in the community as her situation deteriorates: Average weekly cost of home care package for local authority in-house provision, England. Residential care costs are incurred when T cannot go home after a fall and period of hospitalisation.	£159 (week) £600 (week)
T has already had a fall in the home, she fell again over Christmas. Further incidents could be likely. Hospital inpatients - average cost per episode (elective and non-elective admissions) Hospital Outpatient	£1864 £125
Unable to manage the garden and outside condition of the home, this can end in enforcement action.	Costs could be from £200 - £3000 if a case went to court.

5.4 Through the case studies we can see the principles of Local Area Coordination emerging:

- The logic of being rooted in the community in terms of building connections. Our Local Area Coordinators, in a short space of time, are becoming a trusted source of support and relationships are being established quickly, people are putting their trust in their Local Area Coordinator.

- Asking people what their vision of a good life is, is clearly evident and drives the work.
- Taking practical action vs. referring on to services. The impact of simple things, securing a bed so someone can sleep better, a table so the family could eat dinner together, small practical help making a big difference to a person's life all sourced within the community.
- Limitless input alongside people without criteria, flexible and creative thinking on how to help people with what they want to change.
- Not signposting people on, finding solutions and building relationships.
- Starting to introduce neighbours with each other and build natural connections.
- Taking introductions from everywhere, particularly through natural connections, the number of people we are supporting introducing to others in the community is growing. This will be a real test of how the community trust and value their Local Area Coordinators.

Stories from Local Area Coordination….
E lost her partner suddenly. He was her carer. E suffers with chronic arthritis and uses a cane and is in the process of being diagnosed with epilepsy. E has a child who is transgender and currently going through the process of transitioning. E is feeling isolated and has mental health concerns. Her late husband was a hoarder, she is finding managing the home and the loss together too much. Havering Mind made an introduction to Trish, one of the Local Area Coordinators for Harold Hill.

What are we doing for E?
Trish has been working with her to deal with the hoarding, identifying things that can be thrown away, items that can be sold. Trish is trying to connect her with a local walking group as she is keen to get out and meet people. We are walking alongside another person who has a child who is transgender and they want to meet when restrictions allow. E has been for her first bereavement counselling session, she said she felt more comfortable talking to Trish and wants to continue the relationship with Trish rather than through counselling. E said that she misses the companionship of her relationship. Trish secured a dining room table so that she can sit and have meals with her 2 children, making more time for family conversations. When Trish dropped it off they had a conversation about making time to sit together and have some family time and the children have agreed to do this. This lifted her mood. She put up Christmas decorations in the house as she felt more positive. E is still clearing out the home. Many items have, or are being sold via selling sites on Facebook locally or have been removed and disposed of.

Benefits of working with E through Local Area Coordination
Helping E connect with others to rebuild her life after suffering a loss. Helping her with small practical changes to make her life better.

Health needs:	
Risk of a fall is high in relation to the clutter in the home and that she is unsteady and walks with a cane. Hospital inpatient cost per episode	£166 (A&E attendance all scenarios) £233 (Ambulance call out) £1935
Fire Risk	

Fire risk to hoarding. Response cost to a fire.	£3828
Mental Health Support:	
Community provision average cost per contact.	£179.10
Average cost of service provision for adults suffering from depression and/or anxiety disorders, per person per year	£4741

5.5 The case study examples show the relationship based support the service can provide is more than signposting. It provides practical help and support to help people achieve change through getting to know people and understanding what they want. At the end of each of some of the stories is a box which represents costs. These are indicative costs of the person's interaction with services, an approximate cost of the service intervention if the person continued on the same trajectory. These costs were developed by Department of Communities and Local Government in 2019 as part of the troubled families work and are agreed unit costs that have been agreed with the treasury and developed alongside Manchester and Birmingham City Councils. In some instances we have worked with the department to establish what we think a local cost would be, where we did not have a comparison available. This will enable us to report on cost avoidance at the end of a person's journey with us and how this is reflected across different service areas. Our performance management information over time will then enable us to have a sense of the cost avoidance we are achieving and we can bring back more developed evidence one the service if further established.

IMPLICATIONS AND RISKS

The key risks to the success of the pilot and the aspiration, should the evaluation prove Local Area Coordination to be effective to roll out borough wide are listed below. The community in Harold Hill have connected well with the service and we will monitor this in Rainham and South Hornchurch. Evaluations in other areas have shown the approach to be effective. The main risk to the future of Local Area Coordination and potential expansion of the service is the willingness and availability of funds across partners to invest in it.

- Communities and organisations across Havering do not engage with the approach. No evidence of this so far, we have had a strong response in Harold Hill.
- The pilot evaluation doesn't show that the service is having impact, drawing people away from services and avoiding higher costs in statutory service intervention. Other areas have seen evidenced excellent outcomes,
- The pilot is effective but there is insufficient support across partners to continue to fund the service.

BACKGROUND PAPERS

None

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HEALTH & WELLBEING BOARD

Subject Heading:	White Paper - Working together to improve health and social care for all
Board Lead:	Alison Blair, Director of Transition, BHR Integrated Care Partnership
Report Author and contact details:	Alison Blair, Director of Transition, BHR Integrated Care Partnership (Alison.blair3@nhs.net)

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

☐	The wider determinants of health • Increase employment of people with health problems or disabilities • Develop the Council and NHS Trusts as anchor institutions that consciously seek to maximise the health and wellbeing benefit to residents of everything they do. • Prevent homelessness and minimise the harm caused to those affected, particularly rough sleepers and consequent impacts on the health and social care system.
☐	Lifestyles and behaviours • The prevention of obesity • Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups • Strengthen early years providers, schools and colleges as health improving settings
☐	The communities and places we live in • Realising the benefits of regeneration for the health of local residents and the health and social care services available to them • Targeted multidisciplinary working with people who, because of their life experiences, currently make frequent contact with a range of statutory services that are unable to fully resolve their underlying problem.
☐	Local health and social care services • Development of integrated health, housing and social care services at locality level.
☐	BHR Integrated Care Partnership Board Transformation Board • Older people and frailty and end of life • Long term conditions • Children and young people • Mental health • Planned Care Cancer Primary Care Accident and Emergency Delivery Board Transforming Care Programme Board

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SUMMARY

On 11th February 2021, the Government published a white paper setting out proposals for health and care integration. The paper set out legislative proposals for a Health and Care Bill. It builds on the collaborations we have seen over the past few years, through COVID to shape a system that's better able to serve people in a fast-changing world.

At its heart, however, this bill is about supporting health and care system working. The proposals build on the NHS Long Term Plan. They aim to:

- Remove the barriers that stop the system from being truly integrated, help integrated care systems play a greater role, delivering the best possible care, with different parts of the NHS joining up better; and the NHS and local government forming partnerships to address some of society's most complex health problems.
- Use legislation to remove transactional bureaucracy that has made decision-making harder setting out a more joined-up approach built on collaborative relationships, so that more strategic decisions can be taken to shape local health and care. It's about population health: using the collective resources of the local system, NHS, local authorities, the voluntary sector and others to improve the health of local areas.
- Ensure a system that is more accountable and responsive to the people that work in it and the people that use it.

At the HWBB there will be a presentation summarising the proposals and highlighting those areas with implications for how we integrate care in North East London and Havering.

RECOMMENDATIONS

The HWBB is asked to note the publication of the White Paper and comment on the implications for our work in BHR and the development of integrated health and care.

IMPLICATIONS AND RISKS

The direction of travel as indicated in the White Paper is supportive of the development of integrated care locally. The consequences of the White Paper will be considered over the next few weeks with a view to amending our local work programme, risk log and system design.

BACKGROUND PAPERS

Link to the White Paper:
https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all

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