Havering Health & Wellbeing Strategy 2012-14

Havering
LONDON BOROUGH

Contents

Executive Summary

Our vision is for the people of Havering to live long and healthy lives, and have access to the best possible health and care services. To help us move towards this vision, we have identified the most pressing health and social care issues in the borough and, by working collectively as a strategic partnership, we will prioritise the actions we need to take to deliver improved outcomes for local people. These are set out clearly in the Health and Wellbeing Strategy, which focuses on three overarching themes and eight priorities for action.

Theme A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

Priority 1: Early help for vulnerable people to live independently for longer

Older and vulnerable people, especially those with long-term conditions, are the most intensive and costly users of health and social care services and there is a clear need for their experience and outcomes achieved to be improved. They account for half of all GP appointments, two thirds of all outpatient appointments and nearly three quarters of all inpatient bed days. As our older population continues to grow, we are faced with increasing demands on these services. By focusing on prevention and early intervention, we hope to relieve some of this pressure on services and enable more people to live independently and safely in their own homes for longer and with a better quality of life.

We will:

- Help more vulnerable people, including those with long-term conditions and complex needs, maintain their independence in the community and reduce use of acute/complex services
- Tackle isolation and support vulnerable people to help maintain independent living
- Improve choice and control over the health and social care people receive
- Deliver more community based support, including volunteer-led services for people recently discharged from hospital and provision of reablement services to help them re-adjust to independent living.

Priority 2: Improved identification and support for people with dementia

Dementia is a clinical syndrome characterised by a widespread loss of cognitive function, including memory loss, language impairment, disorientation, change in personality, self neglect and behaviour that is out of character. It is an extremely distressing illness and a particularly pertinent issue for Havering due to our large, and growing, older population.

We will:

- De-stigmatise dementia and ensure sufferers and their carers receive the best possible support in managing their condition
- Ensure high quality and accessible dementia information by improving data collection on the prevalence of dementia and data sharing between organisations
- Clinically train professionals to recognise the symptoms of dementia leading to earlier diagnosis and improved outcomes for sufferers and their carers
- Deliver more universal services and better quality of care for people with dementia.

Priority 3: Earlier detection of cancer

About 1,200 people in Havering (one in every 200) are diagnosed with some form of cancer each year and more than 600 a year die of the disease. National research shows that more than 40% of all cancer cases are attributable to avoidable risk factors such as smoking, alcohol, poor diet and lack of exercise. Most people could significantly reduce their risk of developing cancer by living more healthily.

We will:

- Maximise participation in the three cancer screening programmes, particularly for bowel cancer, which is a relatively recent development
- Raise public awareness of the signs and symptoms of cancer. To this end, we will evaluate the recently commissioned local awareness raising campaign and continue to support relevant national and London wide campaigns.
- Further improve the identification and investigation of patients with signs and symptoms suggestive of cancer in primary care settings
- Improve quality of cancer care services and patients' experience of care, including maintaining excellent performance on waiting times between referral of patients with suspected cancer and first consultant contact (two week waits) and 31/62 day targets for receiving treatment quickly after diagnosis; and increasing access to optimal treatment, particularly radiotherapy and surgery.

Priority 4: Tackling obesity

Being overweight or obese increases a person's risk of developing diabetes, cancer and cardiovascular disease. Being obese can restrict mobility and contribute to poorer mental health, which can limit a person's participation in their community and reduce their quality of life. Obesity is a complex issue that is affected by a range of behavioural, psychological, social, cultural and environmental factors.

We will:

- Intervene early to slow down the rise in obesity levels in adults and children
- Promote healthier lifestyles and increase levels of physical activity to maintain healthy weight
- Raise awareness of the health risks associated with being overweight and obese.

Theme B: Integrated support for people most at risk

Priority 5: Better integrated care for the 'frail elderly' population

Future demographic change will significantly increase the proportion of older people in the population. As a result, the number of 'frail elderly' residents will also increase. These are people with the most complex needs that currently provide the greatest challenge to health and social care providers.

We will:

- Ensure with partners, seamless, integrated and efficient care pathways for 'frail elderly' people with care needs
- Improve pathways into and through community-based health services and general practice by working closely with the hospital and GPs
- Reduce the incidence and impact of falls that often lead to the hospitalisation of older people and improve the efficiency of care following injury as a result of a fall, including hip fracture
- Enhance independence and capability of individuals to manage their conditions at home

- Provide support to people within the community who have recently been discharged from hospital or who are at risk of admission/re-admission
- Improve care in nursing and residential homes, including better management of demand to reduce avoidable hospital admissions and monitoring of safeguarding controls
- Improve support to people not currently engaged with social care such as self funders and those with lower levels of need to ensure that greater opportunities to benefit from prevention, improved health and wellbeing and support are provided
- Ensure informed choice on end of life care through robust information and guidance for patients and carers.

Priority 6: Better integrated care for vulnerable children

Healthy, happy and educated children are more likely to become healthy happy and productive adult members of society. Setbacks experienced in childhood as a result of troubled family backgrounds can result in long-lasting harm that persists throughout life and has a spiral effect leading to significantly reduced outcomes for those young people. Vulnerable children, such as those in care or with learning disabilities, face particular, more complex, issues and our priority is to support them to realise the same positive and sustainable outcomes as rest of the population.

We will:

- Provide intensive, bespoke, support to families with multiple complex needs to address their problems earlier
- Improve the stability of care placements and reduce placement breakdown, including reducing the number of placements between foster care and adoption
- Improve health outcomes for children and young people, particularly those in care
- Improve the transition from children's to adults care packages for young people with disabilities
- Reduce teenage conceptions and improve sexual health through the delivery of targeted campaigns that raise awareness of health risks
- Commission universal and targeted access to health visitors and schools nurses to deliver the Healthy Child Programme
- Reduce the numbers of children experiencing poverty in Havering by working collectively to deliver actions in the Child Poverty Strategy
- Provide access to high-quality therapies for vulnerable children and young people.

Priority 7: Reducing avoidable hospital admissions

Hospital admissions, especially avoidable admissions, are extremely costly to the NHS and disrupt the lives of those affected, as well as causing unnecessary distress to family and friends. Long and frequent hospital stay also cause increased dependency and ill health and reduce people's confidence to manage at home. We are keen to reduce unnecessary and unplanned hospital admissions, particularly for ill-health or injury that could have been avoided and repeat hospital admissions where individuals are admitted into hospital on a frequent basis.

We will:

- Manage the care of patients proactively in the community through planned care transformation such as integrated case management
- Increase independence skills of people within the community who have recently been discharged from hospital or who are at risk of admission/re-admission

- Reduce inappropriate and unplanned discharges, which lead to re-admissions and seek greater collaborative approaches to ensure that planning for discharges takes place closer to an individual's point of admission
- Ensure that vulnerable people are safeguarded from neglect and abuse when receiving care at home
- Ensure high quality prescribing of medications to reduce unnecessary hospital admissions.

Theme C: Quality of services and patient experience

Priority 8: Improving the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

Ensuring patients, and their families and carers, receive the best quality health and social care services is crucial to achieving the best long-term outcomes for patients. We would like to see consistently high levels of quality of care in all health and care services provided in Havering. Through collaborative working and robust provider performance management, the CCG will continue to improve the quality and safety of services to deliver its aim of improving patient, family and carer experience. We want patient experience of health and care services in Havering to be positive.

We will:

- Bring about big improvements in quality of care and patient safety, especially maternity services in Queens Hospital
- Minimise the incidence of avoidable harms in hospital and community settings, including pressure sores, falls, urinary tract infections and VTE
- Ensure patient experience in A&E is improved by reducing waiting times and diverting people away from A&E where appropriate
- Focus on quality of care in community residential settings and implementation of a scheme to increase medical care in nursing homes
- Ensure sound financial management of the NHS budget for Havering so that quality of services is not compromised
- Risk is managed by providers systematically and accurately to reduce likelihood of occurrence of serious untoward incidents
- Commission and performance manage Healthwatch to high levels of ensure patient and public engagement activity that can affect improvement.

Foreword

The Health and Wellbeing Strategy sets out how we will work together to improve the health and wellbeing of local people and improve the quality of, and access to, local healthcare services.

We have a lot to be proud of in Havering. Life expectancy is high and residents feel that the borough offers a very good quality of life. The borough is one of the greenest in London, with plenty of parks and open spaces. There are a wealth of entertainment and shopping facilities, high quality cultural facilities, excellent schools, good transport links and relatively high levels of employment.

However, when it comes to people's health and social care, we know there are things we can improve on, such as the quality of our local hospitals and community care services. We can do more to improve cancer survival through better provision of healthcare services and by raising people's awareness of the signs and symptoms of cancer so they come forward for treatment at an earlier stage. We can also do more for our older residents by improving support for people with dementia and doing all we can to prevent older people ending up in hospital unnecessarily.

This strategy has been developed after listening to the concerns of our residents, engaging with local health and social care professionals about how we can improve our health system, and analysing the evidence we have on the health and wellbeing of our population and the performance of local health services.

We are in a period of great change in the way health services are commissioned. From 2013, clinical commissioning groups, made up of local GPs, will control most of the health service budget. The Council will also have specific responsibilities around improving the health of the public. A new Health and Wellbeing Board, made up of GPs, local councillors, and healthcare professionals, as well as other commissioners of health services and patient involvement networks, will oversee the delivery of the strategy. The Health and Wellbeing Board will monitor and publish its progress against this strategy each year.

Good health is everyone's responsibility. We hope that this new direction of partnership working will deliver improvements in local healthcare services and raise the health and wellbeing of Havering residents.

Cllr Steven Kelly

Chair of Havering Health and Wellbeing Board

Dr Atul Aggarwal

Chair of Havering Clinical Commissioning Group

Introduction

Our vision

Our vision is for the people of Havering to live long and healthy lives, and have access to the best possible health and care services.

Purpose of the strategy

The Health and Wellbeing Strategy sets out how we will work together to improve the health and wellbeing of local people and improve the quality of, and access to, local healthcare services. It provides the overarching direction for the commissioning of health and social care services in Havering and is the responsibility of the new Health and Wellbeing Board. Within the strategy are our priorities for action and each has a jointly agreed plan for how we will deliver improved outcomes for local people. The strategy will be delivered by partners of the Health and Wellbeing Board (see Appendix A for membership details of the Board).

The Board is committed to ensuring that health and social care services in Havering are effective and cost-effective. Plans will be continually reviewed against the best available evidence and amended, where necessary, to ensure that the best possible outcomes are achieved within the resources available.

Havering's Joint Strategic Needs Assessment

The JSNA analyses the health and wellbeing needs of the local population by drawing upon a range of data and intelligence from various sources, including feedback from local people. It enables us to compare Havering's performance with other areas, and identify where health and care services perform well and where we need to improve. The collection of JSNA resources and information, which includes other needs assessments and reports, is regularly updated and made publicly available on the Havering Data Intelligence Hub at **www.haveringdata.net/research/jsna.htm**

Stakeholder engagement

In March 2012, a workshop was held with partners of the shadow Health and Wellbeing Board, which included clinical commissioners (GPs), local authority and health commissioners, elected members and other agencies with an interest in improving the health and wellbeing of local people. The workshop focused on the key issues emerging from the JSNA. It also looked at the indicators contained within the three national outcomes frameworks for the NHS, public health and social care, and identified where Havering's performance was above or below the national average against these measures. From this session, the key priorities for the Health and Wellbeing Strategy emerged and were subsequently agreed at the next Health and Wellbeing Board meeting. Further to this, stakeholder engagement took place through the Integrated Care Strategy to test priorities for health and social care, most recently in June 2012.

Public consultation

A summary of the strategy, providing an overview of the themes, priorities and outcomes, was made available for public comment on the Council's website during September and October 2012.

Equality analysis

In line with the Council's obligations under the Public Sector Equality Duty, the strategy has been assessed for its equality implications and the impact of the proposed actions on disadvantaged groups of the population. This document is available on the Council's website.

Havering, the Place

Overview

The population of Havering is generally fairly healthy. It has long life expectancy rates, excellent schools, a strong local economy, an active cultural scene and plenty of pleasant green open spaces. As an outer north east London borough, transport connections to the centre of London and surrounding areas are good.

However, dig deeper beneath the surface of these facts and there are stark differences in how long people can expect to live, depending on where they live and the circumstances of their upbringing; significant inequalities in how likely certain groups of people are to develop certain illnesses or make unhealthy lifestyle choices; large variations in affluence and poverty; pockets of poor housing; and in some areas, relatively high levels of worklessness.

Population

Havering has 237,200 residents and 243,508 people registered with a Havering GP. It has one of the largest older populations in London, with 21% (49,000 people) of retirement age. It has a large younger population too, with 24% (56,700 people) aged 19 and under. Population projections show that the population is likely to grow at a faster rate than the London average – 5.4% (12,699 people) by 2016 and 11.5% (27,095 people) by 2021. The projected increase in the older population is likely to result in larger numbers of residents experiencing cardiovascular disease (CVD), cancer, respiratory illnesses (e.g. bronchitis and pneumonia), dementia, osteoporosis (and fractures due to falls), incontinence and hearing impairment, placing further demand on local health and social care services, hospitals and community services to help manage long-term conditions.

Deprivation

Havering is ranked 177 out of 326 local authorities for deprivation (with 1 being most deprived and 326 being least deprived). However, pockets of deprivation still exist, with two small areas of Havering falling into the 10% most deprived areas in England (areas in Gooshays and South Hornchurch). When compared to other London boroughs, Havering has a relatively small proportion of children living in poverty. However, 19.3% of children are still estimated to be living in poverty in Havering.

Public perception

Results from the 2011 ‘Your Council, Your Say’ residents survey, carried out by the Council, identified health services as the top priority for local people in making the borough a good place to live. It also found that 25.3% of residents class themselves as having a ‘long standing illness or disability’.

Havering's Health & Wellbeing Priorities

The Health and Wellbeing Board has agreed the following eight priorities, which are focused around three overarching themes:

Themes	Priorities for Action
Prevention, keeping people healthy, early identification, early intervention and improving wellbeing	1. Early help for vulnerable people to live independently for longer
	2. Improved identification and support for people with dementia
	3. Earlier detection of cancer
	4. Tackling obesity
Better integrated support for people most at risk	5. Better integrated care for the 'frail elderly' population
	6. Better integrated care for vulnerable children
	7. Reducing avoidable hospital admissions
Quality of services and patient experience	8. Improving the quality of health services to ensure that patient experience and long-term health outcomes are the best they can be

A plan for action

The strategy contains actions for improving key outcomes under the eight priorities. Within each, a variety of interventions will be required that include individual, targeted and population-wide initiatives. Each intervention seeks to provide the most beneficial outcome for individuals, whilst operating within the constraints of health and social care budgets. Where appropriate, performance indicators are included to measure the individual and collective outcomes that the strategy aims to achieve.

Monitoring

Performance against the key actions and indicators set out in this strategy will be monitored and published every six months by the Health and Wellbeing Board, and the strategy will be critically reviewed and revised at the end of the two-year period.

THEME A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

Priority 1: Early help for vulnerable people to live independently for longer

Why is this important in Havering?

Older and vulnerable people, especially those with long-term conditions, are the most intensive and costly users of health and social care services and there is a clear need for their experience and outcomes achieved to be improved. They account for half of all GP appointments, two thirds of all outpatient appointments and nearly three quarters of all inpatient bed days. As our older population continues to grow, we are faced with increasing demands on these services. By focusing on prevention and early intervention, we hope to relieve some of this pressure on services and enable more people to live independently and safely in their own homes for longer and with a better quality of life.

One of the most effective prevention methods is to reduce the isolation and social exclusion experienced by many older and vulnerable people, which can contribute to mental health conditions such as depression. Tackling isolation will be a focus of our preventative work and more will be done within the community to better support these people.

Our continued focus on reablement and rehabilitation services after a period of illness and support for older and vulnerable people in managing long-term conditions will help to maintain independent living.

THEME A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

What is the current situation in Havering?

Our Joint Strategic Needs Assessment[1] tells us that;

- The retirement population (21%) is much larger than the London average
- 39,000 people are estimated to have one or more long-term health conditions
- 1,200 older people have particularly complex health and social care needs, with around 900 older people accounting for 38% of all emergency bed days
- A smaller proportion of people receive residential care, nursing care and community services than in England generally
- 16,300 older people are estimated to be living alone and this is predicted to rise to 17,948 by 2020
- Nearly 15,000 older residents are estimated to be unable to manage at least one self-care task on their own and more than 18,000 are estimated to be unable to manage at least one domestic task on their own (e.g. shopping, washing etc)
- 3,760 older people are estimated to have depression and this is predicted to rise to 4,146 by 2020 (although the level of depression across all age groups is lower than the London and national averages)
- More than 1,100 people are registered blind or partially sighted
- 5,276 older people are estimated to have diabetes
- There are around 140 excess winter deaths annually, most of whom are older and vulnerable people
- More than 1,900 people are admitted to hospital annually as a result of a fall
- 3,050 older people are estimated to have dementia and this is predicted to rise to 4,691 by 2030
- There are approximately 560 users of learning disability services, of which around 70 are aged 60 plus
- 45.2% (2,656) of adult social care clients receive some form of self-directed support, with 22% of these (578) using a personal budget or direct payment.

[1] JSNA 2011/12, Chapter 10: Supporting Vulnerable Adults and Older People

THEME A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

The number of people recorded as having a long-term health condition on Havering's GP registers is significantly below the number that might be expected given the results of national population surveys. This suggests that many people may be undiagnosed and, therefore, not benefiting from treatments that could slow progression and improve wellbeing.

A small number of patients have complex problems and therefore receive regular and multiple types of health and social care services. Despite this, these patients have persistent poor health and, in many cases, frequent hospital admissions. Our targeted response to reducing avoidable hospital admissions is set out under Priority 7.

A range of public and voluntary sector organisations provide services to support older and vulnerable people in Havering, including: integrated health and social care services; the information and advice centre 'Care Point' based in Romford; day centres; dementia support services; and support for those with specific long-term health conditions to remain independent for longer.

The Council is also encouraging the development of volunteer-led initiatives such as Help not Hospital (a volunteer scheme to offer to support to vulnerable people recently discharged from hospital), Cold Weather Befrienders, to help prevent the effects of fuel poverty and a range of befriending schemes to combat social isolation.

There are also a wealth of cultural activities and services provided through local libraries, parks and open spaces, museum, theatre and leisure centres aimed at improving the health and wellbeing of older people e.g. housebound library services, Knit and Natter and other social activity groups and physical activity programmes.

Where do we want to be in Havering?

By working collectively as a strategic partnership, the Health and Wellbeing Board will deliver improved outcomes for vulnerable people.

Our objectives are to:

- Help more vulnerable people, including those with long-term conditions and complex needs, maintain their independence in the community and reduce use of acute/complex services. We will do this by better co-ordinating health and social care provision in individuals' own homes; developing rehabilitation strategies; and better utilising assistive technologies through targeting people who will benefit from them most
- Tackle isolation and support vulnerable people to help maintain independent living. We will do this by commissioning innovative and targeted volunteer-led schemes that focus on befriending and supporting vulnerable people, including people recently discharged form hospital
- Improve choice and control over the health and social care people receive. We will do this by increasing personal health budgets to a greater proportion of eligible users
- Deliver more community based support, including volunteer-led services for people recently discharged from hospital and provision of reablement services to help them re-adjust to independent living. We will do this by working with the voluntary and community sector to support people in the community.

How will we deliver improved outcomes?

Below are the key actions that we will take to deliver improved outcomes for vulnerable people. Each action is owned by a lead partner(s) of the Health and Wellbeing Board. Our performance will be measured by the successful delivery of these actions and improvements against key indicators.

THEME A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

Objectives	Actions	Lead Partners
Help more vulnerable people, including those with long-term conditions and complex needs, maintain their independence in the community and reduce use of acute/complex services	Through joint working, provide co-ordinated health and social care support to individuals in their own homes, including identifying vulnerable patients living with long-term conditions through risk stratification and commissioning appropriate primary care and community responses	LBH (Adults and Health) & HCCG
	Develop and implement community rehabilitation strategies for COPD, diabetes and chronic heart failure	LBH (Adults and Health) & HCCG
	Utilise assistive technologies to support the needs of a targeted group of vulnerable people with long-term conditions and complex needs, including people with COPD, chronic heart failure, cardiovascular disease, diabetes and dementia	LBH (Adults and Health) & HCCG
	Commission a rapid response service that reduces demand on urgent care centres and reduces avoidable admissions	HCCG
	Redirect people attending the urgent care centre back to primary care	HCCG
	Increase identification of people with learning disabilities and improve access to primary care services for this population and their carers	LBH (Adults and Health) & HCCG
	Enhance primary care support to nursing and residential homes to ensure proactive early intervention, thus increasing the quality of care and reducing avoidable hospital admissions	HCCG
	Ensure that contracted services have systems in place for safeguarding adults that are consistent with local and national guidance	LBH (Adults and Health)
Tackle isolation and support vulnerable people to help maintain independent living	Commission innovative and targeted volunteer-led schemes that focus on befriending and supporting vulnerable people, including people recently discharged from hospital i.e. Activate Havering and Help Not Hospital	LBH (Adults and Health) & (Culture and Leisure)
	Better market social and activity groups for older people provided by the libraries and voluntary and community sector and continue to engage older people in our parks and open spaces, museum, theatre and leisure centres	LBH (Culture and Leisure)
Improve choice and control over the health and social care people receive	Increase personal budgets to a greater proportion of eligible social care users	LBH (Adults and Health)
	Increase choice of venues for people to access outpatient services enabling care to be delivered closer to home	HCCG
	Implement integrated case management to enable people to proactively manage their long-term condition	HCCG
	Implement the Gold Standard Framework across all practices enabling people to die in their preferred choice of place	HCCG

THEME A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

Objectives	Actions	Lead Partners
Deliver more community based support, including volunteer-led services for people recently discharged from hospital and provision of reablement services to help them re-adjust to independent living	Work with the voluntary and community sector to support vulnerable people in the community, including provision of respite care	LBH (Adults and Health) & (Culture and Leisure)

Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Proportion of people who having undergone reablement and returned to Adult Social Care 91 days after completing reablement and require an ongoing service	H: 7.8% L: local indicator, therefore no benchmark E: local indicator, therefore no benchmark (2011/12)	7% (2012/13)	LBH (Adults and Health)
Proportion of adults with learning disabilities who live in their own home or with their family	H: 51.4% L: 65.1% E: 70.4% (2011/12)	52% (2012/13)	LBH (Adults and Health)
People with learning disabilities in settled accommodation	H: 43.9% E: 59.1% (2011 DIH)	N/A	LBH (Adults and Health)
Proportion of adults in contact with secondary mental health services living independently with or without support	H: 89.4% L: 73.8% E: 59.6% (2011/12 NASCIS)	88% (2012/13)	LBH (Adults and Health)
Proportion of people who use services who have control over their daily life	H: 68.9% L: 69.9% E: 75.3% (2011/12 NASCIS)	To achieve an improvement relative to the London average	LBH (Adults and Health)
Employment for those with a long-term health condition including those with a learning disability/ difficulty or mental illness	H: 6.1% (adults with learning disabilities in employment); 8.7% (adults receiving mental health services in employment) (2011/12) E: 6.6% (adults with learning disabilities in employment); 9.5% (adults receiving mental health services in employment) (2011 DIH)	8% (adults with learning disabilities in employment); 11% (adults receiving mental health services in employment) (2012/13)	LBH (Adults and Health)
Proportion of people using social care who receive self-directed support and those receiving direct payments	H: 45.2% L: 47.0% E: 43.0% (2011/12 NASCIS)	60% (2012/13)	LBH (Adults and Health)
Direct payments as a proportion of self-directed support	H: 9.8% L: 17.5% E: 13.8% (2011/12)	15% (2012/13)	LBH (Adults and Health)
Proportion of people feeling supported to manage their condition	H: 56% L: 57% E: 64% (2011 GP Patient Survey)	No target set yet	HCCG

THEME A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Access to non-cancer screening programmes – diabetic retinopathy	H: 85.58% L: E: 90.92% (2009/10 NHS IC)	No target identified	PHE
Excess winter deaths (compared to summer)	H: 14.4% (06-08) 18.1% (06-09) L: 15.3% (06-08) E: 15.6% (06-08) 20% (06-09) (2006-08 ONS; 2006-09 Excess Winter Deaths Atlas)	Achieve a reduction year on year	LBH (Adults and Health) & HCCG
Proportion of people who use services and carers who find it easy to find information about support	H: 50.90% L: N/A E: N/A (2010/11)	Achieve an increase year on year	LBH (Adults and Health)
Proportion of people who use care services who feel safe	H: 56.20% L: N/A E: N/A (2010/11)	Achieve an increase year on year	LBH (Adults and Health)
Seasonal influenza vaccine uptake in those aged 65 years and over	H: 72.8% L: 72.2% E: 74% (2011/12 DH)	75% (2012/13)	LBH (Public Health)
Number of new cases of psychosis served by Early Intervention teams	H: 16	29 (2012/13)	HCCG
Crisis Resolution Home Treatment	H: 152	384 (2012/13)	HCCG
Improved access to Psychological Services	H: 1.9%	1.2%	HCCG

THEME A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

Priority 2: Improved identification and support for people with dementia

Why is this important in Havering?

Dementia is a clinical syndrome characterised by a widespread loss of cognitive function, including memory loss, language impairment, disorientation, change in personality, self neglect and behaviour that is out of character. The most common types of dementia are Alzheimer's disease and Vascular Dementia, which affect about 62% and 17% of sufferers. It is an extremely distressing illness that costs the national economy around £17 billion a year.

We know that:

- Dementia is more common in women than in men, especially in the older age groups
- On average, people with dementia live for seven or eight years after the illness has been first diagnosed, although there are wide individual variations
- Many of the carers of older people with dementia are themselves elderly. Up to 60% are partners/spouses
- Carers of people with dementia generally experience greater stress than carers of people with other kinds of needs, with a large proportion experiencing some kind of mental health problem themselves.

Supporting people with dementia is a high priority both nationally and locally. The National Dementia Strategy[2] sets out the strategic framework for local services to operate in. It includes clear objectives for delivering improvements in the quality of services and promoting a wider understanding of the causes and effects of dementia. Dementia is a particularly pertinent issue for Havering due to our large, and growing, older population.

[2] Living Well with Dementia, 2009

THEME A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

What is the current situation in Havering?

Our Joint Strategic Needs Assessment[3] tells us that:

- In 2007, 2,440 people were estimated to have dementia in Havering and this is predicted to rise by 23.5% to 3,014 people by 2021 (compared to an overall London projected increase of 12.3%)
- A more recent estimate, however, suggests that 3,101 people have dementia in Havering and this is predicted to rise by more than 50% in the next 20 years as the population continues to age
- The majority of cases are currently undiagnosed and thus unmanaged
- In 2010/11, dementia-related costs to Havering (health and social care) were in excess of £2 million. Another £2.9 million was spent on dementia-related care home placements. Additional activity and costs to universal services incurred in caring for people with dementia is not captured and hence is difficult to quantify
- As well as the costs to health and social care, the bulk of care for dementia sufferers, particularly for the undiagnosed, is provided by family and friends. In 2001, more than 1 in 10 Havering residents identified themselves as a carer; the highest proportion of any borough in London.

Where do we want to be in Havering?

Our objectives are to:

- De-stigmatise dementia and ensure sufferers and their carers receive the best possible support in managing their condition. We will do this by establishing a Dementia Partnership Board to oversee the implementation of the Havering Dementia Strategy, in line with the national strategic framework
- Ensure high quality and accessible dementia information. We will achieve this by improving our data collection on the prevalence of dementia in Havering and improving data sharing between organisations. This will ensure seamless, high quality care as people pass through the dementia care pathway
- Clinically train professionals to recognise the symptoms of dementia leading to earlier diagnosis and improved outcomes for sufferers and their carers. Patients will only go into hospital if this will secure the best clinical outcome
- Deliver more universal services and better quality of care for people with dementia. As part of this, we will investigate the potential to develop a dementia centre of excellence community facility that works effectively with outreach and local services.

How will we deliver improved outcomes?

Below are the key actions that we will take to deliver improved outcomes for people with dementia. Each action is owned by a lead partner(s) of the Health and Wellbeing Board. Our performance will be measured by the successful delivery of these actions and improvements against key indicators.

[3] JSNA 2011/12, Chapter 4: Dementia

THEME A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

Objectives	Actions	Lead Partners
De-stigmatise dementia and ensure sufferers and their carers receive the best possible support in managing their condition	Establish a multi-agency Dementia Partnership Board to implement a Havering Dementia Strategy, in line with the national strategy	LBH (Adults and Health) & HCCG
	Mainstream the application of assistive technologies to support people with dementia as part of a programme of purposeful walking	LBH (Adults and Health)
Ensure high quality and accessible dementia information by improving data collection on the prevalence of dementia and data sharing between organisations	Establish a system to monitor GP recorded prevalence and practice (any reporting unusually low prevalence will be encouraged to participate in training to aid diagnosis)	HCCG
	Share practice data to allow the CCG to monitor and take accountability for quality assurance, enabling prioritisation of dementia strategy work targeted to practices	HCCG
	Link care for people with dementia to deliver seamless care across all agencies	LBH (Adults and Health) & HCCG
Clinically train professionals to recognise the symptoms of dementia leading to earlier diagnosis and improved outcomes for sufferers and their carers	Develop a new training strategy/pathway for professionals working with and supporting people with dementia	LBH (Adults and Health) & HCCG
	Support the National Dementia and Antipsychotic Prescribing Audit and Reduction Exercise	HCCG
	Review assessed and diagnosed cases, to assess success of early diagnosis and performance against QOF/DES targets.	HCCG
	Develop a training package for staff working with people with dementia, to include monitoring to record training sessions/people attending/feedback	HCCG
	Embed workforce development plans/appraisals programme into practices	HCCG
	Make available mentoring support system to key professionals, including clinical supervision	HCCG
Deliver more universal services and better quality of care for people with dementia	Investigate the potential for a dementia centre of excellence community facility and progress plans for this accordingly	LBH (Adults and Health)
	Commission a rapid response service for people with dementia and their carers to provide support and medical assistance during times of crisis or escalation of symptoms/deterioration	HCCG
	Incorporate end of life planning into services for people with dementia, to enable them to have a dignified and painless death, and adequate provision of support for their families	HCCG
	Develop education sessions for families about how to best support someone with dementia	LBH (Adults and Health) & HCCG

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Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Rated 'green' for each of the five aims of the National Dementia Strategy	'Green' for four of the five projects	'Green' for each of the five projects comprising Havering's response to the National Dementia Strategy	LBH (Adults and Health)
Trusts to demonstrate that for 90% of discharges of patients with dementia the information has been provided to the patient's GP and family/ carer where appropriate within 2 weeks	No data	90%	HCCG
All patients aged 75 and over who have been screened following admission to hospital, using the dementia screening questionnaire	H: 47%	25%	HCCG
All patients aged 75 and over, who have been screened as at risk of dementia, who have had a dementia risk assessment within 72 hours of admission to hospital, using the hospital dementia risk assessment tool	H: 97%	90%	HCCG
All patients aged 75 and over, identified as at risk of having dementia who are referred for specialist diagnosis	H: 99%	90%	HCCG
Dementia and its impacts (all people with dementia and percentage of people expected to have dementia in 2021)	H: 1.08% (2007); 1.29% (2021) L: 0.77% (2007); 0.78% (2021) E: 1.14% (2007); 1.43% (2021) (2007-21 DIH)	To achieve an improvement relative to the national average	LBH (Adults and Health) & HCCG
Ratio of diagnosed to expected cases of dementia	3:1 Diagnosed 1,248 (2011 QOF) Expected 3,273 (2012 POPPI)	Improve diagnosis ratio	LBH (Adults and Health) & HCCG
Minimising mental health delayed transfers of care	July 2012 data shows Trust meeting target	<7.5%	HCCG

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Priority 3: Earlier detection of cancer

Why is this important in Havering?

Cancer is a common disease. About 1,200 people in Havering (one in every 200) are diagnosed with some form of cancer each year and more than 600 a year die of the disease.

National research shows that more than 40% of all cancer cases are attributable to avoidable risk factors such as smoking, alcohol, poor diet and lack of exercise. Most people could significantly reduce their risk of developing cancer by living more healthily e.g. by making one or more of the following changes – stopping smoking, reducing their consumption of alcohol, improving their diet and taking more exercise.

The immediate costs of cancer treatment, ignoring wider societal costs, are very large, accounting for about 6% of the total NHS expenditure in Havering.

What is the current situation in Havering?

Our Joint Strategic Needs Assessment[4] and Public Health Annual Report 2010 tell us that:

- The age standardised incidence rate of cancer in Havering is lower (better) than the national average and mortality rates are similar to the England average
- Nonetheless, large numbers of residents are diagnosed with (1,200) and die (600) from cancer each year; due in part to Havering's relatively old population. Numbers will increase still further as the population continues to age
- Breast, bowel and lung cancer are the most common cancers in women, with prostate, lung and bowel cancer being the most common in men
- There are health inequalities within Havering with regard to cancer related health outcomes e.g. death rates from cancer and the prevalence of lifestyle related risk factors for cancer are higher in more disadvantaged communities

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- The majority of residents are aware that smoking greatly increases the risk of developing cancer – but 1 in 5 continue to smoke
- Public awareness of other risk factors for cancer, including diet and obesity, is much lower
- In addition, relatively few residents are aware of the early signs and symptoms of cancer or that early diagnosis greatly increases the likelihood of survival for many cancers
- Rates of survival one year after diagnosis have stayed more or less unchanged in Havering over recent years, whereas they have increased across England as a whole. As a result, survival rates in Havering are now significantly below (64.2%) the national average (66.5%).

Poor short term survival rates are often attributed to late diagnosis. Late diagnosis can result from one or more of:

- Low participation in population screening programmes
- Late presentation by patients with the early signs of cancer
- Failure by GPs to identify patients with symptoms suggestive of cancer
- Delays in the investigation of patients referred with suspected cancer.

We know that, in Havering:

Although uptake of cancer screening programmes could be improved, particularly for the newly introduced bowel cancer programme, levels of participation are generally similar to those achieved nationally and above national minimum targets.

- On average, GP referral practice in Havering is similar to, if not better than, the national average
- Delays in the investigation of patients with suspected cancer are uncommon
- Therefore, whereas we must seek to improve all aspects of the cancer care pathway, work to increase public awareness of the early signs and symptoms of the disease is a particular priority locally.

Where do we want to be in Havering?

By working collectively as a strategic partnership, the Health and Wellbeing Board will deliver improved outcomes in cancer.

Our objectives are to:

- Maximise participation in the three cancer screening programmes, particularly for bowel cancer, which is a relatively recent development
- Raise public awareness of the signs and symptoms of cancer. To this end, we will evaluate the recently commissioned local awareness raising campaign and continue to support relevant national and London wide campaigns
- Further improve the identification and investigation of patients with signs and symptoms suggestive of cancer in primary care settings
- Improve quality of cancer care services and patients' experience of care, including maintaining excellent performance on waiting times between referral of patients with suspected cancer and first consultant contact (two week waits) and 31/62 day targets for receiving treatment quickly after diagnosis; and increasing access to optimal treatment, particularly radiotherapy and surgery.

[4]JSNA 2011/12, Chapter 9: Cancer

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How will we deliver improved outcomes?

Below are the key actions that we will take to deliver improved outcomes for earlier detection of cancer. Each action is owned by a lead partner(s) of the Health and Wellbeing Board. Our performance will be measured by the successful delivery of these actions and improvements against key indicators.

Objectives	Actions	Lead Partners
Maximise participation in the three cancer screening programmes	Promote breast screening for women aged 50-70 and, if possible, extend to women aged 47-73, ahead of the 2016 national deadline	PHE
	Promote cervical screening to younger women who are currently least likely to participate	PHE, NHSCB & HCCG
	Promote uptake of bowel cancer screening to achieve levels significantly above the national minimum target of 60%	PHE
	Extend bowel cancer screening from those aged 60-70 to those aged 60-75 ahead of the national deadline	PHE
	Through primary care improvement, make screening for cancer a priority	HCCG
Raise public awareness of the signs and symptoms of cancer	Evaluate effectiveness of, with a view to roll out to additional wards, the community engagement campaigns to raise awareness of cancer in the four wards with the highest mortality in Havering (delivered by Age Concern)	LBH (Public Health)
	Run local campaigns to complement and maximise the impact of national and regional awareness campaigns. Undertake evaluation to ensure cost effective investment	LBH (Public Health), PHE & LHIB
	Raise awareness of prostate cancer, its signs and symptoms, and link to the national awareness programme “Prostate cancer risk management”. Undertake evaluation to ensure cost effective investment	LBH (Public Health) & HCCG
Further improve the identification and investigation of patients with signs and symptoms suggestive of cancer in primary care settings	Provide regular educational updates for GPs and other health professionals relevant to the early detection of cancer	LBH (Public Health) & HCCG
	Regularly provide GPs with comparative data regarding their cancer referral practice	LBH (Public Health) & HCCG
	Provide GPs with direct access to four diagnostic tests recommended by the Department of Health	HCCG
Improve quality of cancer care services and patients’ experience of care	Use results of national cancer audits and national patient cancer survey to ensure that BHR and London Cancer (the integrated cancer system for North and North East London) improve the quality and patient’s experience of cancer care	HCCG

Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Cancer screening coverage – breast (coverage of women aged 53-64, less than 3 years since last test)	H: 78.7% L: 69.3% E: 77.4% (2011 NHS IC)	Maintain coverage above national minimum target (70%)	PHE

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Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Cancer screening coverage – cervical (aged 25-64, less than 5 years since adequate test)	H: 80.2% L: 74.0% E: 78.6% (2010/11)	Maintain coverage above national minimum target (80%)	PHE, NHSCB & HCCG
Cancer screening coverage – bowel (aged 60-69, within 6 months of invitation)	H: 54.3% E: 57.5% (2010/11 NCIN)	Surpass national minimum target for coverage (60%)	PHE
Cancer diagnosed at stage 1 and 2	New indicator – data not available	No target identified	LBH (Public Health), PHE, HCCG & LHIB
All cancer two-week wait (patients urgently referred for suspected cancer by their GP seen by a specialist within 14 days of referral)	H: 93%	93%	HCCG
31 day (diagnosis to first treatment) wait for all cancers (patients receiving their first definitive treatment for cancer and began that treatment within 31 days)	H: 96%	96%	HCCG
62 day (urgent GP referral to first treatment) wait: all cancers (patients receiving first treatment for cancer following an urgent GP referral for suspected cancer and began treatment within 62 days of referral)	Target not met (as at June 2012)	85%	HCCG
Percentage cancer survival at 1 year	H: 68.5% L: 75% E: 75% (2007-09)	To improve survival within Havering faster than that achieved nationally so that survival rates within Havering are similar to the average for England within 3 years	LBH (Public Health), PHE, HCCG & LHIB
Under 75 mortality rate from all cancers	H: 111.4 L: 102.9 E: 108.1 (2010/11 NHS IC)	Maintain current performance relative to England average	LBH (Public Health), PHE, HCCG & NHSCB

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Priority 4: Tackling obesity

Why is this important in Havering?

Obesity is defined as an excess of body fat, to the point where it is often detrimental to a person's health. Being overweight or obese increases a person's risk of developing diabetes, cancer and cardiovascular disease. Being obese can restrict mobility and contribute to poorer mental health, which may limit a person's participation in their community and reduce their quality of life. Obesity is a complex issue that is affected by a range of behavioural, psychological, social, cultural and environmental factors, which can make it difficult for people to maintain a healthy weight.

Obesity is measured using Body Mass Index (BMI) which is a ratio of a person's weight to their height, and adults with a BMI of 30kg/m2 are considered obese. Some people or sections of the community are at greater risk of becoming obese, such as children of obese parents, babies whose mother was obese during pregnancy and babies who are bottle-fed, people with certain learning disabilities or physical disabilities that limit activity, older people, disadvantaged groups and some ethnic groups.

The National Obesity Strategy[5] sets out a new approach to public health that will enable effective action on obesity. It encourages people to reduce their consumption of excess calories, make healthier lifestyle choices and calls on industry, as well as more traditional partners, to take responsibility for tackling obesity.

[5]Healthy Lives, Healthy People: A call to action on obesity in England, 2011

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What is the current situation in Havering?

Our Joint Strategic Needs Assessment[6] tells us that:

- An estimated 27.3% of adults in Havering are obese. This is higher than the England average of 24.2% and the London average of 20.7%
- Obesity rates are particularly high in Harold Hill and South Hornchurch
- 1 in 5 children in Havering are obese by the age of 11, which is similar to the national average
- 12% are obese by the age of 5, which is significantly higher than the national average of 10%
- High rates of breastfeeding are associated with lower levels of obesity and rates of breastfeeding in Havering are very low.

Services for preventing and treating obesity in Havering include universal services such as leisure and recreational facilities; targeted services such as the national child measurement programme and breastfeeding support; and specialist services such as obesity medication, weight-loss programmes and bariatric surgery.

Where do we want to be in Havering?

By working collectively as a strategic partnership, we will deliver improved outcomes for tackling obesity.

Our objectives are to:

- Intervene early to slow down the rise in obesity levels in adults and children. We will do this by commissioning targeted obesity prevention, weight management programmes and breastfeeding support services
- Promote healthier lifestyles and increase levels of physical activity to maintain healthy weight. We will do this by continuing to deliver and facilitate, and where possible, increase, the amount of organised sport and physical activity in local parks and open spaces
- Raise awareness of the health risks associated with being overweight and obese. We will do this through targeted campaign work and making the most of contact points such as the National Child Measurement Programme and NHS Health Checks.

How will we deliver improved outcomes?

Below are the key actions that we will take to deliver improved outcomes for tackling obesity. Each action is owned by a lead partner(s) of the Health and Wellbeing Board. Our performance will be measured by the successful delivery of these actions and improvements against key indicators.

Objectives	Actions	Lead Partners
Intervene early to slow down the rise in obesity levels in adults and children	Continue to offer a high quality school food service that meets nutritional standards and work to increase the uptake of free school meals	LBH
	Commission targeted community obesity prevention/weight management services for adults and children. Undertake evaluation to ensure cost effective investment	LBH (Culture and Leisure), (Public Health) & HCCG
	Encourage women who are pregnant or trying for a baby to achieve a healthy weight before and after the birth by offering weight management support as part of ante and post-natal care	LBH (Public Health)

[6]JSNA 2011/12, Chapter 3: Obesity

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Objectives	Actions	Lead Partners
Promote healthier lifestyles and increase levels of physical activity to maintain healthy weight	Continue to deliver and facilitate, and where possible, increase the amount of organised sport and physical activity in local parks and open spaces	LBH (Culture and Leisure)
	Continue to deliver the leisure centre investment programme and support the development of a new leisure facility in Romford to increase physical activity	LBH (Culture and Leisure)
Raise awareness of health risks associated with being overweight and obese	Continue to deliver campaigns on healthy eating, physical activity and breastfeeding to raise awareness of the health risks associated with obesity. Undertake evaluation to ensure cost effective investment	LBH (Culture and Leisure) & (Public Health)
	Health professionals to raise the issue of obesity during routine and targeted appointments, including NHS health checks, and refer individuals to support where appropriate	LBH (Public Health)
	Continue to commission the Child Measurement Programme	LBH (Public Health)

Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Excess weight in 4-5 and 10-11 year olds (prevalence of overweight children in reception and in Year 6)	H: 13.5% (4-5); 16% (10-11) L: 12.4% (4-5); 15.1% (10-11) E: 13.2% (4-5); 14.4% (10-11) (2011 DH)	To reduce prevalence of obesity at a faster rate than achieved nationally so that the prevalence of obesity amongst reception age children in Havering is similar to or better than the national average within 5 years	LBH (Public Health), HCCG, NHSCB & PHE
Excess weight in 4-5 and 10-11 year olds (prevalence of obese children in reception and in Year 6)	H: 10.8% (4-5); 19.3% (10-11) L: 11.1% (4-5); 21.9% (10-11) E: 9.4% (4-5); 19% (10-11) (2011 DH)	To maintain performance relative to national average	LBH (Public Health)
Mothers initiating breastfeeding (percentage of maternities where status of breastfeeding initiation is known)	H: 66.7% L: 86.3% E: 73.6% (2010 DH)	No target identified	LBH (Public Health) & HCCG
Breastfeeding (prevalence at 6-8 weeks after birth)	H: 39.9% L: 66.5% E: 44.4% (Qtr1 2010 DH)	To increase initiation and prevalence faster than achieved across England so that both are similar to or better than the national average within 5 years	LBH (Public Health)

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Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Proportion of physically active and inactive adults (adults participating in recommended levels of physical activity)	H: 9.87% L: 9.99% E: 11.45% (2010 DH)	To increase rates of activity faster than achieved nationally so that rates are similar to or better than the average for England within 5 years	LBH (Public Health)
Take up of the NHS health checks programme by those eligible	H: 9.4% eligible population (8,066 checks) (2010/11)	To offer a check to 20% of eligible patients each year/100% over 5 year cycle	LBH (Public Health)

THEME B: Better integrated support for people most at risk

Priority 5: Better integrated care for the 'frail elderly'

Why is this important in Havering?

Future demographic change will significantly increase the proportion of older people in the population. As a result, the number of 'frail elderly' residents will also increase. These are people with the most complex needs that currently provide the greatest challenge to health and social care providers. Given Havering's demographics, this priority is extremely important in ensuring Havering's 'frail elderly' people experience the best possible quality of care in later life.

A large amount of resources are allocated to managing the care of this very vulnerable group. Significant reasons for this are delays in hospital discharges - there is an overreliance on bed-based rather than community-based solutions - and a higher incidence of repeat hospital admissions than any other population group.

Outcomes for the 'frail elderly' people are better where independence is promoted and adequate support is given to help them do things for themselves, rather than the worse outcomes that come from lack of independence and moving into residential care homes. Priority 7 of this strategy is dedicated to the work that will take place to reduce avoidable hospital admissions.

What is the current situation in Havering?

Our Joint Strategic Needs Assessment[7] tells us that:

- Nearly 15,000 older people are estimated to be unable to manage at least one self care task on their own, and more than 18,000 are estimated to be unable to manage at least one domestic task on their own (e.g. shopping, washing etc)
- 3,760 older people are estimated to have depression, which is predicted to rise to 4,146 by 2020

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- 16,300 older people are estimated to be living alone, which is predicted to rise to 17,948 by 2020
- More than 1,100 people are registered as being blind or partially sighted
- There are around 140 excess winter deaths annually among Havering residents, many of whom are vulnerable older people
- More than 1,900 people are admitted to hospital annually as a result of a fall
- St Francis' Hospice end of life care services were used nearly 19,000 times by Havering residents in 2010/11 and demand for services is increasing.

Innovative collaborative work is taking place between the Council, Havering CCG and the Integrated Care Coalition, working on cross-borough strategic solutions to achieving integrated care to make wide ranging health and social care improvements.

Where do we want to be in Havering?

By working collectively as a strategic partnership locally and more broadly across the local health and social care economies in Barking & Dagenham and Redbridge, we will deliver improved outcomes for the 'frail elderly'.

Our objectives are to:

- Ensure with partners, seamless, integrated and efficient care pathways for 'frail elderly' people with care needs. We will do this by bringing together all existing provision based around prevention, reducing hospital admission, combating social exclusion and protecting those most at risk. The Integrated Care Pilots programme and evidence reviews undertaken by the King's Fund have demonstrated that integration can result in significant benefits for individuals where this is targeted at those whose care is currently poorly co-ordinated
- Improve pathways into and through community-based health services and general practice by working closely with the hospital and GPs
- Reduce the incidence and impact of falls that often lead to the hospitalisation of older people and improve the efficiency of care following injury as a result of a fall, including hip fracture
- Enhance independence and capability of individuals to manage their conditions at home
- Provide support to people within the community who have recently been discharged from hospital or who are at risk of admission/readmission
- Improve care in nursing and residential homes, including better management of demand to reduce avoidable hospital admissions and monitoring of safeguarding controls
- Improve support to people not currently engaged with social care such as self funders and those with lower levels of need to ensure that greater opportunities to benefit from prevention, improved health and wellbeing and support are provided
- Ensure informed choice on end of life care through robust information and guidance for patients and carers. We will do this by working collectively with colleagues to develop an end of life care pathway and implement the Gold Standard Framework of care within primary care.

The Integrated Care Commissioning Strategy is being developed across the Barking & Dagenham, Havering and Redbridge Integrated Care Coalition, which will further develop and facilitate delivery of the above outcomes.

[7]JSNA 2011/12, Chapter 10: Supporting Vulnerable Adults and Older People and Chapter 11: Keeping People Out of Hospital

THEME B: Better integrated support for people most at risk

How will we deliver improved outcomes?

Below are the key actions that we will take to deliver improved outcomes for better integrating care for the 'frail elderly'. Each action is owned by a lead partner(s) of the Health and Wellbeing Board. Our performance will be measured by the successful delivery of these actions and improvements against key indicators.

Objectives	Actions	Lead Partners
Ensure seamless, integrated and efficient care pathways for 'frail elderly' people with care needs	Develop and deliver an Integrated Care Strategy that will bring together all existing provision based around prevention and protecting those most at risk	LBH (Adults and Health) & HCCG
	Develop a single set of performance and outcome metrics for integrated care against which performance can be measured and support further steps and recommendations in relation to the Integrated Care Strategy	LBH (Adults and Health) & HCCG
	Develop a new model for the Social Work team and seek opportunities for closer integration and support improved pathway access	LBH (Adults and Health)
	Develop Community Treatment Teams model to provide alternative to emergency admission/ hospital care for older people with ambulatory care sensitive conditions.	LBH (Adults and Health)
Improve pathways into and through community-based health services and general practice by working closely with the hospital and GPs	Implement plan to improve pathway after a stay in hospital to include reduction in transfers between like for like units, improved length of stay and better discharge planning	LBH (Adults and Health)
Reduce the incidence and impact of falls that often lead to the hospitalisation of older people and improve the efficiency of care following injury as a result of a fall, including hip fracture	Support the implementation of the Falls Prevention Strategy across Adult Social Care working with Health and Housing	LBH (Adults and Health
	Undertake a falls audit within non-acute health services to inform Integrated Care Coalition thinking on further development of the Falls Strategy	LBH (Adults and Health
	Commission a Falls Community Exercise programme and an outreach service into care homes and telecare clients	LBH (Adults and Health)
	Commission a falls prevention and management training programme for staff in care homes and assistive technologies staff	LBH (Adults and Health)
	Hold BHRUT to account for achievement of 'blue book' standards	HCCG
Enhance independence and capability of individuals to manage their conditions at home	Develop improved pathways to ensure greater opportunities and impacts for Havering residents to access support	HCCG & Out of Hours Services
	Increase the take up of Telecare and Telehealth services as part of the Council's reablement offer	LBH (Adults and Health)
	Develop a Self-Funders Strategy to improve the outcomes of people not eligible for free state support	LBH (Adults and Health)
Provide support to people within the community who have recently been discharged from hospital or who are at risk of admission/readmission	Provide low-level intervention to support people following hospital discharge or to prevent them being admitted such as Help Not Hospital volunteer led services	LBH (Adults and Health)

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Objectives	Actions	Lead Partners
Improve care in nursing and residential homes, including better management of demand to reduce avoidable hospital admissions and monitoring of safeguarding controls	Commission an enhanced and equitable primary care led service for care homes, leading to improved management of long-term conditions and reduce unnecessary admissions to acute hospitals and the inappropriate use of out of hours services	HCCG
	Improve the identification and treatment of malnutrition and prescribing of oral nutritional supplements in care homes	HCCG
	Improve the prescribing of wound care products. Implement a 'limited wound care formulary' and 'buffer stock" first aid list for emergency use in nursing homes.	HCCG
Improve support to people not currently engaged with social care such as self funders and those with lower levels of need to ensure that greater opportunities to benefit from prevention, improved health and wellbeing and support are provided	Provide support to nursing and residential homes in order to maintain residents within the home environment	LBH (Adults and Health)
Ensure informed choice on end of life care through robust information and guidance for patients and carers	Develop an end of life care pathway	LBH (Adults and Health)
	Implement the Gold Standard Framework of care within primary care based service and care homes	HCCG

Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Life expectancy at age 65 years	H: 18.2 (male); 21.4 (female) L: 18.7 (male); 21.5 (female) E: 18.2 (male); 20.8 (female) (2008-10 ONS)	To improve life expectancy at age 65 at the same or faster rate than that achieved nationally	LBH (Public Health), HCCG, NHSCB & PHE
Emergency hospital admissions for hip fractures in over 65s (directly age standardised rate)	H: 424 L: 423 E: 452 (2010/11 APHO)	To reduce rate of fracture in line with national average	LBH (Adults and Health)
Permanent admissions to residential and nursing care homes (aged 65 plus) per 100,000 population	H: 551.8 L: 531.2 E: 713.8 (2011/12 NASCIS)	470 (2012/13)	LBH (Adults and Health)
Integrated Care Coalition indicators	In development	No target identified	HCCG & LBH (Adults and Health)

THEME B: Better integrated support for people most at risk

Priority 6: Better integrated care for vulnerable children

Why is this important in Havering?

Healthy, happy and educated children are more likely to become healthy happy and productive adult members of society. Setbacks experienced in childhood as a result of troubled family backgrounds can result in long-lasting harm that persists throughout life and has a spiral effect leading to significantly reduced outcomes for those young people. A significant and growing body of evidence shows that the care and support a child receives in the early years of their life, including pre-birth, is critical to their development and their behaviour, mental and physical wellbeing in the long-term. For these reasons, targeting children most 'at risk', as part of our 'early help' offer, will be our focus going forward.

Vulnerable children, such as those in care or with learning disabilities, face particular, more complex, issues and our priority is to support them to realise the same positive and sustainable outcomes as rest of the population. Young women who become pregnant in their teenage years are also vulnerable and at risk of significantly poorer outcomes.

Research has found that children and young people in care experience significantly worse mental health than their peers. In Havering, there were 183 looked after children in 2011/12. These children are extremely vulnerable. They are less likely to achieve qualifications or have employment prospects; are more at risk of exploitation; are more likely to get involved in criminal activity; and are more susceptible to drug and alcohol abuse.

THEME B: Better integrated support for people most at risk

What is the current situation in Havering?

Our Joint Strategic Needs Assessment[8] tells us that:

- Of 30,000 families in Havering, around 400 are categorised as having 'multiple complex needs' and over 200 are 'barely coping'. Of these, a significant proportion will reach a level of need where they require expensive specialist or statutory services. The Council's new Troubled Families initiative is working to improve the outcomes of these families through better integrated early support
- 35% of the budget of Children and Young People's Services is spent on specialist services; a disproportionate amount considering the number of individuals in receipt of these services. Preventing need for these services will reduce the level of spend, thus enabling a more equitable balance of expenditure on the under 18 population
- There were 183 looked after children in 2011/12 (equating to 36 in 100,000 population aged under 18). Educational attainment of these children and young people is significantly below the average for their peers
- Although the under 18 conception rate at 29.3 (per 1,000 girls) is lower than the London and national rates, the needs of this vulnerable group of teenagers remain a priority
- 20% of children in Havering live in poverty, and two small areas of Havering (in Gooshays and South Hornchurch) fall into the 10% most deprived areas in England
- The number of children with learning difficulties and disabilities is projected to increase 7.5% by 2017, mainly among children aged 5-11
- The most common categories of learning difficulties and disabilities are moderate learning disability (30%); behaviour, emotional and social difficulties (19%); and speech, language and communication needs (17%).

Specialist services available to vulnerable children and young people in Havering include child protection and safeguarding; youth offending; child and community psychology; Foundation Years and Independent Advice Service (FYIAS); short breaks and activities for disabled children and young people; Havering Community Alcohol Team (HCAT); Havering Children's Rights and Advocacy Service; learning difficulties and disabilities and physical and sensory disabilities teams; family and carer support; domestic violence forum; Multi-Agency Safeguarding Hub (MASH); Havering Child and Adolescent Mental Health Service (CAMHS); and several children's centres catering to different needs, providing access to our 'early help offer'.

Where do we want to be in Havering?

Effective preventative and 'early help' services, delivered at the earliest opportunity, such as our Troubled Families initiative, aim to avoid escalation of common problems experienced by families with multiple problems, which may include domestic violence, alcohol and/or substance misuse and mental health issues. Targeting our efforts on children at risk will be the most effective way to reduce demand for expensive specialist and intensive services, prevent negative outcomes and save money in future years. By working collectively as a strategic partnership, we will better integrate care for vulnerable children.

Our objectives are to:

- Provide intensive, bespoke, support to families with multiple complex needs to address their problems earlier. We will do this by identifying families who are most at risk of failing and working collectively to support them
- Improve the stability of care placements and reduce placement breakdown. We will do this by increasing the number of foster families and by placing children more quickly with adoptive families; better engaging with children and young people; and improving access to CAMHS

[8]JSNA 2011/2, Chapter 12: Supporting Vulnerable Children

THEME B: Better integrated support for people most at risk

- Improve health outcomes for children and young people, particularly those in care
- Improve the transition from children's to adults care packages for young people with disabilities by working with young people earlier to better plan this transition
- Reduce teenage conceptions and improve sexual health through the delivery of targeted campaigns that raise awareness of health risks
- Commission universal and targeted access to health visitors and school nurses to deliver the Healthy Child Programme
- Reduce the numbers of children experiencing poverty in Havering by working collectively to deliver actions in the Child Poverty Strategy
- Provide access to high-quality therapies for vulnerable children and young people. We will improve access to Child and Adolescent Mental Health Services (CAMHS), speech and language therapies and occupational therapies.

Over and above these priorities, we will continue to put the safety of children and young people first and ensure that safeguarding arrangements in Havering are second to none.

How will we deliver improved outcomes?

Below are the key actions that we will take to deliver 'early help' and improved outcomes for better integrating care for vulnerable children. Each action is owned by a lead partner(s) of the Health and Wellbeing Board. Our performance will be measured by the successful delivery of these actions and improvements against key indicators.

Objectives	Actions	Lead Partners
Provide intensive, bespoke, support to families with multiple complex needs to address their problems earlier	Identify with all partners those families who are most at risk of failing without the right sort of help	LBH (Children's Services) & HCCG
	Deliver better joined up intervention for complex families through our Troubled Families initiative	LBH (Children's Services)
	Provide a more proactive children's safeguarding service through the Multi Agency Safeguarding Hub (MASH)	LBH (Children's Services)
Improve the stability of care placements and reduce placement breakdown	Undertake fostering recruitment campaign to increase in-house fostering families and reduce placement breakdown, and improve the matching of children and young people with foster carers	LBH (Children's Services)
	Restructure services to enable better continuity of social work support	LBH (Children's Services)
	Introduce parallel planning for children to place more quickly with permanent/adoptive families	LBH (Children's Services)
	Better engage with children and young people through training, mentoring and befriending	LBH (Children's Services)
	Improve access to CAMHS through working with partners on the re-established CAMHS commissioning board, reviewing current use of provision, undertaking a commissioning exercise this year and introducing new ways of working including advice surgeries for social care staff	LBH (Children's Services)

THEME B: Better integrated support for people most at risk

Objectives	Actions	Lead Partners
Improve health outcomes for children and young people, particularly those in care	Deliver the children and young people physical activity programme	LBH (Culture and Leisure)
	Improve the immunisations of looked after children	LBH (Childrens Services) & (Public Health)
	Ensure all looked after children receive regular health and dental checks	LBH & HCCG
Improve the transition from children's to adults care packages for young people with disabilities	Work with young people earlier to better plan the transition between children's and adults care packages	LBH (Adults and Health) & (Children's Services)
Reduce teenage conceptions and improve sexual health	Targeted campaigns to reduce numbers of conceptions in under-18s and rates of Chlamydia in 15-24 year olds	LBH (Public Health) & (Children's Services)
	Commission sexual health and contraception services to meet the needs of Havering's teenagers	LBH (Public Health) & (Children's Services)
Reduce numbers of children experiencing poverty in Havering	Work with partners to continue to reduce child poverty and deliver actions from the Child Poverty Strategy	LBH (Children's Services)
Provide access to high-quality therapies for vulnerable children and young people	Improve access to Child and Adolescent Mental Health Services (CAMHS), speech and language therapies and occupational therapies	LBH (Children's Services) & HCCG

Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Children with three or more placements	H: 20% L: 11.3% E: 10.7% (2011/12)	13%	LBH (Children's Services)
Placements lasting at least two years	H: 50.9% L: 68.1% E: 68.6% (2011/12)	75%	LBH (Children's Services)
Under 18 conceptions (rate per 1,000 15-17 year olds)	H: 38.34 (2011/12) L: 43.7 E: 40.2 (2007-09 DIH)	35	LBH (Public Health) & (Children's Services)
Chlamydia diagnoses 15-24 year olds (diagnosis rate per 100,000 aged 15-24)	H: 1250.6 L: No data available E: 1940.2 (2011/12 HPA)	No target identified	LBH (Public Health) & (Children's Services)
Total Looked After Children with up-to-date health assessment	H: 83.9% (104) (2011/12)	100%	LBH (Public Health) & (Children's Services)

THEME B: Better integrated support for people most at risk

Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Looked After Children continuously looked after for at least one year	H: 124 (2011/12)	No target identified	LBH (Public Health)
Looked After Children with immunisations up to date	H: 96% L: 81% E: 79% (2011)	100%	LBH (Children's Services)
Looked After Children with dentist check-ups	H: 96% L: 87% E: 82% (2011)	100%	LBH (Children's Services)
Looked After Children with substance misuse problems	H: 4% L: 6% E: 4% (2011)	Below 4%	LBH (Children's Services)
Emotional wellbeing of Looked After Children (emotional and behavioural health)	H: 14.4 E: 13.8 (2009)	No target identified	LBH (Children's Services)
Children in poverty (children in families in receipt of IS/ JSA or where income is less than 60% of median income)	H: 21.65% (9,300) E: 24.45% (2008 DIH)	To reduce the proportion of child poverty in Havering	LBH (Children's Services)

THEME B: Better integrated support for people most at risk

Priority 7: Reducing avoidable hospital admissions

Why is this important in Havering?

Hospital admissions, especially avoidable admissions, are extremely costly to the NHS and disrupt the lives of those affected, as well as causing unnecessary distress to family and friends. Long or frequent hospital stays also cause increased dependency and ill health and reduce people's confidence to manage at home – particularly older people. From a financial perspective, hospital admissions, especially emergency or unplanned admissions and repeat admissions, are extremely costly to the NHS and can disrupt the delivery of elective (planned) care.

Avoidable admissions include conditions that can often be managed in the community; an unplanned readmission that might have been avoided had the original discharge been better planned or that plan implemented better; and the absence of more appropriate, community-based, models of care.

Unplanned re-admissions occur as an emergency within a short time of an initial admission. The initial admission may itself have been planned or unplanned. The subsequent readmission may be due to an entirely unrelated problem but a significant proportion is due to surgical complications or a failure at discharge. Unplanned admissions account for nearly two thirds of all hospital bed days in England, with 15-20% thought to be avoidable.

THEME B: Better integrated support for people most at risk

What is the current situation in Havering?

Our Joint Strategic Needs Assessment[9] tells us that:

- Emergency hospital admissions are significantly lower (better) than the average for London and England. Nonetheless in 2010/11 there were more than 21,000 admissions at a cost of nearly £43 million (more than 10% of the total HCCG budget)
- Moreover, both the number (up 27%) and cost (up 18%) of emergency admissions have increased steadily in the three years 2008/09-2010/11
- A number of groups including the old, the very young, disadvantaged communities, those with pre-existing long-term conditions or who live close to A&E units are at greater risk of unplanned admission
- In 2010/11, there were 1,500 admissions of residents aged 65 or older following a fall. Age standardised rates of admission were higher, but not significantly higher, than the national average and at least 20% higher than PCTs in the best performing quartile
- More than 300 residents were admitted to hospital following a stroke in 2009/10. Rates of admission for stroke were very similar to the national average
- The majority of unplanned admissions follow from an A&E attendance. Avoiding the use of A&E services wherever possible would help to reduce avoidable hospital admissions. There were 64,000 A&E attendances in 2010/11. The indirectly age standardised rate of A&E attendance was 252 per 100,000; significantly below the national average (387) and lowest for any borough in London. Moreover, attendance rates in Havering have declined over the last three years whereas rates have increased nationally
- There were 2,329 readmissions within one month of discharge in 2009/10 (12% of all patients discharged that year). This is higher than the national average of 11%. Readmission rates have risen by more than 4% over the last 10 years, in line with national trends
- BHRUT has a high readmission rate (6.5%) relative to the national average (5.5%) and Acute Trusts serving similar populations. Excluding cancer treatment, the highest rates of readmission occur in geriatric medicine, general medicine and general surgery
- The likelihood of readmission increases following discharge to nursing homes.

Some admissions may reflect the lack of availability of more appropriate forms of community based care. Although almost 75% of people say they would prefer to die at home, a majority continue to die in hospital. Admissions ending in death are the biggest single cause of complaint against hospitals, demonstrating how difficult it is to meet the needs of patients and their families for end of life care in an acute setting. Although the proportion of people dying at home has increased in Havering over the last three years, it is still only 35% compared with a national average of more than 40%. The majority of the remaining deaths (1,309 in 2010/11-2011/12) would have occurred in hospital at considerable cost (see Priority 5 for more information on end of life care.

There is a professional consensus that unplanned admissions can be reduced. Many different approaches have been advocated, focused on different stages along the patient journey and varying in complexity from simply increasing rates of vaccination amongst vulnerable groups to proactive disease management. Similarly, 'out of hours' arrangements that minimise the likelihood of unnecessary presentation at A&E are thought likely to reduce hospital admissions.

The Havering Commissioning Strategy Plan 2012-15 sets out the strategic priorities of the HCCG including *"shifting services from hospital to the community through integration of services across primary, secondary and social care, and ensuring the community and primary care infrastructure*

[9]JSNA 2011/12, Chapter 11: Keeping People Out Of Hospital

THEME B: Better integrated support for people most at risk

is in place to enable this". The ONEL Primary Care Strategy sets out plans to ensure consistently high quality primary care services for residents across the cluster. In addition, plans[10] to consolidate A&E services, coupled with the implementation of the ONEL model of urgent care, will ensure that senior clinical cover is available to all those needing emergency care.

Where do we want to be in Havering?

We are keen to reduce unnecessary and unplanned hospital admissions, particularly for ill-health or injury that could have been avoided and repeat hospital admissions where individuals are admitted into hospital on a frequent basis. By working collectively as a strategic partnership, we will reduce avoidable hospital admissions.

Our objectives are to:

- Manage the care of patients proactively in the community through planned care transformation such as integrated case management. We will identify patients most at risk of being admitted to hospital and manage their care in the community via a multi-disciplinary team across health and social care, led by general practice
- Increase independence skills of people within the community who have recently been discharged from hospital or who are at risk of admission/re-admission. We will do this by providing low level interventions such as the Help Not Hospital project and developing a Rapid Response installation process for installation of assistive technologies
- Reduce inappropriate and unplanned discharges, which lead to re-admissions and seek greater collaborative approaches to ensure that planning for discharges takes place closer to an individual's point of admission
- Ensure that vulnerable people are safeguarded from neglect and abuse when receiving care at home
- Ensure high quality prescribing of medications to reduce unnecessary hospital admissions.

How will we deliver improved outcomes?

Below are the key actions that we will take to deliver improved outcomes on reducing avoidable hospital admissions. Each action is owned by a lead partner(s) of the Health and Wellbeing Board. Our performance will be measured by the successful delivery of these actions and improvements against key indicators.

Objectives	Actions	Lead Partners
Manage the care of patients proactively in the community through integrated case management	Establish a joint working group consisting of health and social care leaders to lead and support development of an Integrated Care Strategy across the wider community served by BHRUT	LBH (Adults and Health) & HCCG
	Provide support to those most at risk of hospital admission through Integrated Case Management, a multi-disciplinary health and social care team led by general practice	LBH (Adults and Health) & HCCG
	Establish pulmonary rehabilitation sessions throughout the borough at accessible community venues to reduce demand for oxygen from GPs and A&E	LBH (Adults and Health) & HCCG
	Increase access to home oxygen assessment and review services	HCCG
	Reduce the number of hospital admissions as a result of falls and fractures from falls and the number of excess bed days	LBH (Adults and Health)
	Utilise assistive technologies for COPD patients to reduce use of hospital services by 50%	LBH (Adults and Health)

[10] H4NEL

THEME B: Better integrated support for people most at risk

Objectives	Actions	Lead Partners
Increase independence skills of people within the community who have recently been discharged from hospital or who are at risk of admission/re-admission	Through the Help Not Hospital project, provide low level interventions to support people following hospital discharge or to prevent them being admitted	LBH (Adults and Health) & HCCG
	Develop a specialist Rapid Response installation process facilitating the identification, referral and installation of a range of assistive technologies as patients are discharged from hospital	LBH (Adults and Health)
	Address unmet demand by converting 13 empty/void bedsit units at Royal Jubilee Court into reablement units	LBH (Adults and Health)
	Substantially increase the capacity of the reablement service to extend the alternatives to hospital and residential care and continue to enable more people to remain in their own homes	LBH (Adults and Health)
Reduce inappropriate and unplanned discharges, which lead to re-admissions	Ensure that planning for discharges takes place closer to an individual's point of admission into hospital	LBH (Adults and Health) & HCCG
Vulnerable people are safeguarded from neglect and abuse when receiving care at home	Ensure safeguarding controls for care agencies employed to care for people in their own homes	LBH & HCCG
Ensure high quality prescribing of medications to reduce unnecessary hospital admissions	Ensure optimal use of medicines in primary care to reduce acute admissions and improve patient outcomes.	HCCG
	Ensure continued clinical training and monitoring around prescribing of medications in primary care	HCCG
	Maintain a primary care antimicrobial prescribing formulary and adhere to specific medications monitored	HCCG
	Develop a joint medication formulary with BHRUT	HCCG

Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Emergency hospital admissions (all causes) (standardised ratio)	H: 86.35 L: 94.44 E: 100 (2003-07)	No target identified	HCCG
Emergency admissions for conditions that should not usually require hospital admission (indirectly age and sex standardised rate per 100,000)	H: 151.81 E: 181.81 (2009/10 NHS IC)	No target identified	HCCG
Emergency readmissions within 30 days of discharge from hospital (indirectly age, sex standardised percent)	H: 11.92 L: 11.9 E: 11.61 (2009/10 DIH)	No target identified	HCCG

THEME B: Better integrated support for people most at risk

Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Proportion of older people (65 plus) still at home 91 days after discharge from hospital into reablement/ rehabilitation	H: 77.2% L: 84.4% E: 82.5% (2011/12 NASCIS)	85% (2012/13)	LBH (Adults and Health)
Proportion of older people offered rehabilitation following discharge from acute or community hospital	H: 76.6% E: 81.9% (2010/11 NHS IC)	No target identified	LBH (Adults and Health)
Overall number of delayed transfers of care from hospital per 100,000 population	H: 13.3 L: 7.6 E: 9.9 (2011/12 NASCIS)	5 (2012/13)	LBH (Adults and Health)
Number of delayed transfers of care from hospital attributable to Adult Social Care and Health per 100,000	H: 5.5 L: 3.0 E: 3.7 (2011/12 NASCIS)	3 (2012/13)	LBH (Adults and Health) & HCCG
Permanent admissions to residential and nursing care homes (aged 18-64) per 100,000 population	H: 9.0 L: 15.1 E: 18.9 (2011/12 NASCIS)	9 (2012/13)	LBH (Adults and Health)
Ambulatory care sensitive admissions (NHS)	H: 457/1000 (2011/12)	No target identified	HCCG & LAS
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (number of admissions)	E: 1,820 (2010/11)	No target identified	LBH (Adults and Health) & HCCG
Top 10 ICD codes for long-term conditions	H: 1,020 emergency admissions (Q1 2012/13)	3,562 admissions (2012/13)	HCCG

THEME C: Quality of services and patient experience

Priority 8: Improving the quality of health services to ensure that patient experience and long-term health outcomes are the best they can be

Why is this important in Havering?

Ensuring patients and their families and carers, receive the best quality health and social care services is crucial to achieving the best long-term outcomes for patients and for the borough's population as a whole. Services should be delivered efficiently, sustainably and safely.

In Havering, we want all patients to have a positive an experience as possible from the care they receive when they become unwell. Monitoring patients' experience of the care they receive is a vital tool in monitoring how well health services are responding to the needs of the local population.The Government has made explicit that quality of care is a national priority for the NHS and defines quality as having three dimensions.

These are:

- **Clinical effectiveness** – good quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes
- **Patient safety** – good quality care is care which is delivered so as to avoid all avoidable harm and risks to the individual's safety
- **Patient experience** – good quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect.

The Health and Wellbeing Board also recognises organisational integrity as a fourth explicit local priority for Havering, in recognition of the serious quality and patient safety concerns that have emerged from the care provided by some of our providers. Recent Care Quality Commission (CQC) reports have identified specific concerns with our major acute care provider, BHRUT.

THEME C: Quality of services and patient experience

What is the current situation in Havering?

In Havering, the two main service 'provider' organisations are Barking, Havering and Redbridge University Hospital Trust (BHRUT) for acute hospital services and North East London NHS Foundation Trust (NELFT) for community (such as district nursing) and mental health services (such as specialist help for people with acute mental health conditions). Community and mental health services are provided in clinics, hospitals and in people's own homes.

In 2011, following a number of warning notices being issued to BHRUT, as well as unannounced inspections during 2010/11 and feedback from patients and the public on poor quality care, the CQC investigated the quality of care provided at the Trust and found some key areas for urgent improvement around quality and safety, particularly at Queens Hospital in Romford. Concerns were particularly raised around maternity services, A&E services, patient experience and the handling of patient complaints, as well as serious workforce and governance issues.

BHRUT has begun to deliver some improvements following the CQC report, and in 2012 the CQC acknowledged that improvements have taken place in the management, culture and working practices of the Trust but that more still needed to be done. All CQC restrictions that were placed on BHRUT following identification of the quality and patient safety issues have now been lifted. BHRUT in partnership with health commissioners are working on a clinical strategy to continue to address all quality, patient experience and financial issues to ensure they are a sustainable organisation with the capability of delivering high quality patient care.

Healthwatch will be the new organisation created to ensure that the voice of local patients of health and social care services and the wider community are heard on the Health and Wellbeing Board. The Council is responsible for commissioning Healthwatch and to ensure it engages with local people on the issues that matter to them about health and that this is used to affect health and social care service improvement.

THEME C: Quality of services and patient experience

Where do we want to be in Havering?

We would like to see consistently high levels of quality of care in all health and care services provided in Havering. Through collaborative working and robust provider performance management, the CCG will continue to improve the quality and safety of services to deliver its aim of improving patient, family and carer experience. We want patient experience of health and care services in Havering to be positive.

Nationally, the Department of Health has some key headline areas of focus which it believes will drive up quality of care. This is written into the Commissioning for Quality and Innovation (CQUIN) Framework that allows commissioners of services to incentivise performance in these areas. The NHS Safety Thermometer is one of these key CQUIN measures, focusing on four key indicators to improve the monitoring of quality of care in hospital and community providers, specifically to reduce harm from pressure ulcers, falls, urinary tract infections in patients with catheters and VTE (venous thromboembolism – also known as blood clots). With more proactive nursing interventions, these are all largely avoidable conditions and are key indicators that quality of care in a provider organisations may be below standard.

Our objectives are to:

- Bring about big improvements in quality of care and patient safety, especially maternity services in Queens Hospital
- Minimise the incidence of avoidable harms in hospital and community settings, including pressure ulcers, falls, urinary tract infections and VTE as measured in the NHS Safety Thermometer
- Ensure patient experience in A&E is improved by reducing waiting times and diverting people away from A&E where appropriate
- Focus on quality of care in community residential settings and implementation of a scheme to increase primary medical care in nursing homes
- Ensure sound financial management of the NHS budget for Havering so that quality of services is not compromised
- Risk is managed by providers systematically and accurately to reduce likelihood of occurrence of serious incidents
- Commission and performance manage Healthwatch to high levels of ensure patient and public engagement activity that can affect improvement.

How will we deliver improved outcomes?

Below are the key actions that we will take to deliver improved outcomes on quality of services and patient experience. Each action is owned by a lead partner(s) of the Health and Wellbeing Board. Our performance will be measured by the successful delivery of these actions and improvements against key indicators.

Objectives	Actions	Lead Partners
Bring about big improvements in quality of care and patient safety, especially maternity services in Queens Hospital	Ensure the CQC 2011 key findings for improvements are delivered across BHRUT	HCCG
	Deliver the four key areas of the NHS Safety Thermometer to minimise the incidence of avoidable harms in hospital and community settings, including pressure ulcers, falls, urinary tract infections and VTE	HCCG
	Improve Serious Incident Management through improved reporting and risk management	HCCG
Ensure patient experience in A&E is improved by reducing waiting times and diverting people away from A&E where appropriate	Improve patient experience in A&E by reducing waiting times and processing patients efficiently	HCCG

THEME C: Quality of services and patient experience

Objectives	Actions	Lead Partners
Improved quality of care in community residential settings and increase primary medical care in nursing homes	Implement the nursing homes scheme to match named GP practices with each of Havering's nursing and residential care homes, ensuring regular visits are made to all residents in care homes and thereby improving medical care and reducing admissions to hospital	LBH (Adults and Health) & HCCG
Ensure sound financial management of the NHS budget for Havering so that quality of services is not compromised	Ensure the CCG and health providers operate within their budgets to avoid overspends	HCCG
Risk is managed systematically and accurately to reduce likelihood of occurrence of serious incidents	Ensure providers are reporting risk accurately and robustly through benchmarking and undertaking audits	HCCG
Commission and performance manage Healthwatch to high levels of ensure patient and public engagement activity that can affect improvement	Council to commission Healthwatch in Havering, putting in robust performance management arrangements to ensure its effectiveness	LBH (Adults and Health)

Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Incidence of category 3 and 4 pressure ulcers (BHRUT)	H: 5 (July 2012)	0	HCCG
Number of (MRSA) bacteraemia	H: 6 cases (September 2012/13)	7 cases for the year	HCCG
Number of Clostridium difficile infections	H: 26 cases (September 2012/13)	59 cases for the year	HCCG
Increase in patients seen by a senior clinician within 12 hours of being admitted, and consultant within 24 hours	H: No data available	75%	HCCG
Breeches of single sex accommodation	H: 19 (August 2012/13)	0	HCCG
Serious untoward incidence – percentage reported within 48 hours (quarterly)	H: 53% (July 2012)	50%	HCCG
Women's experience of maternity services	H: 20/24 questions BHRUT performed worse than other Trusts; 3/24 performed similarly to other Trusts' 1/24 performed better than other Trusts (2009/10 BHRUT Maternity Survey)	BHRUT perform favourably to other Trusts against all 24 questions	HCCG
Complaints responded to in line with agreement with patients	H: 87% (July 2012)	80%	HCCG

THEME C: Quality of services and patient experience

Indicators	Current Performance (H = Havering; L = London; E = England)	Targets	Lead Partners
Patient experience of outpatient services	H: 27/50 questions BHRUT performed worse than other Trusts; 23/50 performed similarly to other Trusts (2009/10 Survey of Adult Outpatients)	BHRUT perform favourably to other Trusts against all 50 questions	HCCG
Category A ambulance response times: target 75% within eight minutes	H: 67% L: 73% (May 2012)	75%	HCCG & LAS
A&E: From arrival to admission / transfer / discharge (maximum waiting times of 4 hours)	H: 88.4% (A&E weekly activity statistics, NHS and independent sector organisations in England)	95%	HCCG
Discharge plan put in place within 24 to 48 hours of admission to A&E	H: No data available	95%	HCCG
Patient experience of hospital care and A&E	H: 26/73 questions BHRUT performed worse than other Trusts; 47/73 BHRUT performed similarly to other Trusts (2009/10 Survey of Adult Inpatients)	BHRUT perform favourably to other Trusts against all 73 questions	HCCG
Patient experience of out of hours services	H: 64% E: 71% (2011)	Havering performs at or above the national average	HCCG
From point of referral to treatment in aggregate (RTT) – non admitted	H: Currently above 95%	95%	HCCG
Patients able to see a GP within 2 days	H: No data available	2012/13 is the baseline year	HCCG
Patients would recommend a practice	H: No data available	2012/13 is the baseline year	HCCG
Patient experience of GP services	H: 23/38 questions GP practices performed better than national average; 9/38 performed similarly to national average; 6/38 performed worse than national average (2010/11 GP Practice Survey)	All GP practises perform at the national average of better for patient experience	HCCG

Appendix 1: Membership of Havering Health and Wellbeing Board

Name	Position
Cllr Steven Kelly	Deputy Leader of the Council and Cabinet Member for Individuals and Health
Cheryl Coppell	Chief Executive, the London Borough of Havering
Dr Gurdev Saini	CCG Board Member (Lead for the Local Authority)
Dr Stephen Farrow	Interim Director of Public Health
Cllr Paul Rochford	Cabinet Member for Children and Learning
Cllr Andrew Curtin	Cabinet Member for Towns and Communities, with special responsibility for Culture
Cllr Lesley Kelly	Cabinet Member for Housing
Lorna Payne	Director of Adult Social Care, the London Borough of Havering
Sue Butterworth	Director of Children's Services, the London Borough of Havering
Conor Burke	Accountable Officer (Designate) CCG
Dr Atul Aggarwal	CCG Chair
TBC	Healthwatch Representative
Non Voting Member:	
Jacqui Himbury	Borough Director, Havering NHS ONEL

Appendix 2: Glossary

A&E	Accident & Emergency
APHO	Association of Public Health Observatories
ASC	Adult Social Care
BHRUT	Barking, Havering and Redbridge University Hospitals National Health Service Trust
CAMHS	Child and Adolescent Mental Health Services
CCG/HCCG	Clinical Commissioning Group / Havering Clinical Commissioning Group
CSU CCT	Commissioning Support Unit Cancer Commissioning Team
CQUIN	Commissioning for Quality and Innovation
DH	Department of Health
DIH	Data Intelligence Hub
HPA	Health Protection Agency
JSNA	Joint Strategic Needs Assessment
LAS	London Ambulance Service
LBH	London Borough of Havering
LHIB	London Health Improvement Board
NASCIS	National Adult Social Care Intelligence Service
NHSCB	National Health Service Commissioning Board
NHS IC	National Health Service Information Centre
NELC	North East London and City
NELFT	North East London Foundation Trust
NCIN	National Cancer Intelligence Network
ONEL	Outer North East London
ONS	Office for National Statistics
PCT	Primary Care Trust
PH	Public Health
PHE	Public Health England
POPPI	Projecting older People Population Information System
QOF	Quality and Outcomes Framework