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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD
AGENDA

1.00 pm	Wednesday, 11 May 2016	Committee Room 3A - Town Hall

Members: 14, Quorum: 10

BOARD MEMBERS:

Elected Members:	Cllr Wendy Brice-Thompson (Chairman) Cllr Meg Davis Cllr Gillian Ford Cllr Roger Ramsey
Officers of the Council:	Cheryl Coppell, Chief Executive Isobel Cattermole, Deputy Chief Executive, Children, Adults and Housing Dr Susan Milner, Interim Director of Health
Havering Clinical Commissioning Group:	Dr Atul Aggarwal, Havering Clinical Commissioning Group (CCG) Dr Gurdev Saini, Board Member Havering CCG Conor Burke, Accountable Officer,Barking & Dagenham, Havering and Redbridge CCGs Alan Steward, Chief Operating Officer, Havering CCG
Other Organisations:	Anne-Marie Dean, Healthwatch Havering John Atherton, NHS England

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

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

What does the Health and Wellbeing Board do?

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

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

1. WELCOME AND INTRODUCTIONS

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

2. APOLOGIES FOR ABSENCE

(If any) – receive

3. DISCLOSURE OF INTERESTS

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

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

4. MINUTES OF LAST MEETING AND MATTERS ARISING (NOT ON ACTION LOG OR AGENDA) (Pages 1 - 8)

To approve as a correct record the minutes of the Committee held on 23 March 2016 (attached) and to authorise the Chairman to sign them (5 minutes).

5. ACTION LOG (Pages 9 - 10)

To consider the attached Board action log (15 minutes).

6. PRIMARY CARE HEALTH CARE STRATEGY FOR COMMENT (Pages 11 - 68)

Attached (20 minutes).

7. HWB TERMS OF REFERENCE FOR SIGN OFF (Pages 69 - 72)

Attached (5 minutes).

8. OUTLINE OF REFRESHED JHWS

Report to follow (20 minutes).

9. ASC LOCAL ACCOUNT (Pages 73 - 106)

Attached (15 minutes).

10. PLACE OF SAFETY REPORT (Pages 107 - 146)

Attached (15 minutes).

11. CLINICAL GOVERNANCE ASSURANCE REPORT (Pages 147 - 164)

Attached (10 minutes).

12. FORWARD PLAN

To be tabled (10 minutes)

13. DATE OF NEXT MEETING

20 July 2016, 1 pm, Havering Town Hall, committee room 3B.

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MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD
Town Hall
23 March 2016 (1.00 - 2.56 pm)

Present:

Board Members present:

Councillor Wendy Brice-Thompson, Cabinet Member, Adult Social Services and Health (Chair) **(WBT)**
Councillor Roger Ramsey, Leader of the Council **(RR)**
Councillor Meg Davis – Cabinet Member, Children & Learning **(MD)**
Cheryl Coppell – Chief Executive, LBH **(CC)**
Isobel Cattermole, Deputy Chief Executive, Children's, Adults and Housing, LBH **(IC)**
Dr Susan Milner, Interim Director of Public Health, LBH **(SM)**
Dr Gurdev Saini, Clinical Director, Havering CCG **(GS)**
Dr Atul Aggarwal, Chair, Havering CCG **(AA)**
Clare Burns, Havering CCG **(CB)** (substituting for Alan Steward)
Anne Marie Dean, Havering Healthwatch **(AMD)**

Also Present:
Phillipa Brent-Isherwood, Head of Business and Performance **(PBI)**
Elaine Greenway, Acting Consultant in Public Health, LBH **(EG)**
Mark Ansell, Public Health Consultant, LBH **(MA)**
John Green, Strategic Commissioning Lead, LBH **(JG)**
Caroline May, Head of Business Management, Adult Services, LBH **(CM)**
Lee Salmon, Learning Disabilities and Autism Commissioner, LBH **(LS)**
Anthony Clements, Principal Committee Officer, LBH (minutes) **(AC)**

All decisions were taken with no votes against.

40 **WELCOME AND INTRODUCTIONS**

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

41 **APOLOGIES FOR ABSENCE**

Apologies were received from Councillor Gillian Ford, Conor Burke, BHR CCGs and Alan Steward, Havering CCG (Clare Burns substituting).

42 DISCLOSURE OF INTERESTS

There were no disclosures of interest.

43 MINUTES OF LAST MEETING AND MATTERS ARISING (NOT ON ACTION LOG)

The minutes of the meeting held on 27 January 2016 were agreed as a correct record. There were no matters arising not dealt with elsewhere on the agenda.

44 ACTION LOG

Item 15.1 – Probation services participation in MASH – completed. Noted that the Probation service was now engaging more in the steering group.

Item 15.2 – Circulation of Healthwatch Annual Report presentation – completed.

Item 15.3 – Comments on CCG commissioning intentions for children's services – comments received, item to be left on action log.

Item 15.4 – Update on backlog of health assessments for Looked After Children – Paediatric specialist now working on clearing backlog, update to be given at next Board.

Item 16.1 – Amendments to January Board minutes – completed.

Item 16.2 – Action log format – completed. File format to be amended to enable inclusion in main agenda papers.

Item 16.3 – Letter of thanks to Cllr Kelly – completed.

Item 16.4 – Circulation of letter re ACO development – completed.

Item 16.5 – Comments on Board terms of reference and strategic priorities – no comments received.

Item 16.6 – Circulation of revised terms of reference and strategic priorities – completed.

45 HWB TERMS OF REFERENCE AND STRATEGIC PRIORITIES FOR DISCUSSION

It was explained that, in line with the practice in neighbouring boroughs, it was proposed to include as members representative of BHRUT and NELFT although they wold be excluded from voting on issues where there was a conflict of interest.

It was **AGREED** to not change Board membership at this stage but to revisit this issue once the overall strategic priorities for the Board had been agreed.

It was **NOTED** that the quorum for meetings of the Board with its current membership was 5 and this would rise if further members joined the Board.

46 **COMBINED VERBAL UPDATE ON ACCOUNTABLE CARE ORGANISATION/URGENT CARE VANGUARD AND DEVELOPMENT OF THE CCG SUSTAINABILITY AND TRANSFORMATION PLAN**

CC explained that the first workstreams were on track to report back in mid-April and that a democratic and oversight group had been established. A lot of work remained to be undertaken however.

It was noted that the expected funding from central Government had not been forthcoming and that this had met with a lot of opposition across London. The Leader of the Council along with the Leaders of neighbouring boroughs had written to Dr Anne Rainsberry concerning this and had also raised the matter at the London Councils Leaders' meeting. A copy of the Leader's letter had now been requested by the Secretary of State for Communities and Local Government.

There was now a national requirement to have transformation plans in place by the end of June and it would be necessary to ensure that the ACO sat within this. The focus would need to be on the overall health and wellbeing of communities with different issues dealt with at local, sub-regional or regional levels as appropriate. CC was leading the East London work on this and felt that, if funding was not forthcoming, the level of community engagement around the work would have to be reduced. The Council and the CCG may still be required to find additional funding for other aspects, should this be required.

47 **MARKET POSITION STATEMENT - COMMISSIONING IN ADULTS SERVICES**

JG explained that there had been a great deal of consultation on the Market Position Statement (MPS) which aimed to show providers what the Council's commissioning intentions were. The MPS showed all types of services that were provided to adult social care.

It was agreed that SM would check the figures in the MPS regarding the proportion of over 65s in Havering's population. People identified as being socially isolated were being visited by adult social care staff over the course of the coming year. Work was also in progress with Housing regarding the building of adapted housing for people with physical or sensory disabilities.

It was accepted that there was a high proportion of staff vacancies and turnover for care roles in Havering. This needed to be addressed by working with employers on areas such as the National Living Wage, staff contracts and staff training & development. There was a wish to present the care profession as more of a career. The Council was aiming to support more homecare providers to become sustainable business models although short term pressures in these areas were difficult.

There had been lower take-up of personalised budgets in Havering compared to other boroughs and JG wished to address the risk aversion of service users in this regard. PBI suggested the Board should look at market shaping work taking place to ensure that there were sufficient services in the market that people wished to spend their personal budgets on.

It was noted that Havering was a big importer of older people from other areas into Havering care homes. A possible solution was to increase reablement to allow more people to continue living at home but the appropriate services were needed to allow this. Attempts had been made to refuse planning permission for the construction of any new care homes within Havering.

WBT suggested that the issue of social isolation should be included within the MPS.

The Board **NOTED** the draft Market Position Statement.

48 TRANSFORMING CARE PARTNERSHIP

JG summarised work in progress which aimed to move people from treatment units in hospital into community-based facilities. These were often complex decisions as it was necessary to ensure that both the service user and the community remained safe. The report before the Board summarised work that was in progress towards developing a combined solution for the Barking & Dagenham, Havering and Redbridge areas. A formal plan was required to be submitted to NHS England by 11 April.

A new learning Disabilities commissioner had recently been recruited and it was confirmed that the learning disabilities partnership board fed into the relevant engagement workstream. Engagement was also taking place with stakeholders and their families and a workshop with key stakeholders would be held shortly in order to develop a communications plan.

It was emphasised that only very small numbers of people (currently 5 in Havering) required the highest level of complex care packages but that each package was very expensive, costing £200,000 - £300,000. CB added that there were many success stories with people with complex care needs

coming out of secure units into community settings. Some people also chose to have placements outside Havering for family or other reasons.

The Board **AGREED** to delegate authority to the Deputy Chief Executive and the Accountable Officer (BHR CCGs) to sign off the final submission before the 11 April deadline.

Action: IC/JG to bring updates on this work to the Board.

49 **BETTER CARE FUNDING PLAN**

CM explained that it had been previously decided that 2015/16 would be used as a planning year but that it was a requirement that an integration plan must be in place by 2017. Technical guidance on Better Care Fund planning had been released in February 2016 and this had confirmed that there was no longer a target for the reduction of non-elective admissions to hospital.

The Council and CCG was however required to have a plan re delayed transfers of care and this had been written into the Batter Care Funding plan. The Disabled Facilities Grant had been increased from £829,000 to £1.4 million and officers were working with housing in order to plan how these funds would be spent.

The minimum requirement of the pooled fund was being invested along with a base budget of £855,000. Assurance on the Better Care Fund plan was currently being awaited and final plans had to be submitted to NHS England by 25 April. The report before the Board therefore proposed final sign-off of the plan prior to 25 April.

PBI added that the definition of delayed transfer of care was changing with timescales now due to start from as soon as a doctor declared a patient fit to leave hospital. This could make Havering's performance on this issue look worse. IC added that this would be discussed locally with the hospital and the Joint Assessment and Discharge team and people would not be taken into a care package if it was not felt that they would be safe. It was important that discharge issues were considered in conjunction with other appropriate agencies.

Action: SM to e-mail the Better Care Fund plan to Board members for comment. A small group of interested Board members would also meet virtually to look at the details of the draft plan.

The Board **AGREED**:

1. **To delegate authority to the HWBB Chair to approve final submission of the BCF Plan 2016/17 to NHS England for submission on 25 April 2016, subject to obtaining approval as required from the Council and the Havering Clinical Commissioning Group (CCG).**

2. **To receive, post 25 April 2016, the final submission that was made, and subsequently to receive monitoring reports at six monthly intervals.**

3. **To delegate authority to the HWBB Chair to approve BCF statutory reporting returns each quarter.**

50 HAVERING SEXUAL HEALTH SERVICES RECONFIGURATION

SM reported that the current provider of sexual health services was BHRUT but the service, as currently configured, was not cost effective. As such, work was currently in progress across the three local boroughs in order to find solutions.

It was proposed to close the sexual health and family planning sites in Havering (at Queen's and four spoke sites) and move to a tier 2 service based in Romford with specialist GUM services based in Barking. It was also possible that a London-wide tariff for sexual health services could be introduced. A six-week public consultation was required on the proposals before they could be implemented.

It was noted that the proposal re consultation was on the Council's Forward Plan and that an Executive Decision form re this would be presented to Councillor Brice-Thompson as the appropriate Cabinet member in late March. It was therefore proposed that consultation would commence from mid-April.

Action: SM to prepare appropriate Executive Decision form for Councillor Brice-Thompson and bring an update on the outcomes of the consultation to future meetings of the Board.

51 DRUG AND ALCOHOL REDUCTION STRATEGY

Officers explained that the drug and alcohol strategy was now contained within one overall strategy which many stakeholders had input to. It was proposed that governance of the strategy and its actions should be split with the area leads for community safety, children & families and public health retaining oversight of the relevant parts of the strategy. There would be an annual meeting of the leads to ensure that actions were being delivered and to develop plans for the forthcoming year. An annual report would also be made to the Board.

It was confirmed that NELFT had been closely involved in the development of the strategy and the Board congratulated officers on producing such a comprehensive strategy.

The Board **AGREED**:

1. **That the Chair of the Health and Wellbeing Board should approve a final draft of the Strategy with further reference to the Board.**

2. **That an Annual report be given to the Board describing progress made.**

52 **OBESITY STRATEGY**

SM advised that the obesity strategy now focussed on place shaping and that a lot of work had been undertaken concerning the Joint Strategic Needs Assessment as regards obesity. The recently announced 'sugar levy' was referred to in the strategy.

It was difficult in practice to prevent planning permission for takeaways located in the vicinity of schools. Officers felt that a possible solution would be for schools to seek to prevent pupils visiting takeaways at lunchtime. The Board congratulated officers on producing the strategy.

The Board **AGREED**:

1. **That the Chair of the Health and Wellbeing Board could approve a final draft of the strategy without further reference to the Board.**

2. **That an obesity working group be established to periodically refresh and oversee delivery of a rolling action plan.**

3. **That an annual report be received describing progress made implementing the action plan and changes in levels of obesity, physical activity and healthy eating locally.**

53 **FORWARD PLAN**

It was noted that AC would circulate confirmed dates for future Board meetings following the next meeting of full Council.

It was agreed that the mental health partnership board item would be removed from the agenda for the main meeting. It was also agreed that the pharmacy item should be removed from the agenda for the May meeting.

The next meeting of the Board would be on **Wednesday 11 May 2016** at 1 pm in Havering Town Hall, committee room 3A.

Chairman

Health and Wellbeing Board Action Log

No.	Date Raised	Board Member Action Owner	Non-Board Member Action Owner	Action	Date for completion	RAG rating	Comments
15.3	11-Nov-15	Alan Steward	Clare Burns	Alan to provide electronic copies of the CCG's commissioning Intentions for children and the children's equipment plan to Sue for circulation to the HWB.	Mar-16		Mar 16: completed but item to be left on action log
15.4	11-Nov-15	Isobel Cattermole	Tim Aldridge, Deborah Redknapp	Provide an update to HWB on the backlog of health assessments for Looked After Children.	Mar-16		Mar 16: Update provided on health assessments for LAC: Paediatric specialist now working on clearing backlog. Further update to be given to next Board
16.7	23 Mar 16	Isobel Cattermole	John Green	Update on progress of Transforming Care Partnership to be given to the Board	20 July 16		
16.8	23 Mar 16	Susan Milner		Better Care Fund plan to be emailed to Board members for comment. A small group of interested Board members would also meet virtually to look at the details of the draft plan	End Mar 16		

No.	Date Raised	Board Member Action Owner	Non-Board Member Action Owner	Action	Date for completion	RAG rating	Comments
16.9	23 Mar 16	Susan Milner		Havering Sexual Health Services reconfiguration: SM to prepare appropriate Executive Decision form for Councillor Brice-Thompson and bring an update on the outcomes of the consultation to future meetings of the Board.	20 July 16		
16.10	23 Mar 16	All		Susan Milner to email to all HWB members draft Terms of Reference and Joint Health and Wellbeing Strategy – all to send comments to SM by email	By 20 Apr 16		
16.11	23 Mar 16	Susan Milner		Produce final draft ToR and outline draft JHWS	11 May 16		

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	**Draft primary care transformation strategy**
Board Lead:	Alan Steward, Chief Operating Officer, Havering CCG
Report Author and contact details:	Sarah See, Director, Primary Care Transformation Tel: 020 8926 5411; E-mail: Sarah.See@onel.nhs.uk

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

- ☐ Priority 1: Early help for vulnerable people
- ☐ Priority 2: Improved identification and support for people with dementia
- ☐ Priority 3: Earlier detection of cancer
- ☐ Priority 4: Tackling obesity
- ☒ Priority 5: Better integrated care for the 'frail elderly' population
- ☒ Priority 6: Better integrated care for vulnerable children
- ☒ Priority 7: Reducing avoidable hospital admissions
- ☒ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

The CCG is developing a strategy for the transformation of primary care over the next five years. The work is framed by national and London policy and the BHR system commissioning challenges and takes account of substantial input gathered from local GPs and wider local stakeholders.

The vision emerging is of primary care leading the provision of joined-up health and social care in localities, with sustainable and productive practices at its foundation. This builds on the King's Funds concept of place-based care and wider evidence from places where this approach has been implement.
In developing this strategy, we have engaged extensively with stakeholders with a role in the Havering health and care economy: patient representatives, patient groups, general practitioners, practice managers, pharmacists, nurses, community and mental health

services provided by NELFT, acute services provided by Barking & Dagenham, Havering and Redbridge University Hospitals Trust (BHRUT), the Partnership of East London Co-operatives (PELC), the Local Medical Council, the Local Authority, NHS commissioners and Care City. We have also consulted with primary care and workforce leads at the NHS England London level. Extensive discussions have taken place with and between local clinical leaders about how this model will facilitate the development of local schemes which will deliver better care for local people and what the implications and opportunities will be for individual GP practices, their autonomy and sustainability.

The transformation programme for 2016/7 will be primarily about provider development – strengthening individual practices, developing collaborative working amongst GP practices in localities and developing extended locality teams, bringing together GPs with all local health and social care professionals to provide the majority of care for patients. The plan is to draw on the CCG's strategies for planned, mental health and urgent and emergency care and identify specific local schemes, which can be used to inform development of collaborative governance and working arrangements in localities and as a proving ground n localities, ensuring they are wholly grounded in the business of local providers and the care needs of local people.

We are now aiming to complete the strategy in time for formal review by the governing body in May 2016.

Development of the strategy has been informed by:

- *Five Year Forward View*
- *Better Health for London*
- *Strategic Commissioning Framework for Primary care in London*
- *Place-based systems of care: a way forward for the NHS in England*

RECOMMENDATIONS

The Health and Wellbeing Board is recommended to:

i) Review the contents of the draft Primary Care Transformation Strategy and comment on potential gaps in the strategy or improvements that could be made to it.

REPORT DETAIL

1.0 Introduction and Background

1.1 The CCG is developing a strategy for the transformation of primary care in Havering over the next five years. The work is framed by national and London policy and the BHR system commissioning challenges and takes account of substantial input gathered from local GPs and wider local stakeholders.

1.2 The Health & Wellbeing Board are requested to comment on the draft strategy attached to allow changes to be incorporated prior to the CCG Governing Body undertaking a formal review of the completed strategy now scheduled for May 2016.

1.3 Further information on the proposals is provided in the attached primary care strategy communications slide pack, which is current as of **01/04/2016**.

2.0 Emerging Vision

2.1 The strategy proposes step-by-step migration to a place-based primary care-led delivery model for care out of hospital in new Havering localities of 50-70,000 population. The model has at its foundation stronger GP practices and involves effective collaborative working across groups of practices and an extended team of community, social care, pharmacy, dental and ophthalmology professionals and the voluntary sector.

2.2 Primary care, strengthened and extended, will have the collective capacity and funding to take on the majority of patient care, as well as prevention services.

2.3 Evidence advanced by the King's Fund, drawing on examples from New Zealand, Chenn Med and elsewhere, is that place-based care works best with a population of 50-70,000 people, and clinical leaders in the borough are assessing the suitability of reorganising existing commissioning clusters as the starting point for deciding on the geographic footprints for localities.

2.4 Practice productivity and collaborative provision and administration will be enhanced through better exploitation of available information, IT and digital solutions.

2.5 A BHR-wide approach to the development of the primary care workforce will create the right staff mix for locality-based working, and localities will be empowered to co-design and deliver locally appropriate solutions for the recruitment and retention of staff.

3.0 Benefits for Patients and Implications for Practices

3.1 The benefits envisaged for patients from the primary care strategy are:

- personalised, responsive, timely and accessible primary care, provided in a way that is both patient-centred and coordinated
- an integrated service that supports and improves their health and wellbeing, enhances their ability to self-care, increases health literacy, and keeps them healthy
- more treatment closer to home where previously provided in secondary care
- involvement in the co-design of services with professionals in their locality.

3.2 The key implications for practices of the strategy are envisaged to be:

- Retention of practice autonomy, with GPs playing leading roles in locality-based care
- Improved financial sustainability through the pooling of resources to reduce costs and the creation of new opportunities to generate income
- Better practice productivity through improved teamworking and better use of IT, reducing administration and freeing up GP time for patient care
- The potential to develop more attractive career offers to recruit and retain primary care workers.

4.0 Implementation Approach

4.1 The King's Fund's framework for implementing place-based models of care will be used as the starting point from the implementation of primary care-led locality-based care in Havering

4.2 It is proposed to work with a single locality within the borough as a pilot to design collaborative governance and working arrangements while working on selected prevention, planned care, mental health and/or urgent and emergency care schemes. This will enable initial lessons from locality-based working to be properly understood and the learning to be reflected in the designs and planning for the other localities.

4.3 A parallel programme of work will be put in place to help practices improve their productivity, make better use of information and IT systems and better understand their financial sustainability.

4.4 There is a 12-18 month target timescale for all localities to be operational and effective.

5.0 Resources/investment

5.1 Resources will be needed to help primary care leaders in localities establish organisational and governance arrangements for collaborative working and operate these effectively and to assist with specific initiatives to strengthen practice productivity and enable wider use of information, IT and digital solutions. Resource will also be needed to run the transformation programme at the BHR level. A review of CCG organisational arrangements may identify some individuals with the right skills and experience from programme roles

5.2 An investment strategy for primary care is currently under development. This will enumerate the funding required for the transformation programme.

6.0 Equalities

6.1 No equalities impact assessment has been explicitly undertaken in relation to these proposals.

6.2 By delivering common standards of prevention, planned care, mental health and urgency and emergency care across the BHR system and organising delivery in localities, the CCG's overall approach aims to both reduce health inequalities and optimise services to meet the needs of local populations in Havering.

7.0 Risk

7.1 An iterative process of risk analysis will be part of the design and implementation phases of the new model of care. Current risks and assumptions identified include:

7.2 **Risks**

- Insufficient grass roots buy-in from GPs and other primary care professionals
- Insufficient capacity within General Practice to participate
- Dependencies on other projects – IT, workforce
- The pace of change demanded vs the time necessary to develop localities sustainably
- Compatibility of the strategy with main providers' strategies
- Insufficient investment in the resources to enable the programme to succeed

7.3 **Assumptions**

- Improving team working in localities will release significant quality and productivity benefits
- GP Practices are receptive to opportunities to improve their practices
- This strategy will have top-level support regardless of whether the Accountable Care Organisation proceeds
- Interoperable IT agenda sufficiently advanced to enable localities to provide continuity of care to patients

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BACKGROUND PAPERS

Draft Primary Care Transformation Strategy – current at 11/04/2016

Primary Care Strategy Communications Slides – current at 11/04/2016

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Transforming Primary Care in Havering

Our strategy 2016 – 2021

April 2016

Contents

1 Executive summary

For patients, primary care and their relationship with their local GP form the foundation of the NHS service they expect and receive. If the NHS is to be clinically and financially sustainable in the years ahead, primary care and the rest of the system need to be transformed. If this can be done right, primary care can be a rewarding place to work for the professionals working in it, now and in future.

Nationally, the NHS faces significant future challenge in the form of the increasing health needs and expectations of the population, changes in treatments and technologies, and increasing pressures on finances - both from reduced spending growth in the NHS and cuts to social care budgets. Current projections from Monitor and NHS England estimate that the NHS will face a £30 billion funding gap by 2020/21. To tackle these challenges within Government funding limits, the *Five Year Forward View*[1] sets out a transformational change agenda for the NHS that involves:

- Reducing variation in care quality and patient outcomes
- Increasing the emphasis on preventative care
- A shift towards more care being delivered in primary care
- Breaking down the barriers in how care is provided through the introduction of new models of care spanning current organisational boundaries
- Action on demand, efficiency and funding mechanisms to improve financial sustainability.

In response to this, the General Practice Forward View offers funding opportunities and practical steps to stabilise and transform general practice through addressing workforce, workload, infrastructure and care design issues.

Havering, along with the wider Barking and Dagenham, Havering and Redbridge (BHR) system, has a greater commissioning challenge than the national average in the form of a system-wide budget gap of over £400m. The BHR system needs to be transformed to:

- Meet the health needs of the growing, ageing population where an increasing number of people are living with one or more long-term condition in its local communities
- Improve health outcomes for these populations and reduce health inequalities overall
- Meet national and regional quality standards for care
- Close a £400m budget gap.

To achieve this, commissioners agree that acute hospital care should be reserved for acutely ill patients and the majority of care should be delivered nearer home. Key themes for the development of primary care are that it should be accessible, coordinated and proactive.

So what is the current state of primary care in Havering and how does it need to be transformed to meet commissioners' requirements and the needs of local people?

Significant progress has been made in improving access to general practice, with the establishment of hub-based urgent evening and weekend GP appointments. However, local GPs and stakeholders have told us that the current model in primary care is unsustainable. The workforce is stretched, with recruitment and retention of staff challenging. Workload is

[1] Five Year Forward View NHS England, October 2014

increasing, and will do further with an ageing population, and practices cannot deliver the quality of care their patients need without becoming financially unsustainable. While national funds are available for clear, coherent transformation strategies, there is no additional on-going funding available in the system beyond funding potentially released through a proportional reduction in acute hospital care. Primary care needs to change to better meet demand and be a rewarding place to work and attractive to future potential recruits.

The CCG's vision is to combine primary care with other community-based health and social care into a place-based care model with productive general practice at its foundation and GPs overseeing care for their patients. This will involve the establishment of geographical 'localities' within Havering, each with a population of 50 to 70,000, as the basis of place-based care.

Locality-based care will be proactive, with a focus on prevention, support for self-care, active management of long-term conditions and avoidance of unnecessary hospital admissions. Patients will have a more joined-up care experience, be enabled to take more control of their care, and more of their treatment will be closer to home.

The locality-based care model has at its foundation highly productive GP practices working collaboratively to deliver care, free up GP time and reduce administrative costs, making best use of available IT solutions. General practice will lead a highly effective extended locality team of community, social care, pharmacy, dental and ophthalmology professionals and the voluntary sector providing local people with the majority of their care. With input from local patients, this team will decide local pathways, how the care workload is shared, and where care delivered from, in line with standards set and common assets managed at the BHR system level.

In configuration terms, locality teams will initially be virtual teams. General practice will have the opportunity to lead and shape the way locality provision develops, learning from the experience of joint working. In 2021, provision may continue in the form of an alliance of autonomous providers. Alternatively, by then, general practices may consolidate into a larger scale provider, or join with community and other providers into a multi-speciality community provider.

A system-wide programme will be established to refresh the roles and mix of professionals needed for locality-based care and to develop the career packages needed to sustainably attract and retain the GPs, nurses and healthcare assistants needed.

With the balance of care delivery shifting away from hospital care, a commensurate share of the existing funding envelope will fall to general practice and fellow locality team providers. In time, it is likely that contractual arrangements will change to incentivise population-level outcomes rather than reward provider activity.

The CCG aims to have locality-based care fully operational within two years. Key changes will be:

1. GP practices will work more productively and free up GP time to provide and oversee patient care.

2. Collaborative working between GP practices in localities and with the extended team of care professional will become established, raising quality and increasing capacity for locality care services and helping reduce the cost of administration.

3. Clear boundaries between primary care and acute hospitals, with good handovers between teams.

4. A programme will be put in place to recruit, develop and retain a primary care workforce suited to delivery in a place-based model in Havering.

5. Increasingly, reliable IT solutions will enable joined-up patient care and the automation of administrative tasks, and locality-based providers will adopt and use them with confidence.

2 Introduction

This strategy sets out a future vision for primary care in Havering in the context of wider change in Havering and the BHR health system, defines the overall scope and approach for the associated primary care transformation programme and provides a detailed plan for 2016/17.

The strategy addresses the future roles, form and sustainability of general practice specifically, given the role of the CCG in commissioning primary medical services. It also considers the future role of other primary care services such as community pharmacy, dentistry and ophthalmology as participants – along with community health, social care and voluntary sector providers – in integrated local care services.

Chapter 3 describes the drivers for change, summarising the commissioning agenda at national, London and local levels and presenting a thematic analysis of the issues and opportunities raised at grassroots level by local stakeholders.

Chapter 4 assesses the strategic options for a future primary care model, making the case for change, and Chapter 5 describes the future vision and how it addresses the drivers for change.

Chapter 6 describes what will change over the first two years of the programme and Chapter 7 presents the detailed 2016/17 plan.

In developing this strategy, we have engaged extensively with stakeholders a role in the Havering health and care economy: patient representatives, patient groups, GPs, practice managers, pharmacists, nurses, community and mental health services provided by NELFT NHS Foundation Trust, acute services provided by Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), the Partnership of East London Co-operatives (PELC), the Local Medical Council (LMC), the local authority, NHS commissioners and Care City. We have also consulted with primary care and workforce leads at NHS England London. Thanks are due to individuals who have provided their time and perspectives.

In formulating the vision, programme and plan we have worked closely with the BHR primary care transformation programme board. Many of the issues that have been identified in the development of this strategy are local and specific to Havering. Others we share with our neighbouring boroughs in Barking and Dagenham and Redbridge, and where we believe that a collaborative approach can be taken to addressing them, we will.

We have also consulted BHR commissioning colleagues responsible for parallel strategic work on planned care, mental health and urgent and emergency care to ensure alignment of vision and clarity on programme scope where proposals overlap.

3 Drivers for change

3.1 The commissioning context

3.1.1 National

Nationally, the NHS faces significant future challenge in the form of the increasing health needs and expectations of the population; changes in treatments and technologies; and increasing pressures on finances, both from reduced spending growth in the NHS and cuts to social care budgets. Current projections from Monitor and NHS England estimate that the NHS will face a £30 billion funding gap by 2020/21. To tackle these challenges within Government funding limits, the *Five Year Forward View*[2] sets out transformational change for the NHS to be driven by commissioners and realised by providers. This involves:

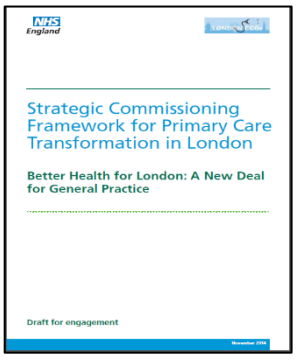
- Reducing variation in care quality and patient outcomes
- Increasing the emphasis on preventative care
- A shift towards more care being delivered in primary care
- Breaking down the barriers in how care is provided through the introduction of new models of care spanning current organisational boundaries
- Action on demand, efficiency and funding mechanisms to improve financial sustainability.

The *Five Year Forward View* recognised that primary care has been underfunded compared to secondary care and general practice faces problems with workforce, workload, infrastructure and care design. In response to this, the *General Practice Forward View*[3] offers funding opportunities and practical steps to stabilise and transform general practice through a plan focusing on:

- Growth and development of the workforce within general practice
- Driving efficiencies in workload and relieving demand
- Modernisation of infrastructure and technology
- Support for local practices to redesign the way primary care is offered to patients.

3.1.2 Regional

At a London level, the *Better Health for London*[4] report from the Mayor's Office contained a range of recommendations that related to primary care. In particular, it called for significant investment in premises, developing at-scale models of general practice and the need for ambitious quality standards. This vision for primary care was further



[2] Five Year Forward View, NHS England
[3] General Practice Forward View, NHS England
[4] London Health Commission: Better Health for London

articulated by the publication of the *Strategic Commissioning Framework for Primary care in London*[5] which outlines a key set of specifications (service offers) aligned to the areas that patients and clinicians feel to be most important:

- **Accessible care** – better access to primary care professionals, at a time and through a method that's convenient and based on choice.
- **Coordinated care** – greater continuity of care between the NHS and other health services, including named clinicians and more time with patients as and when needed.
- **Proactive care** – more health prevention by working in partnerships to improve health outcomes, reduce health inequalities, and move towards a model of health that treats causes and not just symptoms.

The 17 indicators under these themes will be used across London to ensure a consistent, high quality service offer is available across the city.

3.1.3 Local

Havering, along with the wider Barking and Dagenham, Havering and Redbridge (BHR) system, has a greater commissioning challenge than the national and London average. The system-wide budget gap for BHR is more than £400m, and the key challenges are set out in figure 1 below.

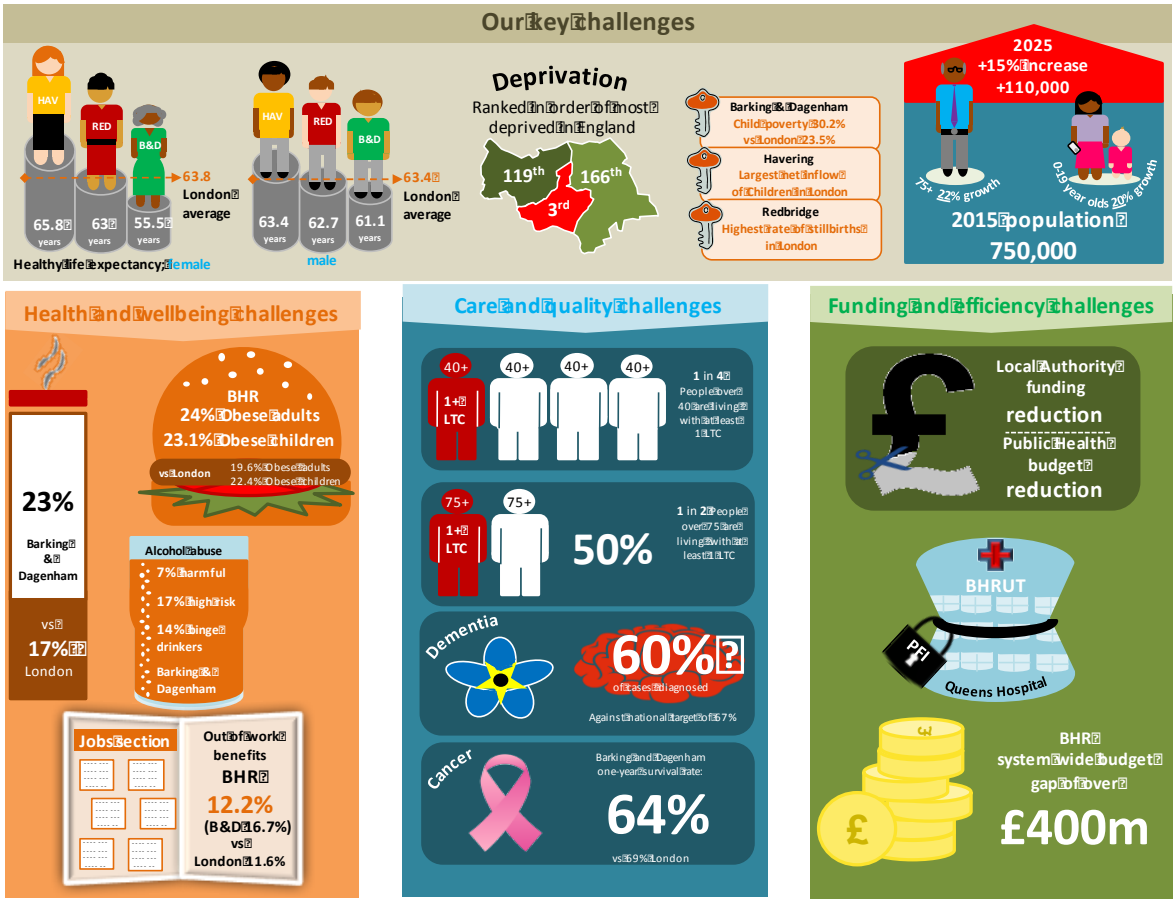


Figure 1: Key challenges for BHR CCGs

The BHR system needs to be transformed to:

[5] Transforming Primary Care in London, NHS England

- Meet the health needs of the diverse, growing and ageing populations in its various local communities
- Improve health outcomes for these populations and reduce health inequalities overall
- Meet national quality standards for care
- Close a £400m gap.

To achieve this, commissioners and local providers agree that acute hospital care should be reserved for acutely ill patients and deliver the majority of care nearer home, and that more emphasis is needed on prevention to improve outcomes and contain demand for care.

Local strategies

Within BHR, strategies are in development that will have a large impact on the transformation of primary care, in terms of future service configuration and contracts, supporting infrastructure, and work that must be coordinated to achieve maximum benefit across the local health system (e.g. workforce development). These include:

- A new model of urgent and emergency care, which will radically transform local urgent and emergency services, removing barriers between health and social care and between organisations. Urgent care will be simple for people to use and services will be consistent, no matter where people use them (i.e. by phone, online or in person). This will be enabled by the use of the latest technology to make care records accessible to patients and clinicians.
- The mental health and planned care strategies, which are in early stages of development.
- The preventative care strategy, which aims to allow all Havering residents to have the support needed to improve their health and wellbeing and to reach their full potential. This involves primary, secondary and tertiary preventative interventions and services to help people get the right care, in the right place, at the right time, enabling them to live independently and at home for as long as possible.
- The BHR partnership is currently drawing up a business case to explore opportunities through an Accountable Care Organisation (ACO) pilot. If implemented, it would deliver structural changes in the local health economy that align incentives and payment mechanisms to enable common goals and integrated working. The creation of an ACO locally would be a further demonstration of local ambition and see a large part of the budget currently controlled by NHS England and Health Education England devolved to the new body to spend on local needs. No decision to form an ACO has yet been taken by BHR partners.

Services within the scope of primary care include:

Preventative care	Health and wellbeing advice: healthy eating, physical activity, mental health, kicking bad habits
	Screening
	Immunisations
Planned care	Self-care, self-management with coaching, education and support from primary care to manage their condition and to have a plan for escalation/emergency
	Planned and preventative case management
	Pharmacy services: dispensing, medicine reviews, prescribing
	Enhanced services
	Specialist input
	Transitions between secondary care/reablement
Urgent and	Urgent care - holistic assessment, streaming, booking

emergency care	Minor ailments advice and treatment
	Planned GP appointment

3.2 Performance and future sustainability of the current primary care model

Our analysis shows that current performance is mixed and the current model will not be able to cope with higher demand and meet care quality expectation. The headlines are:

- Our primary care workforce is already stretched
- Demand is growing due to a growing and younger population, with high levels of migration in and out of the borough, and more patients having more than one long term condition
- A high proportion of GPs are nearing retirement, and recruitment and retention is challenging
- There is too much variation in primary care quality
- There has been substantial progress in improving the accessibility of general practice, but there remains more to do
- There is too much variation in patient satisfaction, particularly around access
- Some of our premises are poor quality
- Patients are being seen in a hospital setting for conditions that could be better managed in primary care.

3.2.1 Workforce

Our workforce is stretched, and recruitment and retention is challenging

Havering has some of the lowest rates of GPs per 1,000 population in London, with 0.47 GPs for every 1,000 registered patients, compared to a London average of 0.55 (see figure 2). The practice nurse picture is more positive with 0.2 nurses per 1,000 population, which is also the London average.

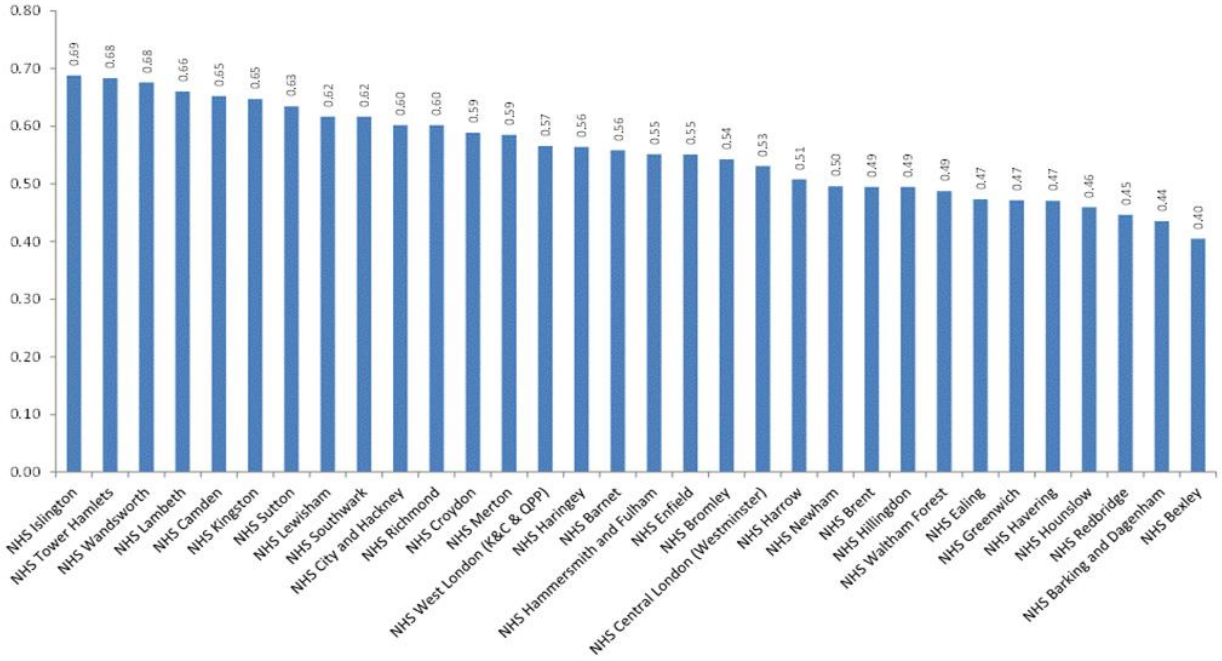


Figure 2. London CCGs rate of full time equivalent GPs (exc. registrars and retainers) per 1,000 patients

Traditionally, outer London has found it harder to attract newly qualified GPs than inner London. It is difficult both to recruit and retain salaried GPs and to attract GP partners in Havering, as well as other members of the primary care workforce. The reasons identified by stakeholders are set out in the following table.

Isolated GPs	Salaried GPs and long-term locums feel disenfranchised and isolated. High numbers of single handed GPs.
Older GPs	High proportion GPs reaching retirement age.
Older nurses	High proportion nurses reaching retirement age.
Overworked GPs	Lowest quartile of GPs per head of population in the country.
Nationwide shortage of GPs	Shortage of medical students going into general practice despite mandate from Health Education England. Training posts remain unfilled.
Cost of living in London	Inner London posts attract inner London weighting whereas outer London posts attract the lower band of outer London weighting.
Brand and reputation	Other parts of London are further ahead in marketing themselves and adjacent opportunities e.g. career development, research opportunities, honorary positions.

High proportion of GPs nearing retirement

In addition to the current challenges faced by the shortage of GPs working in Havering, the age profile (see figure 3) of the GP workforce signals that this challenge will be greater in future years. Havering has more than twice as many GPs over the age of 60 than the national average: 34% of GPs are over 60, compared to 15% in London and

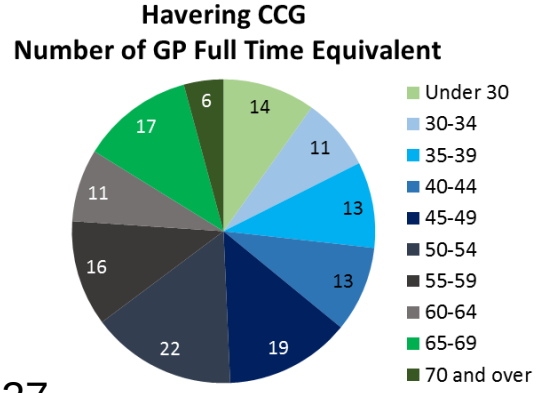


Figure 3: GP age profile, (practice reported): HSCIC General and Personal Medical

9% nationally (figure 3). With potential retirements in this already stretched workforce, this is clearly a local priority.

3.2.2 Workload

Local stakeholder interviews provided us with a consistent narrative of increased demand, increased workload and, especially, increased time spent on bureaucracy and administrative tasks. Havering's GPs find their current workload unsustainable. Many are overworked, and feel they are spending too much time on administrative tasks and chasing information, with not enough time for patient care. This work can be from external sources (e.g. patients who are discharged from secondary care with increased demands from primary care) as well as work generated within their practices (e.g. time spent on repeat prescriptions). Delegating care to other healthcare professionals/services can be difficult, with uncertainty over resources and capacity elsewhere in the system. Lack of information sharing between services makes it difficult for all members of the primary care team to know what other professionals are doing. This means work may be duplicated and confidence in the whole system working in an integrated way is reduced.

Patient behaviour also contributes to GP workload. Many patients find the primary care offer around urgent care confusing and will seek an appointment with their own GP, on top of contact with GPs/other professionals in urgent care, to 'check' their treatment is correct. Others still feel they need to see their GP for minor illnesses such as coughs and colds when another professional such as a community pharmacist could provide that care.

Population growth and demographic change – growing population and a rise in the number of patients suffering from one or more long term conditions

The population of Havering is growing and local healthcare needs are changing.

- Havering's population in 2014 was almost 246,000 and is projected to increase by 6%, 11% and 13% in 2020, 2025 and 2030 respectively.
- The largest increase will occur in children (under 18s) and older people (65 years and above). These groups are the most likely to access healthcare and older people are more likely to have a number of long-term conditions.
- More than 21,000 residents are aged 75 or over, of whom about 5,250 (25%) live alone. The retirement age population is expected to grow by almost 20% by 2025, even though the borough already has the highest proportion of pensioners in London.

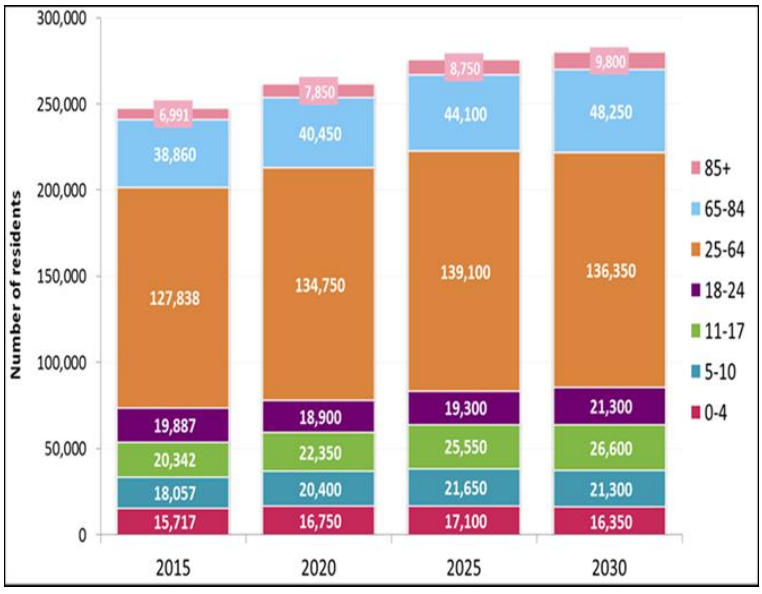


Figure 2. Havering projected population growth 2015-2030, ONS

Overall, it is a relatively affluent borough but has pockets of deprivation to the north and south. Life expectancy is 80 years for males and 84 years for females. Havering's population is predominantly white (83%) though this is a projected to decrease slightly to 80% in 2030 with the black African population expected to increase as a share of population.

Long-term conditions

In addition to the growth in population, Havering is seeing a growth in the number of people living with one or more long term conditions.

- About 10% of the population has caring responsibilities for someone who is ill, frail or disabled.
- Of those aged 75 and over living alone in the borough, almost 4,100 (41%) are living with a long term condition and 1,317 have dementia. In 2014, 357 elderly people needed hospital admission following a fall and 256 had a stroke.
- The annual patient survey (2015) indicated that 43% of patients in Havering do not feel they have enough support to manage their long term condition, against a national average of 36%.

General practice has a key role in the identification, treatment and management of long term conditions and mental health. These trends impact on the demand on GPs and the primary care team.

Improved care coordination is central to the model of care provided to patients with long term conditions. It has been shown to deliver better health outcomes, improve patient experience and is vital for people living with multiple conditions. Better care coordination is key to delivering an integrated health service. However, care coordination is complex and requires a shared approach across the healthcare system.

3.2.3 Quality

There is variation in the patient outcomes across Havering. General practice makes a significant contribution to improving the health of the population and influencing patient health outcomes. Across Havering there are examples of excellence in practice. We need to learn from these examples of excellence to reduce the variation that currently exists.

Quality outcome framework (QOF) achievement in Havering is an indicator GP practices will be familiar with, which highlights the needs for reducing variation in the quality of care between practices in the borough. The variance in QOF achievement in 2014/15 ranged from 282 to 559 (maximum). Lower QOF scores affect both the care of patients with long-term conditions and practice income.

CCG	Average achievement (559 maximum)	Lowest score	Highest score
Barking and Dagenham	530	458	559
Havering	516	282	559
Redbridge	522	443	559
London	521	139	559
England	530	139	559

Table 1: BHR CCGs QOF achievement, 2014/15

Achievement against the general practice outcome standards (GPOS) allow us to see how GP practices perform against a set of 26 indicators for quality improvement agreed with GP leaders, clinicians, the London-wide LMCs, commissioners and other health care professionals, think tanks and patient groups. Havering CCG has a higher proportion of GP practices rated as 'achieving' against GPOS compared to London as a whole. However, 29% of practices are in the lowest performing category of 'review identified' (14 practices). Practices in this category have nine or more triggers in total, or at least three level two triggers (where they are well below target/England average). For more detail on individual indicators where comparison to the England average is possible see figure 6 below.

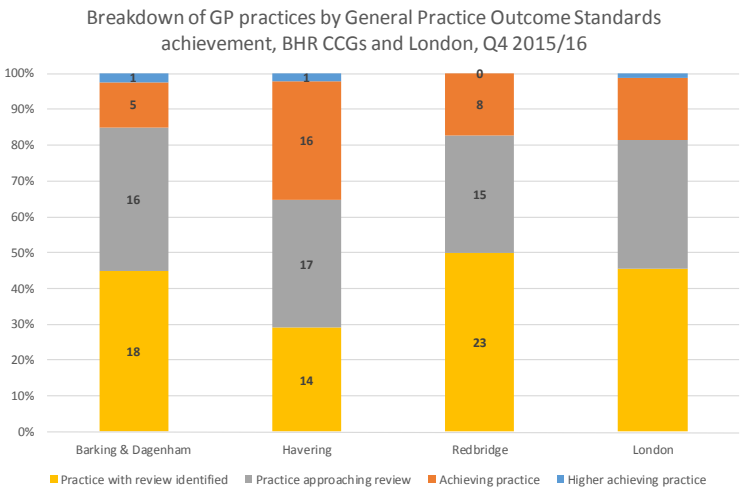


Figure 3: Breakdown of GPOS performance by BHR CCG

Indicator Name	Period	CCG Avg	England	Chart
4) Recording Smoking Status	Y13Q0	89.3	86.63	
5a) Smoking Cessation Advice	Y13Q0	97.08	94.65	
6c) Anti-Coag for AF	Y13Q0	84.32	84.66	
8a) Flu Vaccination (over 65s)	Y13Q0	71.22	72.99	
8b) Flu Vaccination (at risk)	Y13Q0	51.75	53.23	
13a) Dementia Diagnosis Rate (Adj)	Y14Q4	51.61	62.06	
14a) %Naproxen and Ibuprofen	Y14Q3	80.86	77.74	
17) Satisfaction (Quality) a-g	Y14Q2	610.57	623.9	
18) Satisfaction (Overall Care) a-b	Y14Q2	152.81	164.13	
20) Patient Experience	Y14Q2	60.26	58.86	
21) Satisfaction (Access) a-c	Y14Q2	233.67	246.9	
25) Detection Rate for Cancer	Y13Q0	52.05	47.57	
26c) Depression Assessment	Y13Q0	91.42	88.88	
27c) SMI Physical Health (BP)	Y13Q0	93.37	91.63	
27d) SMI Physical Health (d1+d2)	Y13Q0	171.96	167.66	

Figure 4: Havering CCG compared with national performance in general practice outcome standards

Key: Yellow diamond represents the CCG value; blue line the national average for the standard; yellow line the level one trigger value; red line the level two trigger value.

Some of our premises are of poor quality and need further investment

To ensure that patients receive high quality, accessible and safe care it is fundamental that general practice is able to deliver care from buildings that are fit for purpose and have the relevant facilities. Investment in primary care estates and IT has lagged behind investment in secondary care. Some general practices are working from inadequate buildings with limited facilities. This creates a poor environment for patients and staff. Much of the primary care estate is out-of-date, under-developed and cannot provide the facilities needed to deliver high quality care.

The primary care estate in Havering presents a mixed picture of some newer health clinics and some primary care services delivered from terraced housing. Some of the primary care estate is in poor condition, with a large number of single-handed practices operating out of old houses.

There are opportunities presented by the new modern primary care facilities, which now need to be fully utilised with extended opening hours. Most of these facilities consist of generic space that would benefit from sessional booking and use. This will allow for rationalisation of the remaining NHS Property Services sites, a lot of which are in poor condition and not fit for purpose.

An additional consideration for the primary care estate in Havering is the number of regeneration schemes that are planned in the borough. Havering is required to meet a target for the provision of 11,400 new homes by 2028 at a rate of at least 760 new dwellings per year. Securing the funding that is available to Havering Council from housing developers through funding to support public infrastructure, such as primary care, as a result of these developments.

There are variable levels of patient satisfaction, particularly in terms of access

Improving access to primary care professionals, at a time and through a method that's convenient and based on choice is outlined as a key priority for the delivery of primary care services in London. General practice core hours of operation are 8.30am to 6.30pm, Monday to Friday. The direct enhanced service for access incentivises practices to open additional hours outside of this core offer. Across Havering there are 11 practices, just under a quarter, that are not open during core hours and this impacts on the amount of access available to their patients

GP must be open more hours. Well trained and responsive reception staff

As part of the engagement on the development of this strategy, a survey was circulated to patients, carers and their representative groups to seek their views on local primary care services. Access to services was highlighted as an issue for some respondents and an area where things could be improved. The boxes on the right show a selection of the comments received about access.

It needs to be easier to get an appointment on the day

Access has been a key priority for primary care development in recent years and work has begun to develop the strong foundations for opening up access to patients across Havering. In collaboration with Barking and Dagenham and Redbridge CCGs integrated primary care services through access hubs during evenings and weekends are being offered across the network, provided by the local GP federations. This new model of extending access has so far achieved a 90% patient satisfaction rate and has opened up an additional c5,000 urgent care slots a month.

GP services are getting worse, unable to make an appointment by phone, nearly always engaged. Shorter hours than previously

Patients are being seen in a hospital setting for conditions that could be better managed in primary care

As the usual first point of contact for patients when accessing the healthcare system, primary care plays a crucial role in preventing unnecessary hospital attendances and admissions.

Across Havering the rate of patients attending A&E is similar to the London average. It may have been appropriate to treat some of these patients in primary care. Figure 7, on the next page, shows the attendance rate per thousand registered patients at each practice in Havering in 2013-14:

- The average attendance rate is 316 per 1,000 registered patients
- The London average in in 2012/13 was 312 per 1,000 population, which was the highest in the country
- Variation locally in A&E attendance rate by practice ranges from approximately 181 to 439 per 1,000 and is unlikely to be as a result of population factors alone.

This suggests that more can be done to treat patients in primary care, ensuring they have access to the care closer to home.

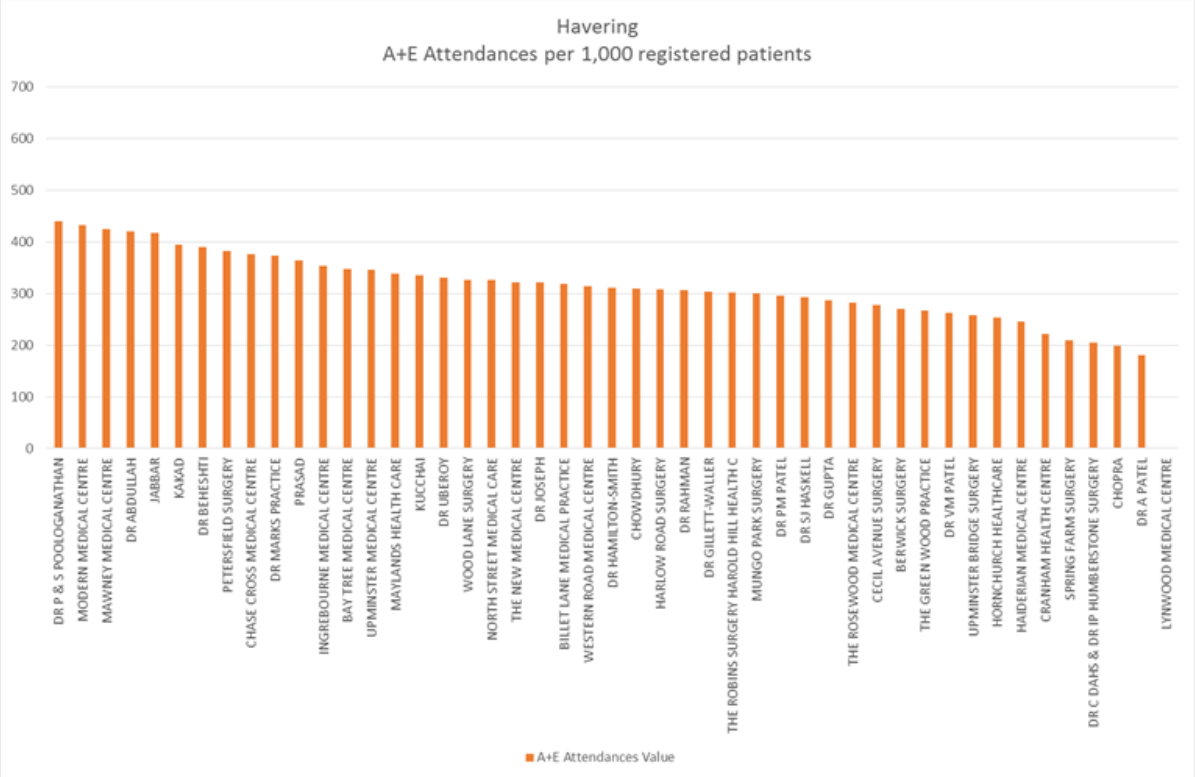


Figure 5: A&E attendance by practice per 1,000 population

Outpatient referrals show a similar trend with variation in referral rates varying across practices (figure 8).

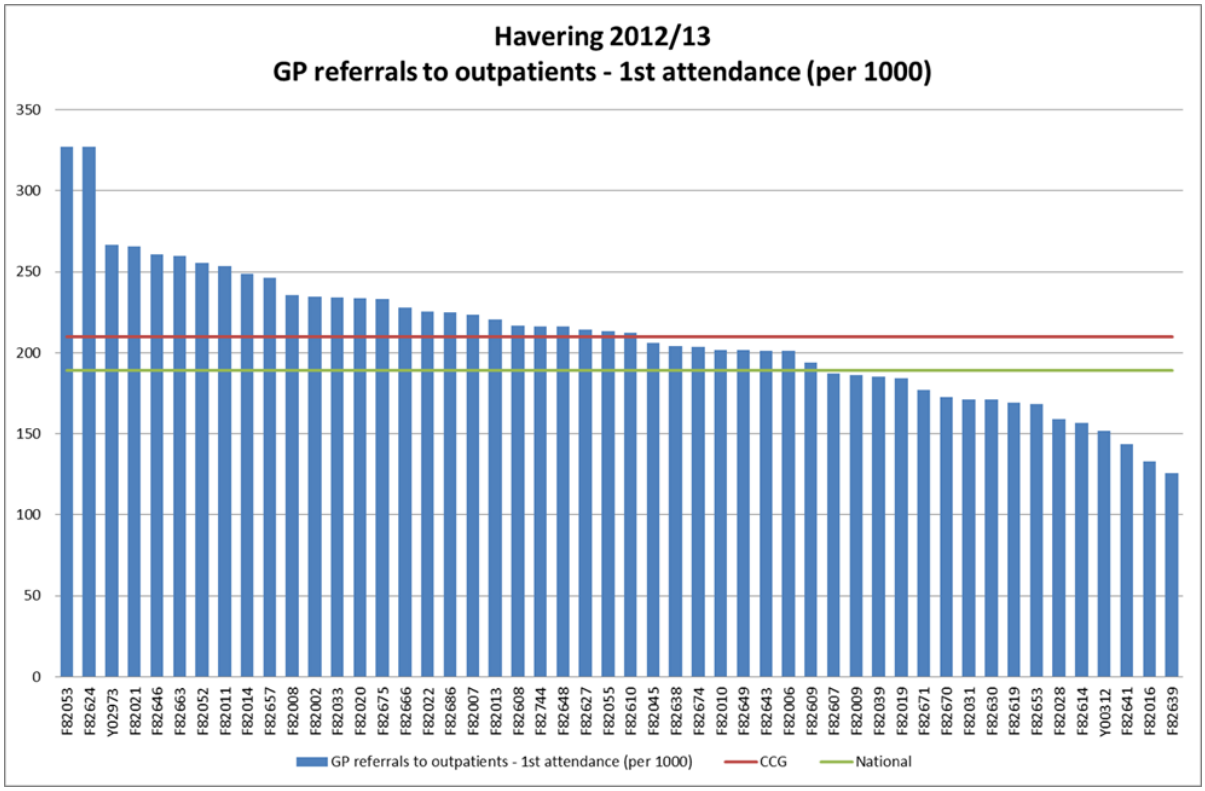


Figure 6. GP referrals to outpatients, first attendance by practice per 1,000 population

3.3 GP and stakeholder perspectives

We have consulted with patient representatives, general practitioners, practice managers, pharmacists, nurses, community and mental health services (NELFT), acute services (BHRUT), the local authority, NHS commissioners and Care City. We have also had conversations with primary care and workforce leads at NHS England London. Local stakeholders have identified issues with primary care as it is now, and potential solutions. There is wide recognition that transformation in primary care is both necessary and desirable.

A full thematic analysis of feedback is available from the primary care transformation team. The key themes are shown below:

Challenge	Aspiration	Solutions offered
The system is fractured – we work in silos and there is a lot of inefficiency and duplication	We want integrated health and wellbeing services that meet our populations' physical, mental and social care needs	• We want more focus on prevention • We need to help patients to self-care • Care should be close to home • Links and handovers between primary, community, secondary and social care should be seamless • To improve quality and reduce costs we should align incentives across providers.
Demands and expectations of GPs are too high	We need to re-define the role of the GP in relation to the rest of the primary care team	• GPs want to retain overall responsibility for their patients but not feel like they have to do everything • We want GPs to be able to delegate work/decisions to other members of the primary

		care team where appropriate • We want GPs to have more time for complex, planned and preventative work • We want the benefits of collective working but also need to balance that against the desire for GP autonomy.
Our workforce is stretched and the workload is getting bigger	There are ways we could tackle our workload and workforce challenges	• We could share staff • We could pilot new care pathways and ways of working • By enhancing people's skills we could enable more sharing of the workload • Shared education and training would help team working and build relationships between professionals • We could train hybrid health and social care workers • Building communities of practice and support across professions would reduce feelings of isolation and allow us to share knowledge • Sharing back office functions would cut down on work.
We are committed to our patients and do some things really well	We want to build on what already works	• We want to roll out the successful pilots we already have • We want to keep what works well.
Poor use of technology and low quality facilities makes our work harder	To do our jobs well we need fit for purpose buildings and good IT	• We need good IT and digital platforms to improve self-care and access for patients • We need integrated IT to improve quality and reduce workload.

4 Primary care strategic options

4.1 Requirements

In summary, the drivers for change described in the previous section give us a set of requirements a new primary care model must aim to meet. These are:

Delivery

- Meet the health needs of the diverse, growing and ageing populations in its various local communities
- Contribute substantially to the improvement of health outcomes for these populations and the reduction of health inequalities overall
- Meet national and regional quality standards for primary care, ensuring care is accessible, coordinated and proactive
- Increase capability/capacity to deliver the majority of patient care – planned, mental health and urgent – out of hospital with a focus on prevention, reducing demand for acute care and enabling savings of £400 million across BHR.

Patient experience

- Patients can continue to benefit from a relationship with their local GP
- Patients receive a joined-up, cost-effective care service with unnecessary duplicate assessment and treatment avoided.
- Patients find it easier to access appropriate primary care

General practice

- Productive GP practices can retain their autonomy and have a financially sustainable future
- GPs have the time they need to provide quality patient care
- The time and effort spent by GPs and practice colleagues on administrative tasks is minimised
- The respective roles and responsibilities of GP practices and all local care providers in delivering care are clearly defined and consistently applied day-to-day by all parties.

Workforce

- The career offer and working environment for GPs in Barking and Dagenham are sufficiently compelling to retain existing GPs and attract new enough recruits.

Infrastructure

- GPs and their fellow professionals can rely on IT to present the information about their patients that they need at the point of care to make the best decisions for patients
- Care is delivered in premises that are fit for purpose in a way that makes the best use of existing assets.

4.2 Strategic options

We have identified five possible options for the transformation of primary care in Havering over the coming five years:

1. “Do nothing” – retain the existing model at current levels of funding.
2. Retain the existing model and increase funding.
3. Invest in improving the quality and productivity of general practice and make it sustainable.
4. Extend primary care incrementally to become a place-based model of care, whereby general practice and other primary and community-based providers collaborate to deliver proactive, joined-up care out of hospital for a local population.
5. Building on the Five Year Forward View, move directly to merging the provision of general practice and community-based care and create a new form of provider, such as a multi-speciality community provider.

Our analysis in section three demonstrates that option one is not sustainable.

Option two is neither clinically sustainable nor financially viable. BHR has a system wide budget gap of over £400m, and there is no additional funding available in the system beyond funding potentially released through a proportional reduction in acute hospital care.

The current primary care model therefore needs to change. A focus on improving general practice (option three) meets a number of the requirements above, but is not sufficient to create the capability and capacity needed to deliver the majority of patient care, or to transform care so it is joined-up and cost-effective with unnecessary duplicate assessment and treatment avoided. This would require closer integration of general practice with other primary and community-based care (option four).

Our recommendation is a vision which combines the strengthening of general practice (option three), maintenance of the patient-GP relationship and the continued autonomy of practices, with the extension of primary care to become place-based care (option four).

Experience of collaborative working in a virtual team may, in time, build a case to move to new forms of provider configuration (option five), but change should be made incrementally by local care professionals with a focus on what will improve services for patients.

5 The vision for primary care in Havering

5.1 Vision for primary care

The CCG's vision is to combine primary care with other community-based health and social care into a place-based care model with productive general practice at its foundation and GPs overseeing care for their patients. This will involve the establishment of geographical localities of 50-70,000 population within Havering as the basis of place-based care. Locality-based care will be proactive, with a focus on prevention, support for self-care, active management of long term conditions and the avoidance of unnecessary hospital admissions. Patients will have a more joined-up care experience, be enabled to take more control of their care, and more of their treatment will be closer to home.

The locality-based care model has at its foundation highly productive GP practices working collaboratively to deliver care, free up GP time and reduce administrative costs, making best use of available IT solutions. General practice will lead a highly effective extended locality team of community, social care, pharmacy, dental and ophthalmology professionals and the voluntary sector providing local people with the majority of their care. With input from local patients, this team will decide local pathways, how the care workload is shared, and where care is delivered from, in line with standards set and common assets managed at the BHR system level.

Collaborative working will include GPs deciding how GP practices will work collectively across localities to offer services to patients both within routine and extended opening hours, as defined by the strategic commissioning framework standards, and how collective working to manage workload will create more time for extended appointments. Localities will also decide what blend of services best meet local need and standards, for example the number of appointments available with GPs and other health professionals, and where those appointments will be offered (e.g. GP practices, hubs). To see how locality-based care will meet each strategic commissioning framework standard, see Appendix A: Strategic Commissioning Framework delivery plan.

In configuration terms, locality teams will initially be virtual teams. General practice will have the opportunity to lead and shape the way locality provision develops, learning from the experience of joint working. In 2021, provision may continue in the form of an alliance of autonomous providers. Alternatively, by then, general practices may consolidate into a larger scale provider, or join with community and other providers into a multi-speciality community provider.

A system-wide programme will be established to refresh the roles and mix of professionals needed for locality-based care and to develop the career packages needed to sustainably attract and retain the GPs, nurses and healthcare assistants needed.

With the balance of care delivery shifting away from hospital care, a greater share of the existing funding envelope will fall to general practice and fellow locality team providers. In time, it is likely that contractual arrangements will change to incentivise population-level outcomes rather than reward provider activity.

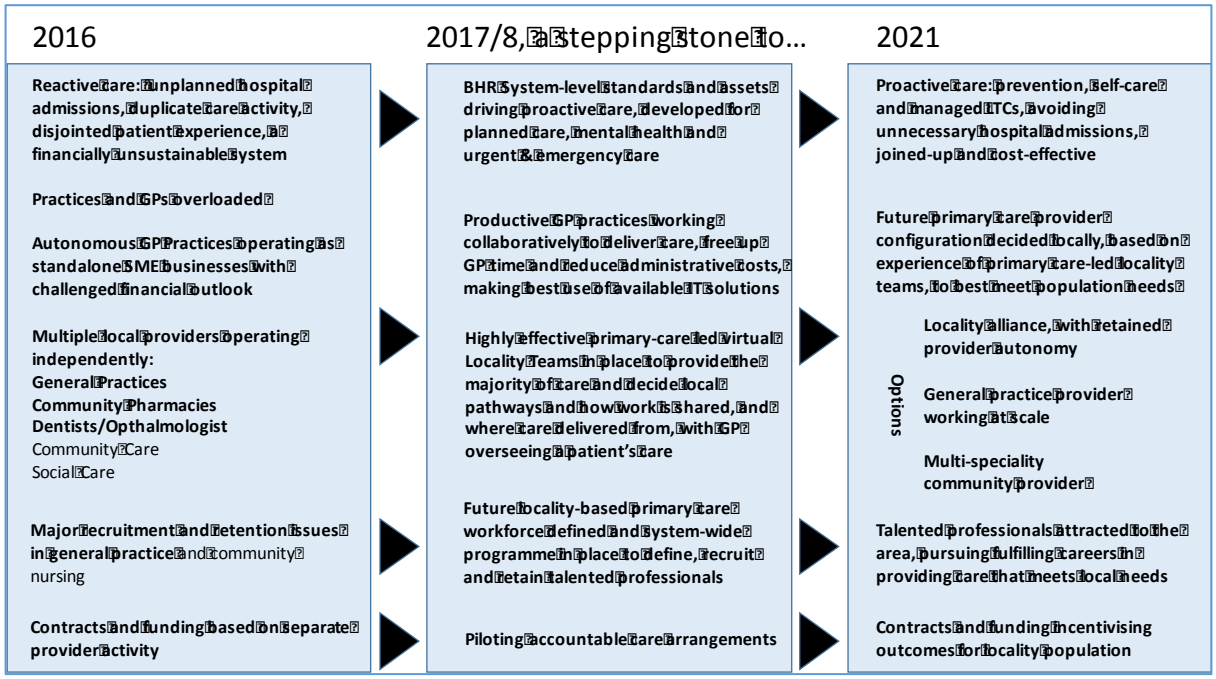


Figure 9. Milestones in journey towards achieving the vision

5.2 What is place-based care?

The King's Fund proposes place-based care as a way to create an environment where health care organisations can effectively work together towards improving health outcomes for the populations they serve. By pooling their resources, providers are freed from the pressure to focus on their own services and organisational survival to the potential detriment of other organisations within the health economy. In place-based care, providers collaborate to manage pooled resources, enabling them to consider the whole health economy when making decisions and to better use resources to meet their local populations' needs. Place-based care is not about top-down change, it's about enabling local systems of care to develop ways of working that effectively meet population need. The King's Fund's framework for developing place-based models of care will be used to develop the model in Havering. More details on this framework are in Section 6.4.3.

Evidence advanced by the King's Fund, drawing on examples from New Zealand, Chenn Med, is that place-based care works best with a population of 50-70,000 people. Havering has a history of working in clusters of 25-50,000 population, so it is proposed that existing clusters (see Appendix B) are reconfigured into localities of 50-70,000 and that place-based care be established within these new locality boundaries.

5.3 How will place-based care in a Havering locality work?

The vision for general practice-led, locality-based care is summarised in figure 10 below. As now, it is founded on GP practices.

Providers and professionals working collaboratively

The locality-based care model comprises multiple layers, operating in parallel:

- Individual GPs, supporting, treating and referring patients on their list, taking, where appropriate, oversight of their care across the system, equipped with the information they need to do so
- Productive GP practices, effective at managing and prioritising their workload, using the full resources of the practice and making best use of IT solutions to free up GP time for patient care
- GP practices working within collaborative arrangements to deliver primary medical and additional services and to manage administrative activity more cost-effectively; existing federation arrangements may offer a starting point for this
- General practice leading an extended multi-professional team of community, social care, pharmacy, dental, ophthalmology and voluntary sector services.

The team in a locality will be sufficiently small (averaging circa 100 team members) to allow the formation of trusted working relationships between clinicians and care workers from different organisations and professional backgrounds, which will be important in improving care quality, patient experience and productivity. The inclusion of patients in that team of 100 will be key for the co-design of services with the population they serve.

It is assumed initially that general practice and fellow providers will come together in a virtual team, with the option to evolve into more formal organisational structures for collaborative working based on experience from delivering care collaboratively.

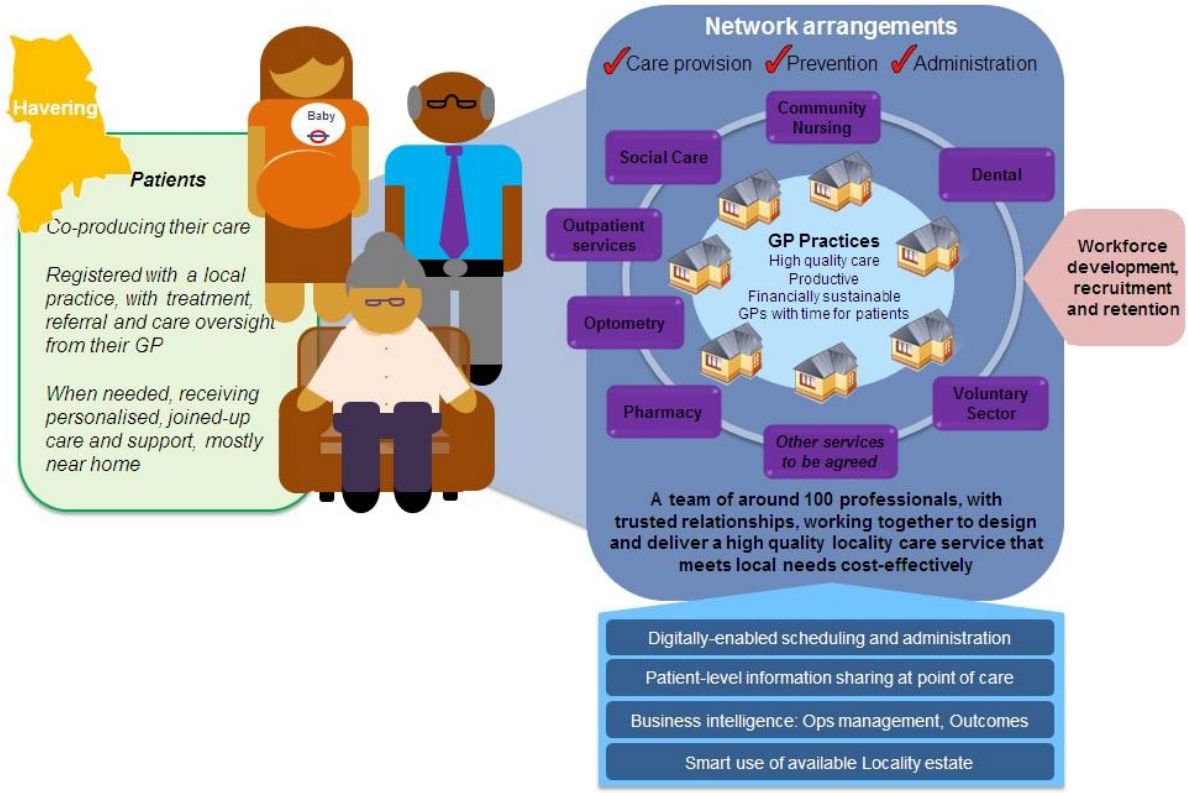


Figure 10. General practice-led locality-based care

Building a locality strategy and plan

To ensure equity and quality of care, localities will need to provide services which meet NHS England's strategic commissioning framework quality standards, and with BHR ambitions set

within a formal quality improvement framework with evaluation via the system's agreed primary care transformation dashboard (Appendix C: Primary care transformation dashboard indicators

Primary care Indicator	Item	Performance Indicator	Description	Source
Diabetes	Proactive Care	Diabetic retinal screening uptake	The proportion of those offered diabetic eye screening who attend a digital screening event	
	Treatment	% Blood pressure of 140/80 mmHg or less	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less.	
		% Cholesterol of 5 mmol/l or less	The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less.	
		% HbA1c is less than 59 mmol/mol	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months.	
		% of newly diagnosed referred to education programme	The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register.	
	Outcome	Admissions due to diabetes	Rate per 1,000 population aged 17+ years	HSCIC
		Preventable sight loss - diabetic eye disease	New Certifications of Visual Impairment (CVI) due to diabetic eye disease aged 12+, rate per 100,000 population. The numerator counts for this indicator includes sight loss due to diabetic eye disease as the main cause or if no main cause as a contributory cause. (These are not counts of diabetics with visual impairments due to any cause)	PHE
		Emergency hospital admissions: diabetic ketoacidosis and coma	Emergency hospital admissions: diabetic ketoacidosis and coma, indirectly age standardised rate per 100,000 persons	HSCIC
		Years of life lost due to mortality, males	Years of life lost due to mortality from diabetes: directly standardised rate per 10,000 European Standard Population, 1-74 years, 3-year average, males	
		Years of life lost due to mortality, females	Years of life lost due to mortality from diabetes: directly standardised rate per 10,000 European Standard Population, 1-74 years, 3-year average, females	
		Diabetic foot amputation	No. of hospital admissions per 100,000 population related to diabetic amputations	SUS/HES
COPD	Proactive Care	Smoking cessation uptake	Crude rate of successful four week quitters per 100,000 population aged 16+ years	PHE
	Treatment	Bronchodilator spirometry	COPD002: The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register	HSCIC
		Health care review	COPD003: The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months	
		Smokers with COPD diagnosis	% of patients referred to stop smoking clinic with denominator as total number of smokers with COPD diagnosis	Health Analytics
		Patients with MRC 3 and above	The % of patients with MRC score 3-5 referred for pulmonary rehabilitation / total number of patients with MRC 3 and above	
		COPD with self management plan	% of patients with severe or very severe Copd who have self management plan/ total number of patients with severe or very severe	
		Smoking prevalence	Percentage of COPD patients who are recorded as currently smoking	Health Analytics
		COPD severity	Mild COPD, confirmed COPD patients with latest predicted FEV1 ≥80%	
			Moderate COPD, confirmed COPD patients with latest predicted FEV1 ≥50% <80%	
			Severe COPD, confirmed COPD patients with latest predicted FEV1 ≥30% <50%	
			Very severe COPD, confirmed COPD patients with latest predicted FEV1 <30%	
	Outcome	Emergency Admissions due to COPD	Rate per 100 patients on the disease register	HSCIC
		Under 75 years of age mortality rate from respiratory conditions considered to be preventable	Age-standardised rate of mortality considered preventable from respiratory disease in those aged <75 per 100,000 population	PHOF
Cancer	Proactive Care	Bowel Screening Uptake	Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)	HSCIC
		Percentage of cancers detected at stage 1 and 2	Early Diagnosis and treatment of cancer	
	Treatment	Two Week Wait Referrals	Percentage of two week wait referrals who have been seen by a specialist within two weeks of an urgent referral by their GP for suspected cancer	Cancer Commissioning Toolkit
			Number of two week wait referrals (TWR) with cancer diagnosis	
	Outcome	Premature mortality from all cancers	Standardised rate of premature deaths (<75 years old) per 100,000 population	PHE
		Premature mortality from lung cancer	Standardised rate of premature deaths (<75 years old) per 100,000 population	
		Premature mortality from breast cancer	Standardised rate of premature deaths (<75 years old) per 100,000 population	
		Premature mortality from Colorectal cancer	Standardised rate of premature deaths (<75 years old) per 100,000 population	
		Emergency admissions due to cancer	Direct standardised rate per 100,000	HES
Cardiovascular Disease	Proactive Care	NHS Health Check uptake	Cumulative % of uptake amongst eligible population	PHE
		Atrial Fibrillation	AF002: The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS2 risk stratification scoring system in the preceding 12 months (excluding those whose previous CHADS2 score is greater than 1), NICE 2011 menu ID: NM24	HSCIC
	Treatment	Atrial Fibrillation	AF004: In those patients with atrial fibrillation whose latest record of a CHADS2 score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy, NICE 2011 menu ID: NM46	HSCIC
		Coronary Heart Disease	CHD002: The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	
			CHD003: The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less	
			CHD005: The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	
		Hypertension	HYP002: The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less	
	Outcome	Heart Disease and Stroke	Premature mortality, rate per 100,000	Healthier Lives, Mortality Rankings - PHE
		Stroke, emergency hospital admissions	Emergency hospital admissions for stroke, indirectly age standardised rate per 100,000, all ages	HSCIC
		Emergency admissions for Hypertension patients	Emergency hospital admissions per 100 individuals on Hypertension LTC list	Health Analytics

Primary care Indicator	Item	Performance Indicator	Description	Source
Mental health	Proactive Care	New diagnosis of depression who have had a review	DEP002: The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 35 days after the date of diagnosis, NICE 2012 menu ID: NM50	HSCIC
		Dementia diagnosis rate	The Diagnosis rate indicates the proportion of patients with dementia on a practice list or within a group who have a diagnosis of dementia. The total number from the aNDPR, and the number with a diagnosis on the QOF dementia register.	HSCIC
		Early interventions, psychosis	New cases of psychosis served by Early Interventions team, annual rate per 100,000 population	PHOF
	Treatment	Access to community mental health services by people from Black and Minority Ethnic (BME) groups	Crude rates per 100,000 population	HSCIC
		Proportion of adults in contact with secondary mental health services in paid employment	The measure (percentage of adults) is intended to measure improved employment outcomes for adults with mental health problems. Employment is a wider determinant of health and social inequalities	
		Blood pressure recorded	MH003: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months, NICE 2010 menu ID: NM17	
		Improving Access to Psychological Therapies (IAPT)- Referrals	The number of people who have been referred to IAPT for psychological therapies during reporting period.	NELFT
		Improving Access to Psychological Therapies (IAPT)- Recovery	The number of people who have completed treatment and are moving to recovery	
		Blood Glucose or HbA1c recorded	MH005: The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months, NICE 2011 menu ID: NM42	HSCIC
	Outcome	Unplanned readmissions to mental health services within 30 days of a mental health inpatient discharge in people aged 17 and over	Indirectly age and sex standardised ratio of unplanned readmissions to a mental health service	HSCIC
		Emergency hospital admissions: schizophrenia	Indirectly age (15-74) standardised rates	
Learning Disabilities		Ldis Health Check uptake	% of QOF recorded LD population who have had LD health check in last 12 months	Health Analytics
GP Survey	ED 1	Rating of GP giving you enough time		GPPS
		Rating of GP listening to you		
		Rating of GP explaining tests and treatments		
		Rating of GP involving you in decisions about your care		
		Rating of GP treating you with care and concern		
		Rating of nurse giving you enough time		
		Rating of nurse listening to you		
		Rating of nurse explaining tests and treatments		
		Rating of nurse involving you in decisions about your care		
		Rating of nurse treating you with care and concern		
	ED 2	Overall experience of GP surgery		GPPS
	ED 3	Overall experience of making an appointment		GPPS

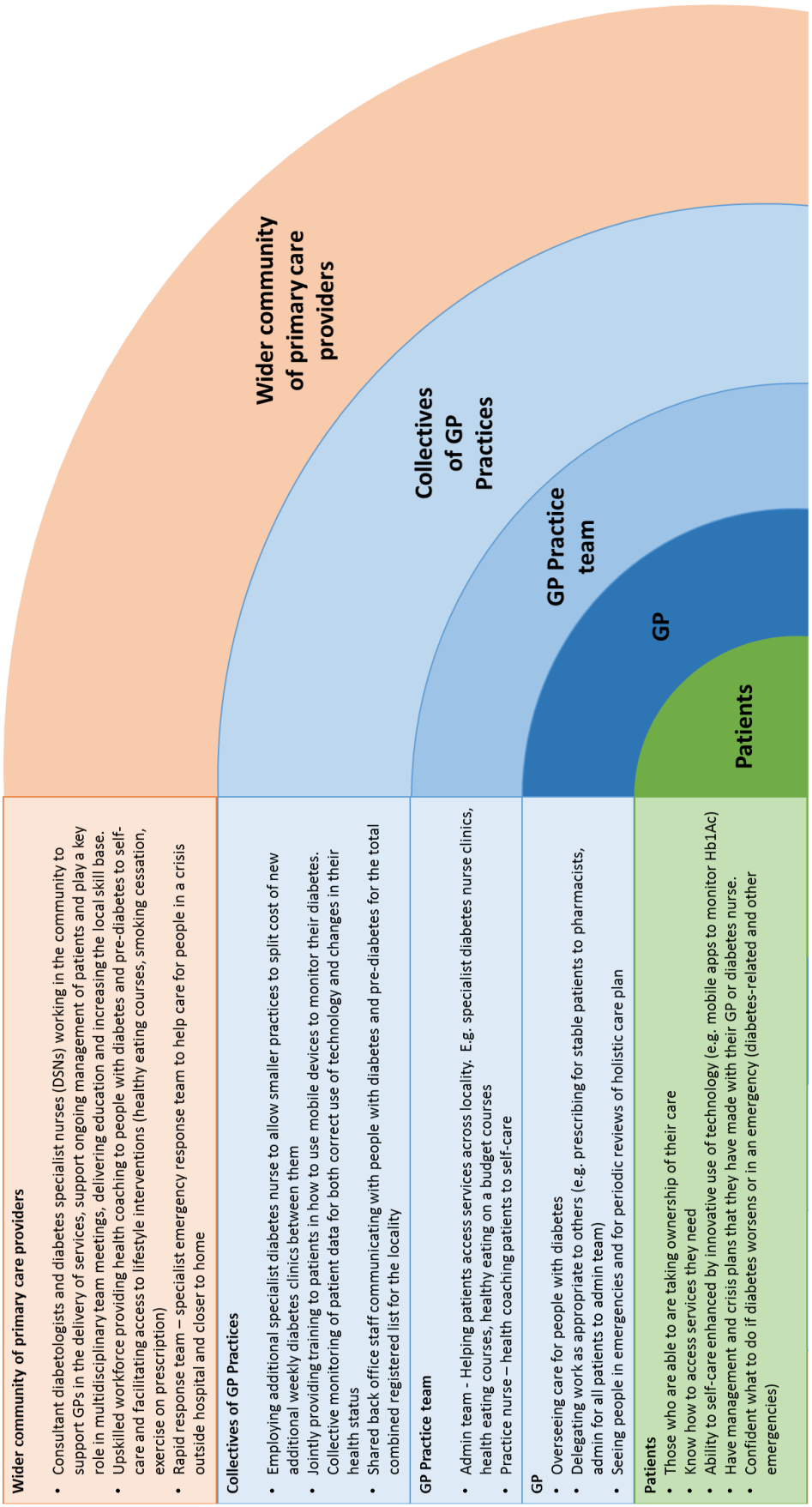
). Within this framework, locality teams will develop a shared strategy and plan to meet the needs, priorities and preferences of the population they serve. They will decide what resources will best meet local health needs, and the specific health outcomes they want to target and track.

Localised pathway design

Pathway design within each locality will be informed by BHR standards for pathways for preventative, planned, urgent and mental health care. Within these standards, localities will be supported to design the pathways that work best for their population. Pathway design at locality level will include:

- Deciding the division of responsibility for delivery of primary care services across GP practices individually, GP practices collectively and the extended team
- Thresholds and protocols for referral to, and discharge from local hospital services
- The relative proportion of GP practice appointment time to be made available for prevention, planned and unplanned care.
- How the locality will utilise the planned new urgent and emergency care ‘click, call, come in’ capacity as part of its urgent care offer
- How care across providers is joined up around the patient
- How providers all play to their strengths
- How quality is assured.

Figure 11: example of how the mix of services might be distributed across the locality team



Enablers and support

BHR CCGs will provide investment and support in the enablers of this vision for primary care-led locality working. They will:

- Provide each locality with dedicated resources to support the development of locality working.
- Identify solutions for the recruitment, retention and development of the GP workforce, as well as nursing, pharmacists and practice management. Other roles, including primary care healthcare assistants, may need to be developed.
- Develop funding and contractual arrangements for primary care and the wider system to incentivise joined-up care, prevention and avoidance of avoidable hospital admissions.
- Enable GPs and the extended primary care team to operate from fit-for-purpose premises, making best collective use of local public service estates.
- Support both patients and their care providers to be confident users of information and IT solutions that enable self-care, care scheduling, joined-up care planning and management, and safe clinical decision-making.

At the same time, the financial sustainability of the system will be enhanced through the de-duplication and appropriate automation of administrative functions, releasing more patient-facing time.

Local authority partners

- Social care services will make up a core part of locality-based teams
- Public health will contribute in a number of ways:
    - input into needs assessments for each locality
    - map the current social capital available within each locality
    - commission services that focus on prevention of ill health
    - evaluate the impact of prevention on care capacity.

Evolution of the way providers are organised and work together

In configuration terms, locality teams will initially be virtual teams. General practice will have the opportunity to lead and shape the way locality provision develops, learning from the experience of joint working. Provision may continue in the form of an alliance of autonomous providers. Alternatively, by 2021, general practices may consolidate into a larger scale provider, or join with community and other providers into a multi-speciality community provider. Local authorities will have joint oversight of the evolution of the system so it continues to meet population need.

5.4 What is the vision for workforce in general practice and the locality?

Throughout our stakeholder interviews, there was a shared vision of integrated primary, community and social care working at a locality level with the patient and GP in the centre.

This strategy, therefore, makes recommendations for the primary care workforce for the first two years whilst the landscape becomes clearer with other strategies and initiatives. These recommendations will create the framework for a more engaged, mature and agile locality-based primary care team empowered to "sense and respond" in a fast-changing world.[6] This will allow benefits from working as part of BHR but will also be locally driven.

[6] Frederic Laloux: Reinventing Organizations: A Guide to Creating Organizations Inspired by the Next Stage of Human Consciousness (Nelson Parker,2014).

As the vision is very much about empowering localities to co-design and deliver locally appropriate solutions, we have set out a range of potential options proposed by stakeholders for workforce development within locality settings. Localities can choose to adopt solutions that suit their population's and workforce's needs. These are set out in Appendix D: Workforce development in primary care.

5.5 What would locality-based care mean for a GP practice in 2018?

Different ways of working will develop within each locality, but GPs will see key changes in their day to day working across Havering take place over the next two years.

1. GP practices will work more productively and free up GP time to provide and oversee patient care.

I'm a Practice Manger for quite a big practice (nine FTE GPs). I did a bit of work with one of our partners looking at the activity in our practice using a tool developed by the RCGP, which we found out about at one of the locality support sessions. I found the tool really helpful, not least because while everyone at our practice feels stretched and that things could be more efficient, they all have different opinions about what the problem is! Having the information about how we were spending our time in black and white made it a lot easier to agree what we should focus on, and ways we could change it.

We realised that a lot of GP time was spent on patients that could be seen by someone else in the practice. For example, GPs were doing routine blood pressure checks that could have been done by the nurse; hospital referral chasing that could have been done by reception; repeat prescriptions could have been done by our admin team. We talked through a couple of options that we'd gone through at a locality workshop and decided we would try 'process triage' at our practice. That means getting reception to ask what appointments were for and directing the routine checks, repeat prescriptions, coughs etc to alternative members of staff or the pharmacy. Of course, if a patient doesn't want to say why they want a GP appointment, we don't push them to say, it's just where they are happy to give that information. It's also not infallible; sometimes patients do reveal they have another problem which needs GP attention during their nurse appointment. Even taking all that into account, we managed to move about 10-15% of our GPs' workload onto other members of the practice team. That frees up about a day a week of GP time that can be spent on more valuable work.

2. Collaborative working between GP practices in localities and with the extended team of care professional will become established, raising quality and increasing capacity for locality care services and helping reduce the cost of administration.

I'm a partner in a small practice and, like many practices, we have a lot of patients with diabetes. A specialist nurse helping to care for these patients would really improve these peoples' care, but we don't have the resources to employ a full-time specialist nurse, and have never been able to recruit one on a part-time basis. Because the practices in our locality have all outsourced our payroll and HR through the same company, it's been easy to join up with two other small practices to create a full-time role for a specialist diabetes nurse that we share between us. We share the cost of her salary, and all our patients get the benefit of specialist nursing. Our nurse likes the variety and was attracted by the full time job close to home. Our practices are close together so it's similar for her in terms of travel, and she's never working too far away from her son's nursery either.

We don't just outsource as a locality though; we also share work between our existing staff. We realised there are a lot of tasks that we didn't want to outsource, but that didn't

make sense for every practice to do its own. Our practice managers have divided up this work we all do between them and now focus each team on doing one thing (e.g. call-recall) really well for the whole locality.

3. Clear boundaries between primary care and acute hospitals, with good handovers between teams.

I used to spend hours chasing up information about my patients that had been discharged from hospital, making sure I knew what care needed to be in place and that it was happening. It was very often reactive, non-medical work, that was draining and frustrating. Having better information flows with our local hospital has improved things a lot. Joined-up IT means I have much more of the information I need to manage patients post-discharge. Reducing the administrative burden associated with discharged patients means I have more time to focus on planned care. For example, working on emergency plans with those patients who are likely to require acute care when their condition deteriorates. By having those plans in place with patients, and other services they will need, we can make the transition between primary and secondary care much better for those patients.

4. A programme will be put in place to recruit, develop and retain a primary care workforce suited to delivery in a place-based model in Havering.

After years of trying, six months ago I finally recruited a new salaried GP to my practice and it's made a huge difference. Before she started I'd been reliant on locums and working myself into the ground. I used to regularly think to myself 'I'm a GP in my prime, I'm highly skilled, do I really want to do this for another 20 years when I could have a much, much nicer life in Australia?!'. Having another full time GP that's committed to the practice and the patients has really helped take some of that pressure off.

I think the recent changes have helped make our borough an attractive option for newly qualified GPs, when they wouldn't have considered it a few years ago. Now we're getting a reputation as the top place in London for innovation, what with the Vanguard and work on integration. She wanted to work somewhere where she would definitely be developed, on top of getting experience in all the multiprofessional working. It also helps that the CCG have got a bit slicker at marketing the area - good house prices compared to the rest of London and so on – as well as the work we do.

5. Increasingly, reliable IT solutions will enable joined-up patient care and the automation of administrative tasks, and locality-based providers will adopt and use them with confidence.

I knew that joined-up IT would release a significant amount of time that my receptionists used to spend printing and scanning paper documents. What I hadn't really expected was the difference it's made in terms of building trust in my colleagues outside my practice, and the benefits that has brought me in my job as a GP. It's not just that I started to build relationships with them in joint IT training sessions, or during Skype MDT meetings. Having shared records where we can access the information we need means I can easily see what community nursing, pharmacies, social care etc are doing to care for my patients. For example, if a patient needs a home visit after coming out of hospital, I can

see when it's happened, what the outcome was and who is doing what. I don't have to hunt for that information, or call to double-check. It's just there. It means that I can really focus on what I need to do as a doctor for my patients, keep an overview of their care, but not feel like I have to do everything myself to be sure it will get done.

5.6 What would be the benefits of locality-based care for patients?

Across primary care there will be an overall improvement in quality of primary care in Havering, and a reduction in the variation of quality between GP practices. Patients will benefit from care that is more proactive, accessible and coordinated, as out outlined in the patient offer of the strategic commissioning framework. Their experience will be of an integrated service that supports and improves their health and wellbeing, enhances their ability to self-care, increases health literacy, and keeps people healthy. Primary care will be personalised, responsive, timely and accessible, and provided in a way that is both patient-centred and coordinated.

Practices across Havering will show improvement in the quality of treatment for key cancer, COPD, diabetes, mental health and patient satisfaction indicators (including four patient access indicators), as measured by progress against baseline in the primary care transformation dashboard (Appendix C: Primary care transformation dashboard indicators

Primary care Indicator	Item	Performance Indicator	Description	Source
Diabetes	Proactive Care	Diabetic retinal screening uptake	The proportion of those offered diabetic eye screening who attend a digital screening event	
	Treatment	% Blood pressure of 140/80 mmHg or less	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less.	
		% Cholesterol of 5 mmol/l or less	The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less.	
		% HbA1c is less than 59 mmol/mol	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months.	
		% of newly diagnosed referred to education programme	The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register.	
	Outcome	Admissions due to diabetes	Rate per 1,000 population aged 17+ years	HSCIC
		Preventable sight loss - diabetic eye disease	New Certifications of Visual Impairment (CVI) due to diabetic eye disease aged 12+, rate per 100,000 population. The numerator counts for this indicator includes sight loss due to diabetic eye disease as the main cause or if no main cause as a contributory cause. (These are not counts of diabetics with visual impairments due to any cause)	PHE
		Emergency hospital admissions: diabetic ketoacidosis and coma	Emergency hospital admissions: diabetic ketoacidosis and coma, indirectly age standardised rate per 100,000 persons	HSCIC
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		Years of life lost due to mortality, females	Years of life lost due to mortality from diabetes: directly standardised rate per 10,000 European Standard Population, 1-74 years, 3-year average, females	
		Diabetic foot amputation	No. of hospital admissions per 100,000 population related to diabetic amputations	SUS/HES
COPD	Proactive Care	Smoking cessation uptake	Crude rate of successful four week quitters per 100,000 population aged 16+ years	PHE
	Treatment	Bronchodilator spirometry	COPD002: The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register	HSCIC
		Health care review	COPD003: The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months	
		Smokers with COPD diagnosis	% of patients referred to stop smoking clinic with denominator as total number of smokers with COPD diagnosis	Health Analytics
		Patients with MRC 3 and above	The % of patients with MRC score 3-5 referred for pulmonary rehabilitation / total number of patients with MRC 3 and above	
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		Smoking prevalence	Percentage of COPD patients who are recorded as currently smoking	Health Analytics
		COPD severity	Mild COPD, confirmed COPD patients with latest predicted FEV1 ≥80%	
			Moderate COPD, confirmed COPD patients with latest predicted FEV1 ≥50% <80%	
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			Very severe COPD, confirmed COPD patients with latest predicted FEV1 <30%	
	Outcome	Emergency Admissions due to COPD	Rate per 100 patients on the disease register	HSCIC
		Under 75 years of age mortality rate from respiratory conditions considered to be preventable	Age-standardised rate of mortality considered preventable from respiratory disease in those aged <75 per 100,000 population	PHOF
Cancer	Proactive Care	Bowel Screening Uptake	Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)	HSCIC
		Percentage of cancers detected at stage 1 and 2	Early Diagnosis and treatment of cancer	
	Treatment	Two Week Wait Referrals	Percentage of two week wait referrals who have been seen by a specialist within two weeks of an urgent referral by their GP for suspected cancer	Cancer Commissioning Toolkit
			Number of two week wait referrals (TWR) with cancer diagnosis	
	Outcome	Premature mortality from all cancers	Standardised rate of premature deaths (<75 years old) per 100,000 population	PHE
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		Premature mortality from Colorectal cancer	Standardised rate of premature deaths (<75 years old) per 100,000 population	
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		Coronary Heart Disease	CHD002: The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	
			CHD003: The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less	
			CHD005: The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	
		Hypertension	HYP002: The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less	
	Outcome	Heart Disease and Stroke	Premature mortality, rate per 100,000	Healthier Lives, Mortality Rankings - PHE
		Stroke, emergency hospital admissions	Emergency hospital admissions for stroke, indirectly age standardised rate per 100,000, all ages	HSCIC
		Emergency admissions for Hypertension patients	Emergency hospital admissions per 100 individuals on Hypertension LTC list	Health Analytics

Primary care Indicator	Item	Performance Indicator	Description	Source
Mental health	Proactive Care	New diagnosis of depression who have had a review	DEP002: The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 35 days after the date of diagnosis, NICE 2012 menu ID: NM50	HSCIC
		Dementia diagnosis rate	The Diagnosis rate indicates the proportion of patients with dementia on a practice list or within a group who have a diagnosis of dementia. The total number from the aNDPR, and the number with a diagnosis on the QOF dementia register.	HSCIC
		Early interventions, psychosis	New cases of psychosis served by Early Interventions team, annual rate per 100,000 population	PHOF
	Treatment	Access to community mental health services by people from Black and Minority Ethnic (BME) groups	Crude rates per 100,000 population	HSCIC
		Proportion of adults in contact with secondary mental health services in paid employment	The measure (percentage of adults) is intended to measure improved employment outcomes for adults with mental health problems. Employment is a wider determinant of health and social inequalities	
		Blood pressure recorded	MH003: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months, NICE 2010 menu ID: NM17	
		Improving Access to Psychological Therapies (IAPT)- Referrals	The number of people who have been referred to IAPT for psychological therapies during reporting period.	NELFT
		Improving Access to Psychological Therapies (IAPT)- Recovery	The number of people who have completed treatment and are moving to recovery	
		Blood Glucose or HbA1c recorded	MH005: The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months, NICE 2011 menu ID: NM42	HSCIC
	Outcome	Unplanned readmissions to mental health services within 30 days of a mental health inpatient discharge in people aged 17 and over	Indirectly age and sex standardised ratio of unplanned readmissions to a mental health service	HSCIC
		Emergency hospital admissions: schizophrenia	Indirectly age (15-74) standardised rates	
Learning Disabilities		Ldis Health Check uptake	% of QOF recorded LD population who have had LD health check in last 12 months	Health Analytics
GP Survey	ED 1	Rating of GP giving you enough time		GPPS
		Rating of GP listening to you		
		Rating of GP explaining tests and treatments		
		Rating of GP involving you in decisions about your care		
		Rating of GP treating you with care and concern		
		Rating of nurse giving you enough time		
		Rating of nurse listening to you		
		Rating of nurse explaining tests and treatments		
		Rating of nurse involving you in decisions about your care		
		Rating of nurse treating you with care and concern		
	ED 2	Overall experience of GP surgery		GPPS
	ED 3	Overall experience of making an appointment		GPPS

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Issues around patient access will be addressed by providing seven day primary care, with integrated IT allowing appropriate sharing of their records between services so that they receive high quality care, no matter where they are. Joined-up services and shared records will enhance patients' confidence in primary care, reduce their reliance on their GP where other professionals could help them, and reduce their frustrations around having to repeat their story to different professionals.

The locality model will also allow patients that would previously have been treated in secondary care to be treated closer to home, for example by bringing consultants out of hospitals and into community clinics hosted in hubs.

Localities will actively engage with the population they serve, with the priorities and preferences of patients feeding into the locality vision and patients involved in the co-design of services with professionals.

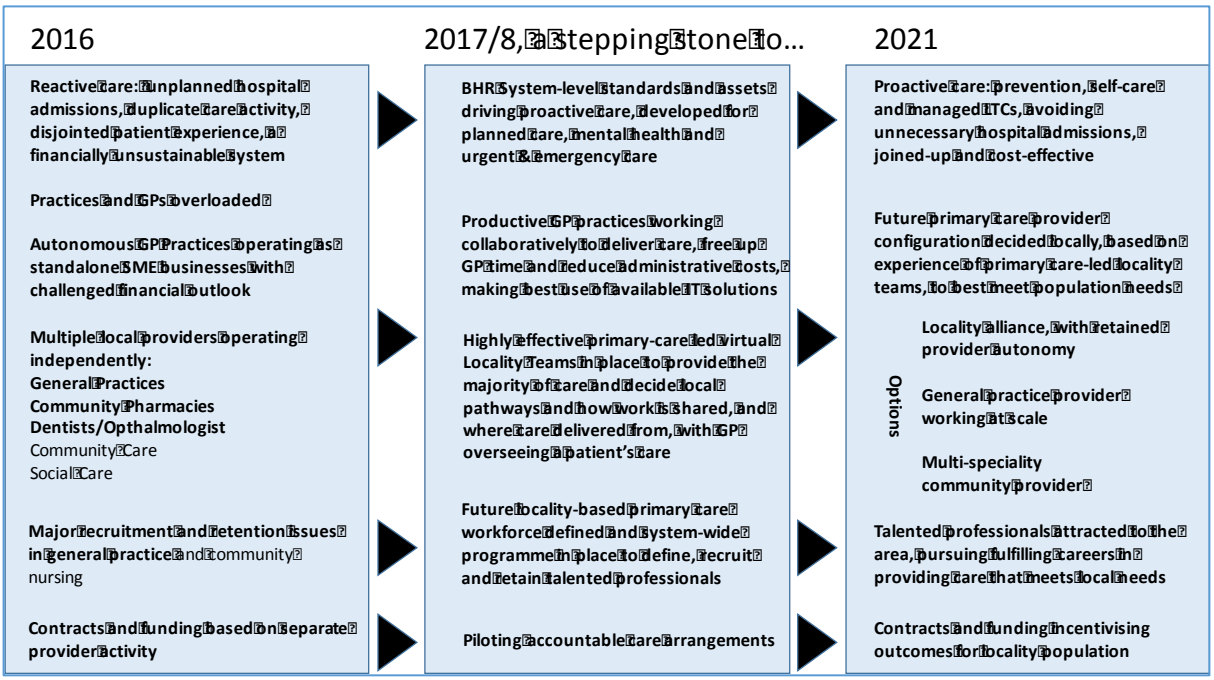
6 The transformation needed in primary care

6.1 What is the transformation needed?

Within the next five years, care for Havering residents will move from reactive to proactive, with a focus on prevention, support for self-care, active management of long term conditions and the avoidance of unnecessary hospital admissions. Patients will have a more joined-up care experience, be enabled to take more control of their care, and more of their treatment will be closer to home.

This will be achieved by:

- Improving the productivity and financial sustainability of GP practices through better management of workload and use of IT, freeing up GP time for patient care
- Introducing/extending collaborative working between GP practices on care delivery and administration
- Transforming further how care is provided and organised in each locality, combining professionals in general practice with those in other primary and community-based health and social care providers into an extended team which provide a joined-up service for the majority of patients' care, with GPs overseeing care for their patients
- Developing BHR system strategies for planned care, mental health, urgent and emergency care and prevention, which establishes common standards and services for the BHR population, including defining standards regarding increasing access for those who are not currently accessing primary care.
- Locality teams working within this framework to decide local pathways, how work is shared and where care is delivered from, to best meet the needs of their population
- Locality teams having the governance, resources and business intelligence to monitor delivery, learn from experience and continuously improve their care quality and cost-effectiveness
- Locality teams are competent at capacity planning, enabling them to effectively design new ways of working taking into account how time spent on secondary prevention can free-up time currently spent on patients who have been discharged after an emergency admission.
- Developing a sustainable workforce for general practice and locality working
- Aligning contractual and funding arrangements with the achievement of population outcomes.



6.2 What will be the outcomes of the transformation?

Operating effectively, locality teams delivering the majority of care, working within the BHR standards framework, should achieve a range of outcomes:

- Reduction in unnecessary duplicate assessments and diagnostic tests
- Enhanced outcomes at individual patient and locality population levels
- Better targeting of local resource to locality health needs
- Increased support for individuals' self-management
- Enhanced life expectancy
- Better access to the right urgent care services
- Reduced unplanned A&E attendances and emergency admissions
- Reduced re-admissions to hospital.

In addition, there are outcomes specifically related to general practice:

- Enhanced patient satisfaction with the general practice service
- Continued high levels of access to GP practice services
- Proportional increase in GPs' patient-facing time
- Improved productivity and financial sustainability of GP practices
- Improved morale, teamworking and patient focus amongst locality-based staff
- Quality and financial benefits realised from investment in digital, IT and business intelligence solutions.

These will all contribute to improved outcomes for patients, which will be monitored via the primary care transformation dashboard (see Appendix C: Primary care transformation dashboard indicators

Primary care Indicator	Item	Performance Indicator	Description	Source
Diabetes	Proactive Care	Diabetic retinal screening uptake	The proportion of those offered diabetic eye screening who attend a digital screening event	
	Treatment	% Blood pressure of 140/80 mmHg or less	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less.	
		% Cholesterol of 5 mmol/l or less	The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less.	
		% HbA1c is less than 59 mmol/mol	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months.	
		% of newly diagnosed referred to education programme	The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register.	
	Outcome	Admissions due to diabetes	Rate per 1,000 population aged 17+ years	HSCIC
		Preventable sight loss - diabetic eye disease	New Certifications of Visual Impairment (CVI) due to diabetic eye disease aged 12+, rate per 100,000 population. The numerator counts for this indicator includes sight loss due to diabetic eye disease as the main cause or if no main cause as a contributory cause. (These are not counts of diabetics with visual impairments due to any cause)	PHE
		Emergency hospital admissions: diabetic ketoacidosis and coma	Emergency hospital admissions: diabetic ketoacidosis and coma, indirectly age standardised rate per 100,000 persons	HSCIC
		Years of life lost due to mortality, males	Years of life lost due to mortality from diabetes: directly standardised rate per 10,000 European Standard Population, 1-74 years, 3-year average, males	
		Years of life lost due to mortality, females	Years of life lost due to mortality from diabetes: directly standardised rate per 10,000 European Standard Population, 1-74 years, 3-year average, females	
		Diabetic foot amputation	No. of hospital admissions per 100,000 population related to diabetic amputations	SUS/HES
COPD	Proactive Care	Smoking cessation uptake	Crude rate of successful four week quitters per 100,000 population aged 16+ years	PHE
	Treatment	Bronchodilator spirometry	COPD002: The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register	HSCIC
		Health care review	COPD003: The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months	
		Smokers with COPD diagnosis	% of patients referred to stop smoking clinic with denominator as total number of smokers with COPD diagnosis	Health Analytics
		Patients with MRC 3 and above	The % of patients with MRC score 3-5 referred for pulmonary rehabilitation / total number of patients with MRC 3 and above	
		COPD with self management plan	% of patients with severe or very severe Copd who have self management plan/ total number of patients with severe or very severe COPD	
		Smoking prevalence	Percentage of COPD patients who are recorded as currently smoking	Health Analytics
		COPD severity	Mild COPD, confirmed COPD patients with latest predicted FEV1 ≥80%	
			Moderate COPD, confirmed COPD patients with latest predicted FEV1 ≥50% <80%	
			Severe COPD, confirmed COPD patients with latest predicted FEV1 ≥30% <50%	
			Very severe COPD, confirmed COPD patients with latest predicted FEV1 <30%	
	Outcome	Emergency Admissions due to COPD	Rate per 100 patients on the disease register	HSCIC
		Under 75 years of age mortality rate from respiratory conditions considered to be preventable	Age-standardised rate of mortality considered preventable from respiratory disease in those aged <75 per 100,000 population	PHOF
Cancer	Proactive Care	Bowel Screening Uptake	Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)	HSCIC
		Percentage of cancers detected at stage 1 and 2	Early Diagnosis and treatment of cancer	
	Treatment	Two Week Wait Referrals	Percentage of two week wait referrals who have been seen by a specialist within two weeks of an urgent referral by their GP for suspected cancer	Cancer Commissioning Toolkit
			Number of two week wait referrals (TWR) with cancer diagnosis	
	Outcome	Premature mortality from all cancers	Standardised rate of premature deaths (<75 years old) per 100,000 population	PHE
		Premature mortality from lung cancer	Standardised rate of premature deaths (<75 years old) per 100,000 population	
		Premature mortality from breast cancer	Standardised rate of premature deaths (<75 years old) per 100,000 population	
		Premature mortality from Colorectal cancer	Standardised rate of premature deaths (<75 years old) per 100,000 population	
		Emergency admissions due to cancer	Direct standardised rate per 100,000	HES
Cardiovascular Disease	Proactive Care	NHS Health Check uptake	Cumulative % of uptake amongst eligible population	PHE
		Atrial Fibrillation	AF002: The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS2 risk stratification scoring system in the preceding 12 months (excluding those whose previous CHADS2 score is greater than 1), NICE 2011 menu ID: NM24	HSCIC
	Treatment	Atrial Fibrillation	AF004: In those patients with atrial fibrillation whose latest record of a CHADS2 score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy, NICE 2011 menu ID: NM46	HSCIC
		Coronary Heart Disease	CHD002: The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	
			CHD003: The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less	
			CHD005: The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	
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		Dementia diagnosis rate	The Diagnosis rate indicates the proportion of patients with dementia on a practice list or within a group who have a diagnosis of dementia. The total number from the aNDPR, and the number with a diagnosis on the QOF dementia register.	HSCIC
		Early interventions, psychosis	New cases of psychosis served by Early Interventions team, annual rate per 100,000 population	PHOF
	Treatment	Access to community mental health services by people from Black and Minority Ethnic (BME) groups	Crude rates per 100,000 population	HSCIC
		Proportion of adults in contact with secondary mental health services in paid employment	The measure (percentage of adults) is intended to measure improved employment outcomes for adults with mental health problems. Employment is a wider determinant of health and social inequalities	
		Blood pressure recorded	MH003: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months, NICE 2010 menu ID: NM17	
		Improving Access to Psychological Therapies (IAPT)- Referrals	The number of people who have been referred to IAPT for psychological therapies during reporting period.	NELFT
		Improving Access to Psychological Therapies (IAPT)- Recovery	The number of people who have completed treatment and are moving to recovery	
		Blood Glucose or HbA1c recorded	MH005: The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months, NICE 2011 menu ID: NM42	HSCIC
	Outcome	Unplanned readmissions to mental health services within 30 days of a mental health inpatient discharge in people aged 17 and over	Indirectly age and sex standardised ratio of unplanned readmissions to a mental health service	HSCIC
		Emergency hospital admissions: schizophrenia	Indirectly age (15-74) standardised rates	
Learning Disabilities		Ldis Health Check uptake	% of QOF recorded LD population who have had LD health check in last 12 months	Health Analytics
GP Survey	ED 1	Rating of GP giving you enough time		GPPS
		Rating of GP listening to you		
		Rating of GP explaining tests and treatments		
		Rating of GP involving you in decisions about your care		
		Rating of GP treating you with care and concern		
		Rating of nurse giving you enough time		
		Rating of nurse listening to you		
		Rating of nurse explaining tests and treatments		
		Rating of nurse involving you in decisions about your care		
		Rating of nurse treating you with care and concern		
	ED 2	Overall experience of GP surgery		GPPS
	ED 3	Overall experience of making an appointment		GPPS

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6.3 How will Implementation of the transformation agenda be organised?

The transformation agenda above is multi-dimensional and, as shown in the table below, will be led from locality teams with support from a primary care transformation programme (PCTP) and adjacent planned care, mental health and urgent and emergency care transformation programmes, all at BHR system level.

Transformation theme	Vehicle
Improving the productivity and financial sustainability of GP practices through better management of workload and use of IT, freeing up GP time for patient care	PCTP
Introducing/extending collaborative working between GP practices on care delivery and administration	PCTP
Transforming further how care is provided and organised in each locality, combining professionals in general practice with those in other primary and community-based health and social care providers into an extended team which provide a joined-up service for the majority of patients' care, with GPs overseeing care for their patients	PCTP
Developing BHR system strategies for planned care, mental health, urgent and emergency care and prevention, which establishes common standards and services for the BHR population	Adjacent BHR transformation programmes
Extending access to urgent care services	Urgent and emergency care programme

Locality teams working within this framework to decide local pathways, how work is shared and where care is delivered from, to best meet the needs of their population	Localities, with BHR adjacent programme input and PCTP organisational development support for first cycle
Locality teams having the governance, resources and business intelligence to monitor delivery, learn from experience and continuously improve their care quality and cost-effectiveness	PCTP
Developing a sustainable workforce for general practice and locality working	BHR System/ CEPN/ Care City
Aligning contractual and funding arrangements with the achievement of population outcomes.	ACO Programme

The primary care transformation programme itself will be primarily about provider development – strengthening individual practices, progressing collaborative working amongst GP practices in localities and developing extended locality teams, bringing together GPs with all local health and social care professionals to provide the majority of care for patients. To bring this to life and establish a learning culture, the approach is to draw on the CCG's strategies for planned, mental health and urgent and emergency care, and identify specific local schemes which can be used to inform development of collaborative governance and working arrangements in localities and as a proving ground in localities, ensuring they are wholly grounded in the business of local providers and the care needs of local people.

The PCTP will be directed by the Clinical Director with a portfolio for primary care and the BHR Director of Primary Care Transformation, and governed by the primary care transformation programme board who:

- Provide system wide leadership and accountability for the transformation of primary care in BHR
- Recommend the priorities for primary care strategy to the Governing Bodies of BHR CCGs and the respective Health and Wellbeing Boards
- Oversee implementation of the strategic commissioning framework for primary care transformation in London.

A programme management office (PMO) will operate at BHR system level to ensure the four BHR transformation programmes are coordinated and aligned so that localities are enabled to deliver the outcomes set out above.

6.4 Transformation plan

6.4.1 Five-year programme

Phase one	Establish effective localities, founded on productive general practice, to provide the majority of patient care	April 2016 to September 2017
Phase two	Localities deliver care to meet local needs, and line with BHR standards, and continue to evolve through learning and trial new contractual and funding arrangements	April 2017 to April 2021
Phase three	general practice and locality provider configuration, evolves where appropriate from virtual team to	April 2018 to April 2021

	alternative provider form	

6.4.2 Phase one objectives and plan

The provider development work associated with improved productivity and the design and mobilisation of collaborative general practice and locality working needs to be undertaken with strong drive but at a measured pace to ensure the work is clinically led, that participating clinicians and care workers buy in, that professional relationships form sustainably and there is the opportunity to learn from experience and adapt the model accordingly.

The implementation will need to involve a collaborative partnership between the centralised BHR/CCG team and teams in each locality. A key requirement of the new model is that the ways of working and approach within each local area should be designed by the teams working within that area. There are however some key attributes that will need to be present in all models and additionally there are synergies and benefits that can be delivered through an understanding of the models under development in all localities, which would not be identified and exploited through a purely devolved implementation approach.

The objective is that locality teams should be working at full capacity and across the full scope of primary, community and social care by September 2018.

Second-level objectives to achieve this are set out in the table below.

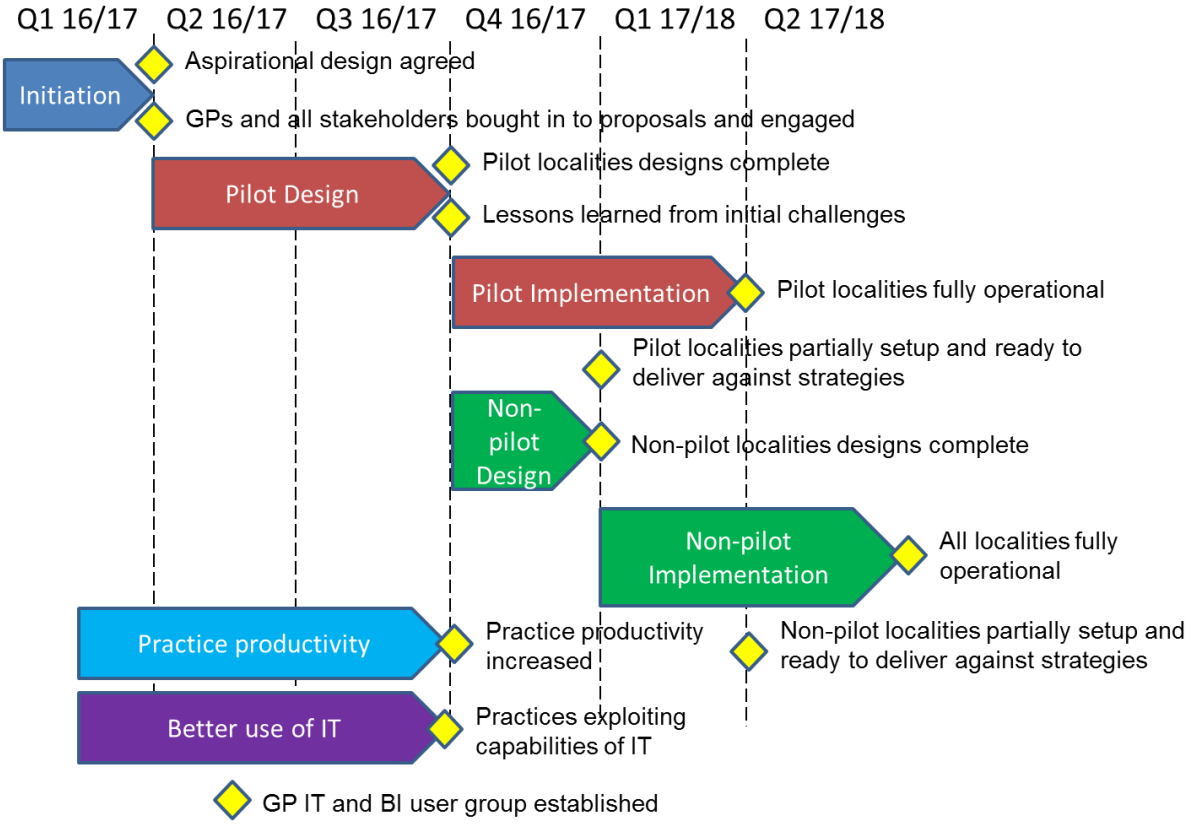
Objectives for primary care transformation phase one	
Provider development: **Practice productivity, collaborative working and locality team development**	• GPs are able to, and effective in, providing appropriate oversight for all of a patient's care • Individual GP practices are effective in managing their workload and focusing GP time where it adds most value • GP practices are clear what IT and digital solutions are available to improve productivity, have implemented them and realised the associated benefits • In each locality, each GP practice is clear on what primary care services it delivers and effective at delegating responsibility for other primary care services to other providers • Members of extended primary care teams in each locality have formed trusted working relationships with colleagues serving the same cohort of patients • Locality teams are clear what IT and digital solutions are available to enable interoperability, effective collaboration and a joined-up patient experience, have implemented them and realised the associated benefits.
Quality	• Individual GP practices sustainably meet and exceed quality standards set out in NHS England Strategic Commissioning Framework for primary care and show progress against baseline in the primary care transformation dashboard.
Locality Pathways	• Arrangements are in place and used for locality pathways to be jointly designed by a cross-section of patients, GPs and other members of the locality team • Arrangements and protocol are in place whereby locality teams work with the BHR planned care, mental health and urgent and emergency care programme to agree mutual expectations for service design, capacity assumptions and outcomes and to communicate progress,

	issues and learning • Each locality has developed and implemented a holistic plan for prevention, including the upskilling of clinicians to coach for health and the organisation of screening and immunisation services • Each locality has pathways for frail elderly patients and for those with multiple co-morbidities • Each locality has determined how the CCG's 'Click, Call, Come In' urgent care solution will be combined with urgent appointments in GP practices to provide an unplanned care service for the local population. They will have a clear plan for implementing this • Each locality has worked with Barts Health and/or BHRUT to develop and implement a full set of protocols for referral to hospital and discharge.
Governance, Intelligence and Learning	• Governance and management arrangements are established for collaborative working in general practice • Governance and management arrangements are established for locality working • Business intelligence arrangements are in place and used actively to monitor operational activity across each locality and to monitor the achievement of outcomes • Protected time is available and used by GPs and fellow locality team members to learn and develop together • Successes are identified, shared and celebrated.

While some work has been done in Havering to establish a GP federation, full implementation of the vision will require a significant change from current ways of working, and therefore it is proposed to start with a pilot. One locality will lead the way for Havering with the designs for the other localities not being started until that for the pilot locality has been completed. This will enable lessons learned from the pilot to be incorporated in the designs and planning for the other localities.

To minimise risk and allow greater chance of success, robust project and programme management arrangements will be put in place and localities will receive significant support from BHR CCGs. This is not to take away from the responsibilities and ownership of teams in localities, but to support them in the design and implementation of change.

Figure 12: key milestones for phase one



6.4.3 Programme for 2016/7

6.4.3.1 Initiation phase

An initiation phase is required to undertake the following tasks:

- Creation of a set of design principles against which all locality models should be designed. These will be based on the King's Fund: 10 principles to guide the development of systems of care in the NHS[7]
- Development of the framework of outcomes that all locality models will need to deliver as a minimum in addition to their locally identified outcomes
- Development of a business case for implementation of the new model articulating the case (costs and benefits) at all levels – system and borough, locality, GP practice
- Agreement of resources needed for implementation and how these resources will be identified
- Definition of each locality area and agreement of these, including development of locality profiles to enable localities to prioritise and plan around the needs of their populations
- Identification of the pilot locality and working with them to mobilise the project to design their new model
- Communications and engagement to gain buy-in and support from all parties across Havering who need to be involved in the design and implementation of the new model.

[7] *Place-based systems of care: A way forward for the NHS in England*. Chris Ham and Hugh Alderwick (2015) The King's Fund.

6.4.3.2 Practice productivity

A workstream will be initiated to help GP practices increase their productivity. This will be delivered through a series of workshops teaching skills and using real-life data from GPs to drive improvement. These workshops will cover:

- Theory and methods of demand and capacity modelling to support analysis of their own practices, e.g. the RCGP's *third available appointment*[8]
- Sharing modelling findings and selection of interventions to trial within their practices
- Sharing of impact and learning from changes made within practices.

This additional independent workstream will involve working with all members of the extended primary care team to help everyone understand the capabilities and make use of their existing IT.

6.4.3.3 Design phase – collaborative working in general practice and across localities

Each locality will design its new operating model, with the pilot locality taking the lead and lessons learned from the pilot feeding into the design of the other localities. This will include work on (but not limited to) the following areas:

- Processes and pathways - including business models of operation for all different areas of the operation and functions (both front and back office), the operational costs of these and the expected performance levels
- Organisation and people – the organisation structure, staffing levels, roles, skill requirements, culture etc
- Estates – how the different accommodation across the locality will be utilised to support the new operating model
- Governance – how the locality will be governed and managed
- Use of IT and information (the designs for IT and information governance will be completed at a system level to achieve economies of scale and consistency across localities).

To develop this new operating model, practitioners from different disciplines will need to come together and will follow a co-design approach. This approach will play a part in developing the organisation and creating trust and relationships between the different groups of professionals within a locality.

The implementation plan to be followed through the next phase of the implementation will also be developed. This will include in detail all of the activity that will need to be completed to move from a design on paper into live operations.

At a system level designs for IT and information governance will be completed incorporating the requirements of the emerging locality models. There will also need to be a re-design of the CCG and system-level support and management arrangements so that they are aligned with and fit-for-purpose with the new locality ways of working. This level will also have responsibility for oversight of the designs that are in development to recognise synergies and opportunities for efficiency and collaboration between localities.

6.4.3.4 Implementation phase

This phase of activity will include all the activity needed to move from a design on paper into live operations. The detail of this cannot be known until the completion of the design phase; however it will touch on all areas of the new operating model.

[8] http://www.rcgp.org.uk/rcgp-nations/rcgp-scotland/treating-access.aspx

7 Risks and assumptions

Risks

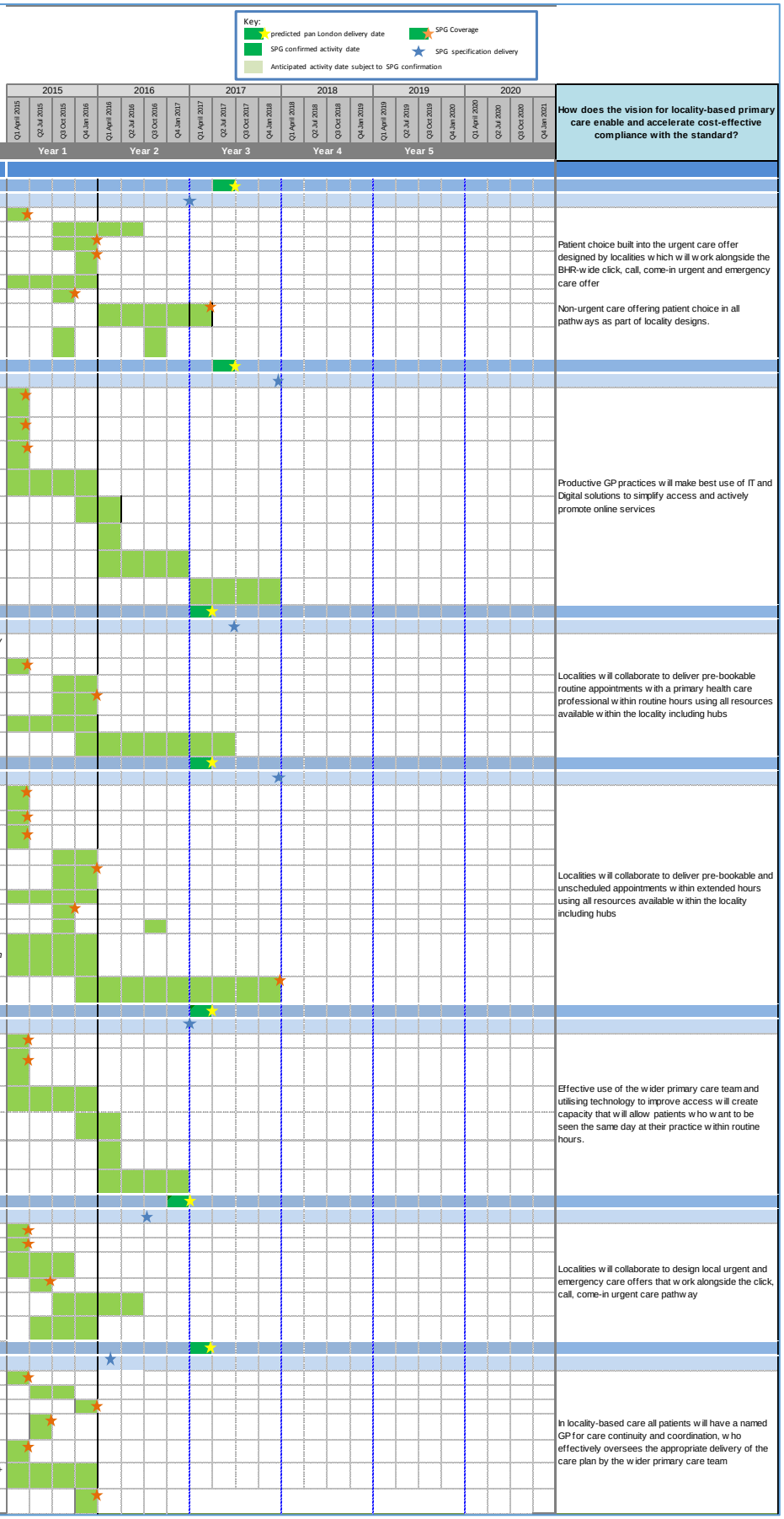
- Insufficient grassroots buy-in from GPs and other primary care professionals
- Insufficient capacity within general practice to participate
- Dependencies on other projects – IT, workforce, estates
- The pace of change demanded vs the time necessary to develop localities sustainably
- Compatibility of the strategy with main providers' strategies
- Insufficient investment in the resources to enable the programme to succeed.

Assumptions

- Improving team working in localities will release significant quality and productivity benefits
- GP practices are receptive to opportunities to improve their practices
- This strategy will have top-level support regardless of whether the ACO proceeds
- Interoperable IT agenda sufficiently advanced to enable localities to provide continuity of care to patients.

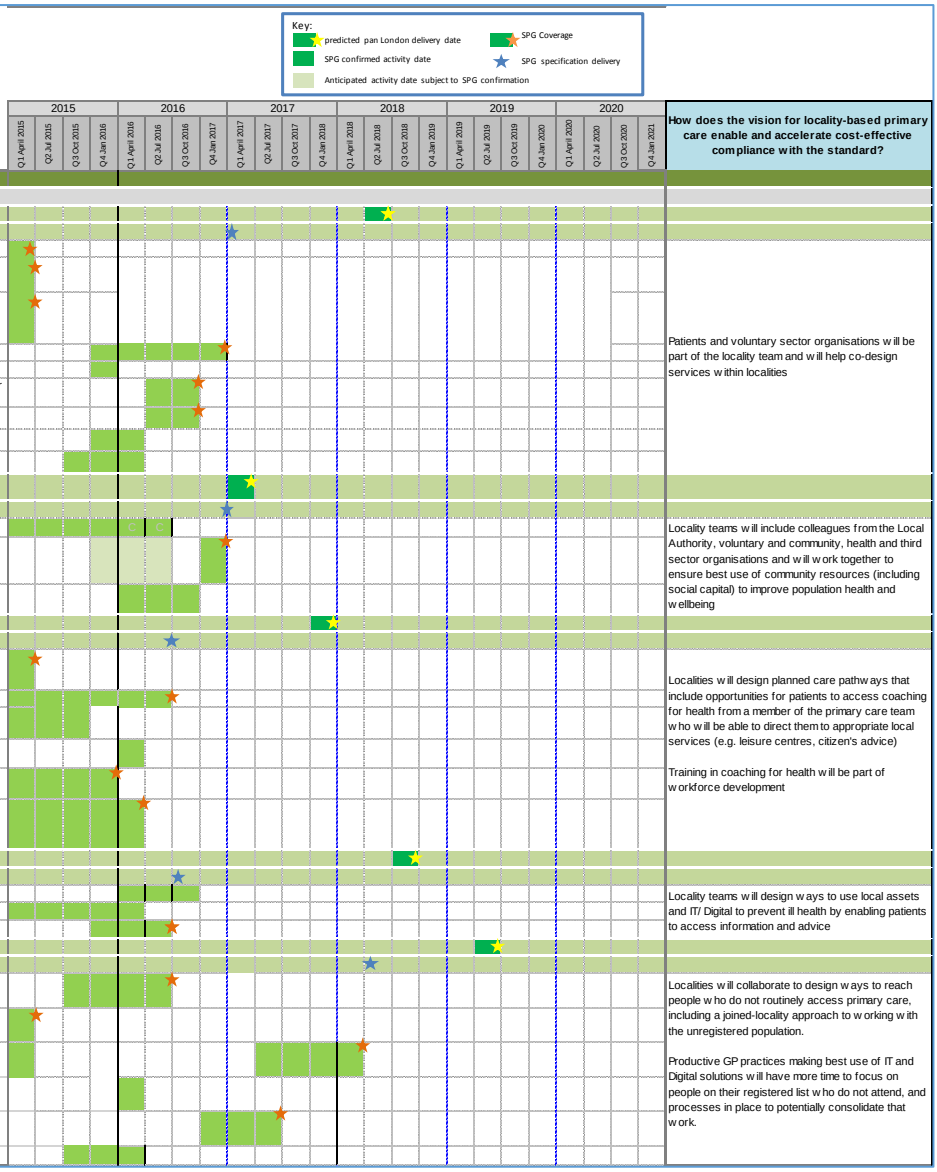
Appendix A: Strategic Commissioning Framework delivery plan

Transforming Primary Care
Live SPG delivery plan



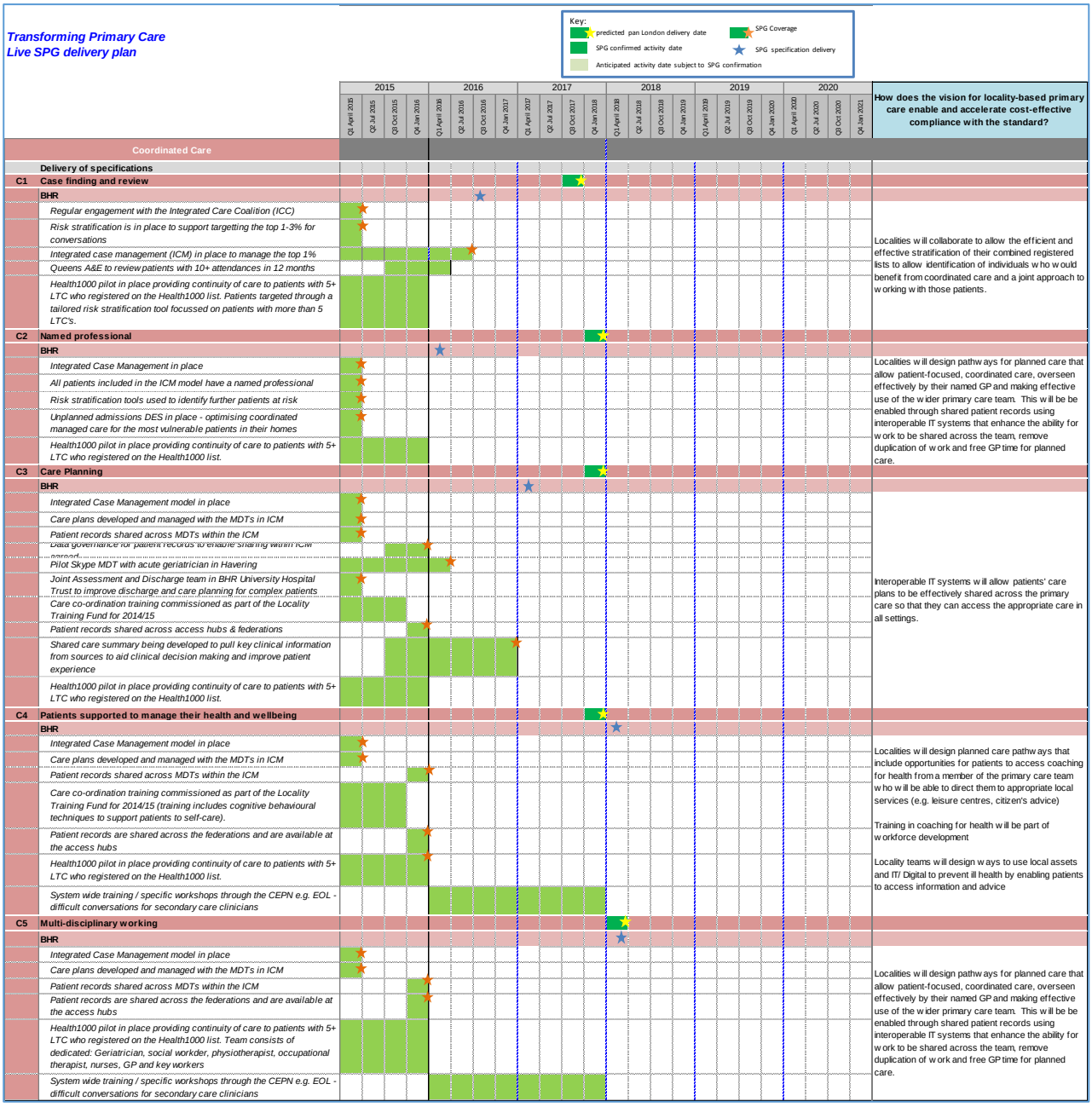
Spec	Examples of supporting activity	How does the vision for locality-based primary care enable and accelerate cost-effective compliance with the standard?
	Accessible Care	
A1	**Patient Choice**	
	BHR	
	Pilot access hubs as part of PMCF in place across BHR	
	Accessible care scheme to be fully defined	
	Patient record sharing functionality in place	Patient choice built into the urgent care offer designed by localities which will work alongside the BHR-wide click, call, come-in urgent and emergency care offer
	Patient records are shared across the federations and are available at the access hubs	
	Access hubs advertised via practice websites and A&E	
	Roll out of additional access hub in B&D	
	MiDoS available to patients with local asset database content loaded into the directory	Non-urgent care offering patient choice in all pathways as part of locality designs.
	Nuffield trust evaluation of success of access hub following completion of pilot stage	
A2	**Contacting the practice**	
	BHR	
	Practices have online functionality through a module within their clinical systems	
	Training of telephone triage/consultation to the federations pilot practices in BHR	
	Practice 'patient on-line' functionality in place and training delivered to allow practices to offer online availability	
	Pilot of telephone triage/consultation (12 practices)	Productive GP practices will make best use of IT and Digital solutions to simplify access and actively promote online services
	Development of BC to enhance telephone triage/consultation through a central (BHR wide) call centre	
	Federations to apply for CEPN funding to rollout telephone triage/consultation training post pilot	
	Further pilot of telephone consultations through central call centres subject to pilot success	
	Rollout of telephone consultations through central call centres subject to BC and pilot success	
A3	**Routine opening hours**	
	BHR	
	No current plans to change contracted routine opening hours, Saturday opening to be achieved via access hubs	
	Pilot access hubs as part of PMCF in place across BHR	
	Patient record sharing functionality in place	Localities will collaborate to deliver pre-bookable routine appointments with a primary health care professional within routine hours using all resources available within the locality including hubs
	Patient records are shared across the federations and are available at the access hubs	
	Access hubs advertised via practice websites and A&E	
	CCG to review requirement to open in-hours as part of federation planned and unplanned care pathway redesign	
A4	**Extended opening hours**	
	BHR	
	Pilot access hubs as part of PMCF in place across BHR, providing 6.30 - 10pm weekdays, and 12-6pm weekends	
	Walk in centres currently providing 8 - 8pm	
	Additional services providing extended opening (FOPAL, CTT team, ICM, intensive rehab service, enhanced psychiatric liaison)	
	Patient record sharing functionality in place	
	Patient records are shared across the federations and are available at the access hubs	Localities will collaborate to deliver pre-bookable and unscheduled appointments within extended hours using all resources available within the locality including hubs
	Access hubs advertised via practice websites and A&E	
	Roll out of additional access hub in B&D	
	Evaluate success of access hub following completion of pilot stage	
	Health1000 pilot in place providing care to patients with 5+ LTC who registered on the Health1000 list. Extended access is provided through on-call within the GP practice	
	Improve alignment between access hub and services such as GP OOH and WIC through CCGs urgent care strategy workplan	
A5	**Same day access**	
	BHR	
	Pilot access hubs as part of PMCF in place across BHR	
	Additional services providing extended opening (FOPAL, enhanced psychiatric liaison). CTT/IRS in place on a pilot basis pending formal establishment	
	Pilot of telephone triage/consultation (12 practices)	Effective use of the wider primary care team and utilising technology to improve access will create capacity that will allow patients who want to be seen the same day at their practice within routine hours.
	Development of BC to enhance telephone triage/consultation through a central (BHR wide) call centre	
	Federations to apply for CEPN funding to rollout telephone triage/consultation training post pilot	
	Further pilot of telephone consultations through central call centres - subject to BC and pilot success	
A6	**Urgent and Emergency Care**	
	BHR	
	CTT work across BHR and in Queens A&E	
	Urgent Care Centres in Queens & King George's run by GPs in place	
	Streamline access to services within A&E (CTT, ambulatory care, enhanced psychiatric liaison and FOPAL)	Localities will collaborate to design local urgent and emergency care offers that work alongside the click, call, come-in urgent care pathway
	Urgent care pathway development to be launched at 1 July conference	
	Urgent care strategy - workplan with milestones to be developed following conference)	
	Federation to develop business case to review new ways of working with in-hours and out of hours	
A7	**Continuity of Care**	
	BHR	
	Integrated case management (ICM) in place	
	Mainstream intermediate care pilot services (CTT-ICM/IRS)	
	Record sharing is available for MDTs with the ICM	
	Joint Assessment and Discharge team established in BHRUT to improve discharge and care planning for complex patients	In locality-based care all patients will have a named GP for care continuity and coordination, who effectively oversees the appropriate delivery of the care plan by the wider primary care team
	Unplanned admissions DES in place - optimising coordinated managed care for the most vulnerable patients in their homes	
	Health1000 pilot in place providing continuity of care to patients with 5+ LTC who registered on the Health1000 list.	
	Patient records are shared across the federations and are available at the access hubs	

Transforming Primary Care
Live SPG delivery plan



		How does the vision for locality-based primary care enable and accelerate cost-effective compliance with the standard?
	Proactive Care	
	Delivery of specifications	
P1	**Co-Design**	
	BHR	
	Focus groups led by the federations with Healthwatch representation	Patients and voluntary sector organisations will be part of the locality team and will help co-design services within localities
	H1000 model developed with UCLP and patient groups linked into the design process	
	Development of the new intermediate care model (ICM, CTT, IRS) followed extensive engagement with stakeholders to determine co-design the model	
	Focus group to review central call centre initiative across the federations	
	CEPN to review workforce planning and training needs	
	Map dementia services across health, social care and voluntary sector in Havering	
	Map health services for over 75s to review the pathway alignment	
	Test impact of new operational resilience schemes	
	Development of the primary care strategy	
P2	**Developing assets and resources for improving health and wellbeing**	
	BHR	
	MiDoS developed to include local asset database	Locality teams will include colleagues from the Local Authority, voluntary and community, health and third sector organisations and will work together to ensure best use of community resources (including social capital) to improve population health and wellbeing
	Work with the local council, community and voluntary services to input into MiDoS (this is dependant on LA sign-up which is being sought through ICC and ICSG)	
	MiDoS used by ICM to locate support and care services close to peoples' homes	
P3	**Personal conversations focussed on an individual's health goals**	
	BHR	
	Risk stratification is in place to support targetting the top 1-3% for conversations	Localities will design planned care pathways that include opportunities for patients to access coaching for health from a member of the primary care team who will be able to direct them to appropriate local services (e.g. leisure centres, citizen's advice) Training in coaching for health will be part of workforce development
	Integrated case management (ICM) in place to manage the top 1%	
	Care co-ordination and Frailty training being commissioned as part of the Locality Training Fund for 2014/15	
	Review whether to roll out intervention pharmacists pilot as a QIPP scheme	
	Health1000 pilot in place providing tailored care to patients with 5+ LTC who registered on the Health1000 list.	
	Everyone counts initiative - GP Practices have been allocated CCG funds based on their list sizes with which to devise new and innovative services to support the >75s within their practice population.	
P4	**Health and wellbeing liaison and information**	
	BHR	
	MiDoS developed to include local asset database	Locality teams will design ways to use local assets and IT/ Digital to prevent ill health by enabling patients to access information and advice
	Clinicians use MiDoS	
	Patients are able to use MiDoS	
P5	**Patients not currently accessing primary care services**	
	BHR	
	Patients encouraged at walk in centres & UCC to register at a practice	Localities will collaborate to design ways to reach people who do not routinely access primary care, including a joined-locality approach to working with the unregistered population. Productive GP practices making best use of IT and Digital solutions will have more time to focus on people on their registered list who do not attend, and processes in place to potentially consolidate that work.
	Homeless patients encouraged to register at walk in centre co-located practices	
	CCG and LA to develop and implement plans to work with local schools and business around healty life styles	
	Review London Commissioned services around homeless practice/provision	
	Primary care strategy developing additional plans to target vulnerable groups	
	Queens A&E to review patients with 10+ attendances in 12 months	

Transforming Primary Care
Live SPG delivery plan



Appendix B: Current clusters

Appendix C: Primary care transformation dashboard indicators

Primary care Indicator	Item	Performance Indicator	Description	Source
Diabetes	Proactive Care	Diabetic retinal screening uptake	The proportion of those offered diabetic eye screening who attend a digital screening event	
	Treatment	% Blood pressure of 140/80 mmHg or less	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less.	
		% Cholesterol of 5 mmol/l or less	The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less.	
		% HbA1c is less than 59 mmol/mol	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months.	
		% of newly diagnosed referred to education programme	The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register.	
	Outcome	Admissions due to diabetes	Rate per 1,000 population aged 17+ years	HSCIC
		Preventable sight loss - diabetic eye disease	New Certifications of Visual Impairment (CVI) due to diabetic eye disease aged 12+, rate per 100,000 population. The numerator counts for this indicator includes sight loss due to diabetic eye disease as the main cause or if no main cause as a contributory cause. (These are not counts of diabetics with visual impairments due to any cause)	PHE
		Emergency hospital admissions: diabetic ketoacidosis and coma	Emergency hospital admissions: diabetic ketoacidosis and coma, indirectly age standardised rate per 100,000 persons	
		Years of life lost due to mortality, males	Years of life lost due to mortality from diabetes: directly standardised rate per 10,000 European Standard Population, 1-74 years, 3-year average, males	HSCIC
		Years of life lost due to mortality, females	Years of life lost due to mortality from diabetes: directly standardised rate per 10,000 European Standard Population, 1-74 years, 3-year average, females	
		Diabetic foot amputation	No. of hospital admissions per 100,000 population related to diabetic amputations	SUS/HES
COPD	Proactive Care	Smoking cessation uptake	Crude rate of successful four week quitters per 100,000 population aged 16+ years	PHE
	Treatment	Bronchodilator spirometry	COPD002: The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register	HSCIC
		Health care review	COPD003: The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months	
		Smokers with COPD diagnosis	% of patients referred to stop smoking clinic with denominator as total number of smokers with COPD diagnosis	Health Analytics
		Patients with MRC 3 and above	The % of patients with MRC score 3-5 referred for pulmonary rehabilitation / total number of patients with MRC 3 and above	
		COPD with self management plan	% of patients with severe or very severe Copd who have self management plan/ total number of patients with severe or very severe COPD	
		Smoking prevalence	Percentage of COPD patients who are recorded as currently smoking	Health Analytics
		COPD severity	Mild COPD, confirmed COPD patients with latest predicted FEV1 ≥80%	
			Moderate COPD, confirmed COPD patients with latest predicted FEV1 ≥50% <80%	
			Severe COPD, confirmed COPD patients with latest predicted FEV1 ≥30% <50%	
			Very severe COPD, confirmed COPD patients with latest predicted FEV1 <30%	
	Outcome	Emergency Admissions due to COPD	Rate per 100 patients on the disease register	HSCIC
		Under 75 years of age mortality rate from respiratory conditions considered to be preventable	Age-standardised rate of mortality considered preventable from respiratory disease in those aged <75 per 100,000 population	PHOF
Cancer	Proactive Care	Bowel Screening Uptake	Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)	HSCIC
		Percentage of cancers detected at stage 1 and 2	Early Diagnosis and treatment of cancer	
	Treatment	Two Week Wait Referrals	Percentage of two week wait referrals who have been seen by a specialist within two weeks of an urgent referral by their GP for suspected cancer	Cancer Commissioning Toolkit
			Number of two week wait referrals (TWR) with cancer diagnosis	
	Outcome	Premature mortality from all cancers	Standardised rate of premature deaths (<75 years old) per 100,000 population	PHE
		Premature mortality from lung cancer	Standardised rate of premature deaths (<75 years old) per 100,000 population	
		Premature mortality from breast cancer	Standardised rate of premature deaths (<75 years old) per 100,000 population	
		Premature mortality from Colorectal cancer	Standardised rate of premature deaths (<75 years old) per 100,000 population	
		Emergency admissions due to cancer	Direct standardised rate per 100,000	HES
Cardiovascular Disease	Proactive Care	NHS Health Check uptake	Cumulative % of uptake amongst eligible population	PHE
		Atrial Fibrillation	AF002: The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS2 risk stratification scoring system in the preceding 12 months (excluding those whose previous CHADS2 score is greater than 1), NICE 2011 menu ID: NM24	HSCIC
	Treatment	Atrial Fibrillation	AF004: In those patients with atrial fibrillation whose latest record of a CHADS2 score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy, NICE 2011 menu ID: NM46	HSCIC
		Coronary Heart Disease	CHD002: The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	
			CHD003: The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less	
			CHD005: The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	
		Hypertension	HYP002: The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less	
	Outcome	Heart Disease and Stroke	Premature mortality, rate per 100,000	Healthier Lives, Mortality Rankings - PHE
		Stroke, emergency hospital admissions	Emergency hospital admissions for stroke, indirectly age standardised rate per 100,000, all ages	HSCIC
		Emergency admissions for Hypertension patients	Emergency hospital admissions per 100 individuals on Hypertension LTC list	Health Analytics

Primary care Indicator	Item	Performance Indicator	Description	Source
Mental health	Proactive Care	New diagnosis of depression who have had a review	DEP002: The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 35 days after the date of diagnosis, NICE 2012 menu ID: NM50	HSCIC
		Dementia diagnosis rate	The Diagnosis rate indicates the proportion of patients with dementia on a practice list or within a group who have a diagnosis of dementia. The total number from the aNDPR, and the number with a diagnosis on the QOF dementia register.	HSCIC
		Early interventions, psychosis	New cases of psychosis served by Early Interventions team, annual rate per 100,000 population	PHOF
	Treatment	Access to community mental health services by people from Black and Minority Ethnic (BME) groups	Crude rates per 100,000 population	HSCIC
		Proportion of adults in contact with secondary mental health services in paid employment	The measure (percentage of adults) is intended to measure improved employment outcomes for adults with mental health problems. Employment is a wider determinant of health and social inequalities	
		Blood pressure recorded	MH003: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months, NICE 2010 menu ID: NM17	
		Improving Access to Psychological Therapies (IAPT)- Referrals	The number of people who have been referred to IAPT for psychological therapies during reporting period.	NELFT
		Improving Access to Psychological Therapies (IAPT)- Recovery	The number of people who have completed treatment and are moving to recovery	
		Blood Glucose or HbA1c recorded	MH005: The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months, NICE 2011 menu ID: NM42	HSCIC
	Outcome	Unplanned readmissions to mental health services within 30 days of a mental health inpatient discharge in people aged 17 and over	Indirectly age and sex standardised ratio of unplanned readmissions to a mental health service	HSCIC
		Emergency hospital admissions: schizophrenia	Indirectly age (15-74) standardised rates	
Learning Disabilities		Ldis Health Check uptake	% of QOF recorded LD population who have had LD health check in last 12 months	Health Analytics
GP Survey	ED 1	Rating of GP giving you enough time		GPPS
		Rating of GP listening to you		
		Rating of GP explaining tests and treatments		
		Rating of GP involving you in decisions about your care		
		Rating of GP treating you with care and concern		
		Rating of nurse giving you enough time		
		Rating of nurse listening to you		
		Rating of nurse explaining tests and treatments		
		Rating of nurse involving you in decisions about your care		
		Rating of nurse treating you with care and concern		
	ED 2	Overall experience of GP surgery		GPPS
	ED 3	Overall experience of making an appointment		GPPS

Appendix D: Workforce development in primary care

Solutions offered include using a greater skill mix of practitioners in primary care, offering a seamless integrated service with clear opportunities for career development for all members of the primary health care team.

Specific ideas for different members of the primary health care team are summarised below.

GPs

Attract young GPs	**Fourth year fellowships in Havering for GP trainees.** **Provide "home" (perhaps a BHR-wide employment agency) with identity, peers and support for ongoing learning, personal and professional development, parental leave, study leave, management opportunities to lead small projects and research opportunities, whether a partner, salaried or long term locum** **Plurality of provider models to include independent contractors, federations, chambers, super practices, and increased salaried working, to achieve economies of scale in management, infrastructure, and clinical resources, and to provide wider ranges of patient services.** **Become exemplars of multiprofessional working**
Attract returning GPs	By marketing package for returning GPs: ongoing support for personal and professional development, family friendly approach, parental leave and carers leave offer, easy to access Ofsted reports, Rightmove and Zoopla. Clarity on career path and ongoing development.
Attract international GPs	From Eastern Europe (via the IMG scheme) GP profile to match changing population profile. Offer IMGs a registrar-level salary while training (as they do in East Midlands) to enable senior experienced GPs to afford to come to London.
Promote sustainable model of General Practice	To promote fulfilling, rewarding and sustainable career. Become known as *the* place in London for excellent integrated care with primary, community and social care building on innovation of the Vanguard and ACO. Time to see patients and deal with issues properly Interesting variety of patients Integrated locality model of working with joint learning and co-development of services with other providers and patients. Identify, prioritise, implement and evaluate local models of QI initiatives Social prescribing Pharmacist prescribing Support older GPs with retirement planning
Market Havering as a place to live and work	Effective HASS in Havering with S75 agreements in place between LA and community provider Affordable housing (for London) Good schools Range of career development pathways identified
Opportunities in Havering as a GP	To develop as clinical leader - locality lead, clinical lead, committee chair, CCG board member To develop as educator and trainer

	To develop as a researcher (with Care City, BHRUT, UCL Partners)
Ongoing learning and development	Protected time for learning with peers both in general practice and with rest of the primary health care team Training in coaching for health Training in solution focused conversations Continue to develop skills e.g. joint injections, update on dermatology
Use workforce modelling data	Available from April 2016 from NHS England (London) to identify existing workforce. Match to current and future models of care, identify gaps and plan to address
Identify areas to prioritise and work on collaboratively	Form localities/communities of practice All GPs part of geographical network (including salaried and long term locums) Find ways to innovate/incentivise joint working e.g. • top slice secondary care services and provide network enhanced services • One HV for network of GP practices • Share services across network of practices e.g. phlebotomy, direct access physio, counsellor • Develop care pathways across the locality • Share back office functions e.g one book keeper, IT support, HR support • Autonomy to use delegated budget at locality level to meet the needs of the local population

Pharmacists

Upskill community pharmacists	In behaviour change Train as health coaches
Develop role of practice pharmacists	Medicines reconciliation Medication review Prescription management Prescription safety/concordance Acute common conditions Chronic disease management Practice performance Primary care practice research
Develop role of pharmacists to work in urgent care settings	Training in coaching for health Training in common clinical conditions Independent prescriber
Upskill to become independent prescribers	For urgent prescriptions as well as LTCs Career path to develop expertise in diabetes, asthma etc
recruit clinical pharmacists	Have “off the shelf” Havering offer, ready to advertise for new clinical pharmacists (London-wide initiative)
Recruit local pharmacists	Through local pharmacy apprentice scheme
Ongoing joint learning	With GPs and other members of the primary health care team Career paths identified
Family friendly	
Introduce Pharmacy First scheme	Free OTC medicines for patients on benefits

Nurses

Attract young nurses	Multi-agency training: acute, primary and community Key worker housing
Retain nurses	Career development pathways identified Ability to work in primary care and community care

	Supported by AHPs Part of a learning community of practice Key worker housing
Recruit international nurses	
Train nurse prescribers	To work with patients with LTC
Train nurse practitioners	To work with patients with LTC Career path e.g. community matron, specialist practice nurse
Family friendly	
Lifelong learning	Ongoing joint learning with GPs, pharmacists and other members of the primary and community health team
Optimise use of pool of nursing resource across a locality	Using practice nurses and community nurses, with links to midwives, health visitors and school nurses.
Develop specialist nurses for non-registered population	e.g HV for the homeless develop working relationship with third sector e.g. AA, narcotics anonymous

Allied Health Professionals

Recruit physician's assistants Physician associates support doctors in the diagnosis and management of patients. They are trained to perform a number of roles including: • taking medical histories • performing examinations • diagnosing illnesses • analysing test results • developing management plans. They work under the direct supervision of a doctor	London-wide scheme to train physicians assistants Have a Havering offer "on the shelf" ready to advertise when PAs graduate See patients for same-day appointments Review test results Booked appointments with patients with LTC Home visits Cryotherapy Teaching Clinical audit Maintaining practice registers Supervision of HCAs Make Havering primary care an attractive place to work by offering apprenticeships (PAs have to find £9,000 tuition fees and loans and grants are not available) NB PAs cannot gain prescribing rights as do not have registration. This is being addressed nationally.
Train generic staff to work across health and social care	Care City to provide mechanism to train generic health and social care workers to work across health and social care. Care City to host peer networks, provide mentorship and facilitate apprenticeships CEPN are developing care navigators
Family friendly	To recruit and retain
Lifelong learning	Framework for ongoing personal and professional development Career paths identified

Admin and clerical

Practice Managers Board	Could be developed to • help PMs share work between them (QOF, call-recall) • develop areas of personal expertise/sub specialisation • develop career path
Receptionists	Develop reception staff skills in signposting Career path as care navigators
Family friendly	

Lifelong learning	Opportunities to continue to learn and develop Career paths mapped out and supported

Havering
LONDON BOROUGH

Havering Health and Wellbeing Board: Terms of Reference
(Amended April 16 – Draft 3)

Purpose of the Health and Wellbeing Board

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

The Havering HWB is set up to

- improve the health and wellbeing of the residents of Havering and to reduce health inequalities.

- join up commissioning across the NHS, social care, public health and other health and wellbeing services in order to secure better health and wellbeing outcomes for the local population, better quality of care for patients/care users and better value for the taxpayer.

Responsibilities

The main responsibilities of the Board are to:

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

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

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

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

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

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

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

Membership

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

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

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

In attendance

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

Reporting and Governance Arrangements

- The Health and Wellbeing Board is a committee of the council.

- The Board will receive regular progress updates from all groups that report to the Board in the attached governance structure.

- The Health and Wellbeing Board will be held in public unless confidential financial or other information should prevent this (as per the Local Government Act, 1972)

- Chairing arrangements – the leader of the Council will be required to nominate the Chair of the Board. Board members will nominate a vice Chair.

- All full members of the board will have voting rights. Where a vote is tied, the Chairman will have the casting vote.

- The Board is quorate when 9 members are present.

- Meetings will be held every other month. Special meetings may be requested by the Board at any time.

- Papers to be circulated at least 5 working days before a meeting

- The Board may co-operate with similar Boards in other locations where their interests align. This may include multi-area commissioning arrangements

- These terms of reference will be reviewed 12 months from the date of formal sign off by the board.

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

Confirmed so far

- Health Protection Forum.
- JSNA Steering group.
- Local Children's Safeguarding Board
- Adult Safeguarding Board
- Care Transformation Board

To be confirmed once the refreshed Joint Health and Wellbeing Strategy (JHWS) approved (In July 16). Could include the following plus any additional groups delivering the aims and objectives of the JHWS

- *Joint Management and Commissioning Forum.*
- *End of Life Strategy Group.*
- *Poverty Reduction Programme Executive.*
- *Mental Health Partnership Board (?Dementia Partnership to be part of this board).*

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

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

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

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Havering's Local Account 2015
Board Lead:	Barbara Nicholls, Assistant Director Adult Social Care and Commissioning
Report Author and contact details:	Caroline May, Head of Business Management

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

- ☒ Priority 1: Early help for vulnerable people
- ☐ Priority 2: Improved identification and support for people with dementia
- ☐ Priority 3: Earlier detection of cancer
- ☐ Priority 4: Tackling obesity
- ☐ Priority 5: Better integrated care for the 'frail elderly' population
- ☐ Priority 6: Better integrated care for vulnerable children
- ☐ Priority 7: Reducing avoidable hospital admissions
- ☐ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

The government requires each local authority to publish annually a "Local Account" of its adult social care activity. This Havering Local Account summarises adult social care and support achievements in 2013-15 and ambitions for the future.

A local account of our services explains:

- What services we support and spend money on
- What we have achieved
- The changes and challenges we face
- Our ambitions and plans for further improvement

It will be published on our website to report publicly on performance and provides accountability to local people and partners.

Havering
LONDON BOROUGH

The Local Account for 2015/16 will be published in the autumn of 2016.

RECOMMENDATIONS

1. That the Health and Wellbeing Board note the Local Account 2015 prior to publication.

REPORT DETAIL

The key messages of the Local Account 2015 include:

1 The services we provide:
Havering Council has a responsibility to care for and protect the Borough's most vulnerable residents but also helps all local people to help themselves. From equipment & adaptions to direct payments, assistive technology to leisure activities, Havering provides a range of support to help people do as much as they can for themselves and stay healthy. For those who need it most, Havering Council and its partners provide services that help them lead better, and more comfortable, lives.

1.1 In 2016/14 we supported **7,000** service users, with 5,500 being over the age of 65, and including 2,600 people over the age of 85. This increased to more than **7,500** in 2014/15 with almost 6,000 of them over the age of 65, and 3,000 over the age of 85.

2. **The financial challenge**

2.1 Havering Council faces financial challenges as it manages funding reductions and inflationary costs, provides services to a growing and ageing local population and meets new legislative responsibilities.

2.2 Adult social care needs to save £10.3 million over the three years 2015/16 to 2018/19. This is on top of the £8.9 million the service has saved in the previous three years 2012/13 to 2014/15. Havering receives the fourth lowest government grant in London.

2.3 The Council has made a strong commitment to deliver all statutory services like adult social care and improve services. It remains committed to protecting the

services that matter most to the residents of Havering and keeping local people safe.

3. Our Objectives

3.1 The Local Account outlines the progress against priority areas in Havering and the plans for the future. These priority areas include:

- Older people
- People with disabilities (physical, sensory and learning)
- People with mental health needs
- Carers
- Providing choice
- Preventing or delaying the need for health and social care
- Improving and maintaining well-being
- Keeping people safe

4. Examples of Good Practice

Safeguarding

4.1 Havering's Multi Agency Safeguarding Hub (MASH) brings together the Council, police, health, and probation services and joins-up information that is already known within separate organisations to inform safeguarding decisions. For those residents that don't meet the statutory thresholds for support, a Multi Agency Risk Assessment Conference (MARAC) enables information to be shared between different statutory and voluntary sector agencies.

4.2 The MASH and MARAC were recognised nationally as Havering was shortlisted in the Innovation in Social Care MJ Achievement Award 2015.

Dementia Friendly Community

4.3 The Havering Dementia Action Alliance was developed with our partners to help those affected by the disease. The Alliance, which has more than 75 member organisations, won the Best Dementia Friendly Community Initiative in the Dementia Friendly Awards, and the Community Organisation Award for Disability in The National Diversity Awards.

Improving Health and Wellbeing

4.4 The work of this Health and Wellbeing Board was shortlisted for the Best Health and Well-Being initiative at the 2015 APSE Awards.

Implementing the Care Act

4.5 Havering has redesigned many of its services to meet our responsibilities under the Care Act 2014.

Improving communication with social care providers

4.6 Havering has launched an online care network for the Borough's social care providers.

5. The challenges ahead

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

IMPLICATIONS AND RISKS

Financial implications and risks:

The financial situation, as outlined in the 2015 local account, remains challenging with large savings targets and growing demand. We continue to work closely with partners and agencies to manage resources wisely and target these to support those who are most vulnerable in our society.

There are no direct implications arising from this report which is for information only.

Legal implications and risks:

The Local Account must be produced and published annually to meet Government requirements.

The Local Account is a key mechanism for demonstrating accountability for performance and outcomes, and for sharing information.

Human Resources implications and risks:

There are no direct implications arising from this report which is for information only.

Equalities implications and risks:

The local account sets out how the Council has delivered and will continue to deliver services to communities in Havering and as such will protect the most vulnerable members within these communities.

BACKGROUND PAPERS

Adult Social Care Services in Havering, a Local Account 2015.

Adult social care services in Havering

A local account

2015

www.havering.gov.uk

www.haveringcarepoint.org

Index

About the local account

Local authorities are required to produce a local account for adult social care.

Like an annual report, a local account is intended to provide an informative overview of the work carried out by Havering's adult social care teams. The account reports publicly on performance and provides accountability to local people and partners.

A local account of our services explains:

- What services we support and spend money on
- What we have achieved
- The changes and challenges we face
- Our ambitions and plans for further improvement

In this account Havering is going a step further and detailing the experiences of service users and their families as we provide a true local account through their eyes and voices.

Foreword: adult social care in Havering

With London's oldest population, adult social care services in Havering are instrumental in helping individuals and their families live independent and fulfilling lives in all parts of the borough.

This is reflected in the amount that Havering spends on adult social care. With the largest budget in the Council of £59.5million - around 36 per cent of the Council's total net budget - we help over 7,500 people each year use services ranging from reablement to residential care.

However, demand for our services are increasing at a time when people are living longer, our population is swelling and funding for services is reducing.

In an age of austerity, making the best use of our resources, working in partnership with a range of care providers, providing choice, shaping the local care market and improving the experience of service users is essential.

We are doing this by integrating our services with health partners, providing early help, intervention and preventative measures to stop care and support needs from developing and helping our residents live as independently as possible in the comfort of their own homes.

The Council has strong partnership arrangements in place with the local NHS, the community and voluntary sector and, with our Integrated Care Coalition, the neighbouring boroughs of Barking and Dagenham and Redbridge.

In this local account, we aim to make it easy to see how we are progressing. Although we recognise that we are on the way to delivering better outcomes for our service users we know we can - and will - do much more to improve the lives of all Havering adults.

Cllr Wendy Brice Thompson, Cabinet Member for Adult Services and Health

Barbara Nicholls, Head of Adult Social Care and Commissioning

Havering in numbers

245,974 residents[1]

Some 253,730 people are registered with a Havering GP[2]

51.99 per cent of Havering's population are female, 48.01 per cent are male

192,716 are aged over 18

45,582, around 18.5 per cent, are over the age of 65 – the largest proportion in London

6,851, around 2.8 per cent, of people are aged over 85 – again the highest in London

With over 43 square miles, Havering is London's third largest Borough. Half of the Borough is greenbelt or parkland

Havering is ranked 177 out of 326 local authorities for deprivation and 26 out of 32 London boroughs

Two wards in the Borough are among the 10 per cent most deprived in London.

The average age of a Havering resident is 40.4. The average age in London is 35.6

Havering's population is set to swell to 291,100 in 2030 – an increase of 18 per cent

The number of over 65s in Havering is set to increase by 33.1 per cent by 2030 to 60,669[3]

The number of over 85s is set to increase by 56.2 per cent by 2030 to 10,701

The life expectancy for men is 79.8 years and 83.8 years for women – higher than the national average

[1] Office for National Statistics, 2014 Mid-Year Estimates
[2] Demographics Chapter, Jan 2014, JSNA
[3] Projecting Older People Population Information System

The services we provide and what they cost

Havering Council has a responsibility to care for and protect the Borough's most vulnerable residents. The Council also helps all local people to help themselves, live independent lives and stay involved in their local community.

From equipment & adaptions to direct payments, assistive technology to leisure activities, Havering provides a range of support to help people do as much as they can for themselves and stay healthy.

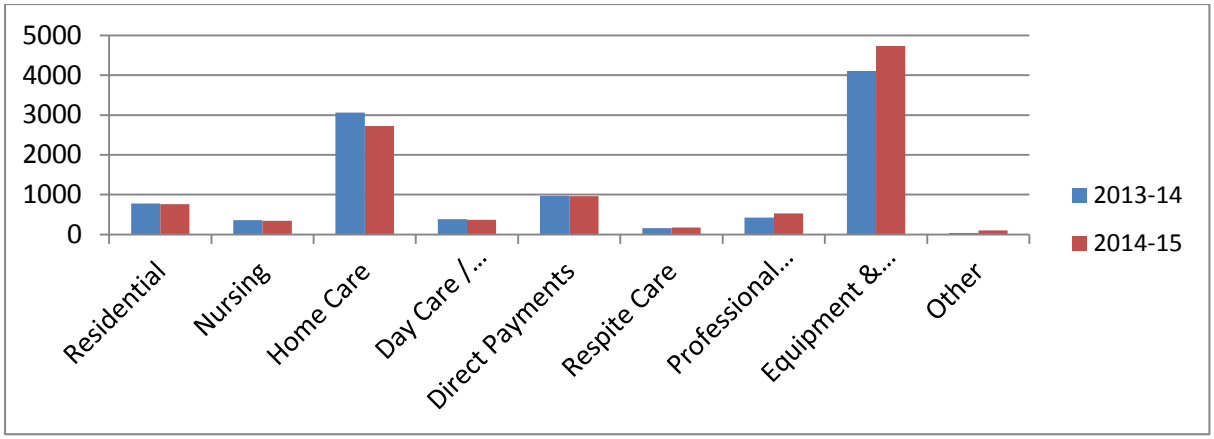
For those who need it most, Havering Council and its partners provide services that help them lead better, and more comfortable, lives.

In 2013/14,we supported **7,000** service users with 5,500 over the age of 65. This included over 2,600 people over the age of 85.

This increased to more than **7,500** in 2014/15 – a 7.1 per cent increase in 12 months - with almost 6,000 of them over the age of 65. This included 3,000 over the age of 85.

The breakdown is detailed below. Some people may receive more than one service during the year.

	2013/14	**2014/15**
Equipment & adaptations	4,105	4732
Home care	3,060	2724
Direct payments	973	961
Residential	777	759
Professional support (services provided as part of a care plan)	422	527
Day care/ transport	384	368
Nursing	357	347
Respite care	162	176
Other	36	102
	10,276	10,366



Case study 1: equipment and adaptions helping Mrs B remain safe at home

Mrs B, a wheelchair user, was having problems getting up from her chair, using the toilet and standing in the shower to wash. She had recently fallen out of the shower when she tripped on the shower tray.

She agreed that a grab rail by the toilet and in the shower, along with some chair raisers, would really help.

The Havering Safe at Home Service was contacted by her occupational therapist and the rails were installed a week later. Mrs B also contacted 1st Mobility for some chair raisers.

She was extremely pleased with the service she received from all involved and Mrs B is now able to use the shower safely and independently within her home.

The financial challenge

Havering Council faces record financial challenges as it absorbs funding reductions and inflationary costs, provides services to a growing and ageing local population and meets new legislative responsibilities. Overall the Council needs to reduce its total budget by around a third by 2018.

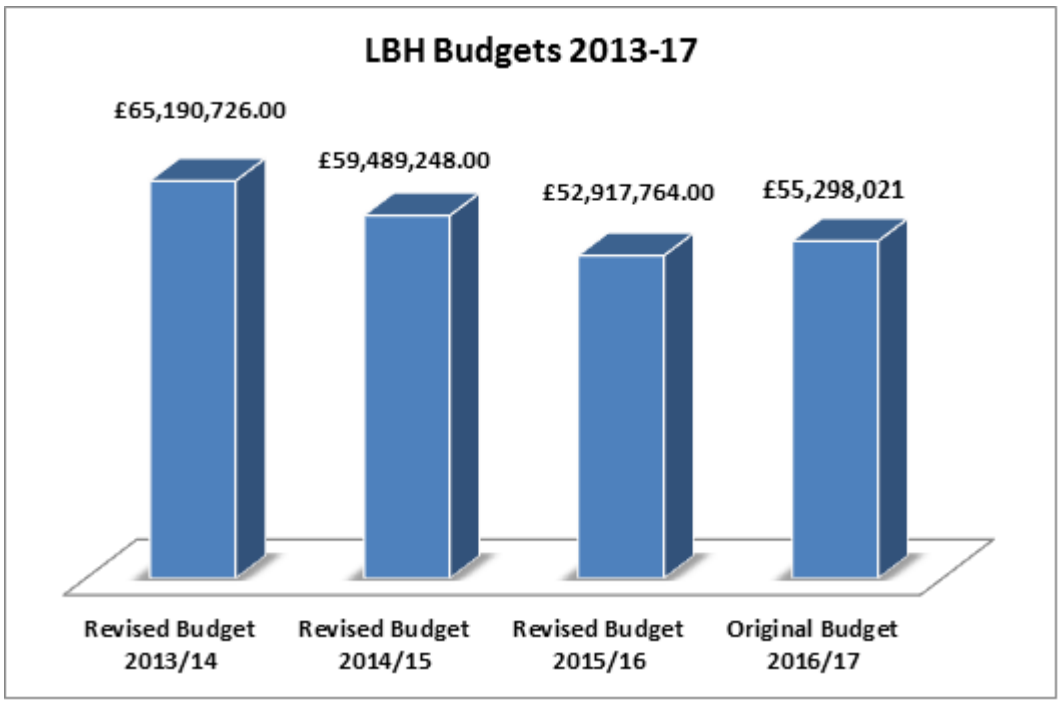
Adult social care is not immune from these pressures and needs to save £10.3 million over the years 2015/16 to 2018/19. This is on top of the £8.9 million the service has saved in the previous three years 2012/13 to 2014/15. Havering receives the fourth lowest government grant in London.

The Council has made a strong commitment to deliver all statutory services like adult social care and improve services. It remains committed to protecting the services that matter most to the residents of Havering and keeping local people safe.

The December 2015 settlement overall was considerably lower than expected. The February 2016 budget report, which was presented to Cabinet and full Council, declares a funding gap of £6.75m to 2018/19. This assumes that council tax increases of 3.99% (including the adult social care precept of 2.00%) will continue to be applied in 2017/18 and 2018/19. If these increases are not applied the funding gap will increase by £7.8m to £14.5m and further savings options will need to be developed.

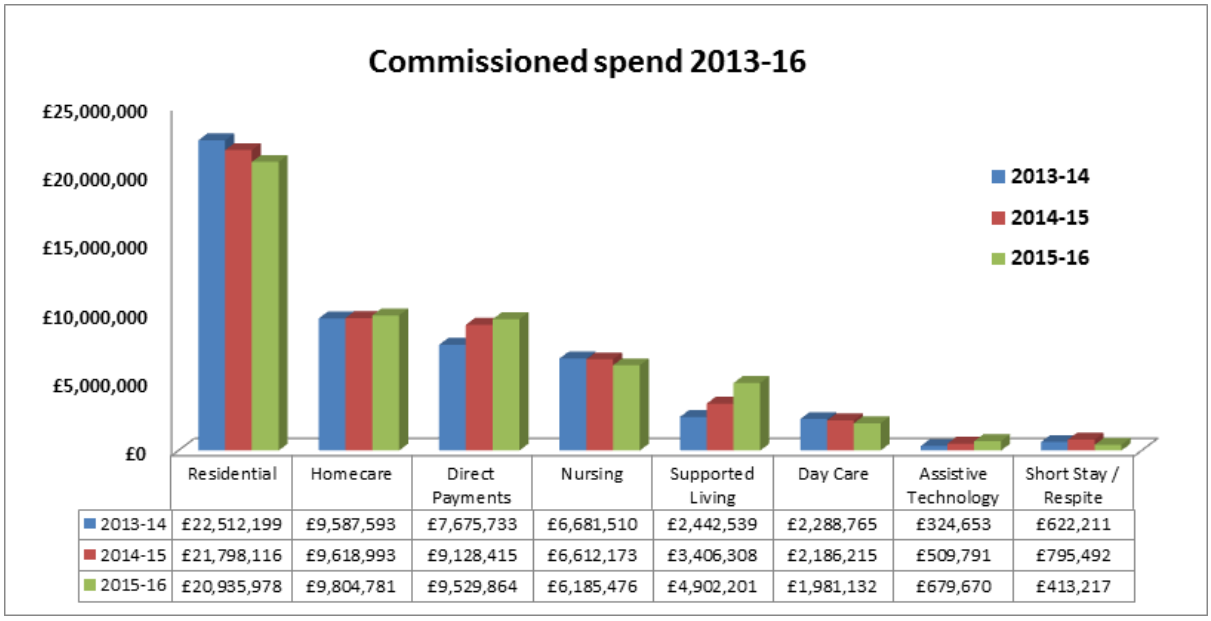
Government has recognised at a national level demand and budgetary pressures facing Local Government, by enabling local authorities to levy an additional council tax precept of 2% for adult social care. In response to this, Havering has included in the financial strategy a provision to increase the budget for adult social care by £3m, which includes the social care levy.

The graph below shows the budgets year on year.



Figures include staffing budgets.

Spend by activity



	Residential	Homecare	Direct Payments	Nursing	Supported Living	Day Care	Assistive Technology	Short Stay / Respite
2013-14	£22,512,199	£9,587,593	£7,675,733	£6,681,510	£2,442,539	£2,288,765	£324,653	£622,211
2014-15	£21,798,116	£9,618,993	£9,128,415	£6,612,173	£3,406,308	£2,186,215	£509,791	£795,492
2015-16	£20,935,978	£9,804,781	£9,529,864	£6,185,476	£4,902,201	£1,981,132	£679,670	£413,217

It should be noted that commissioned spend includes elements of non-delivery, so actuals costs will be less than commissioned.

Our objectives

Clean • Safe • Proud

The Council's vision is of a Borough that is clean and safe and where residents are proud to live.

For Havering to be safe and proud we need to meet the social care needs of residents where they are vulnerable and have social care needs. We do this by **supporting our community** by helping people do as much as possible for themselves and keeping them safe in their homes and their community, **using our influence** and **leading by example.**

Case study 2: leading by example and supporting our community (with Pic)

Havering College's Realistic Opportunities for Supported Employment (ROSE) programme helps place people with learning disabilities into paid employment.

Havering Council supports the Programme and has helped several residents develop their skills – and confidence – with paid work placements across the Council.

Tommy (pictured) works in the Deputy Chief Executive for Children, Adults and Housing's Office and started with a range of office duties including filing, photocopying and shredding. He quickly progressed and now works with a number of services across the Council who rely on Tommy's support and appreciate his can-do proactive approach to his work.

Older people

In Havering some 45,600 people are aged over 65. At over 18 per cent of the Borough's total population this is the largest proportion of older people in London. This age group tends to have the highest health and social care needs.

Most older people in Havering live healthy, independent and active lives without support from the Council and a large number receive care and support from family and friends – around 27,000 according to the 2011 census.

Last year around one in seven people aged 65 or over in Havering received support from our adult social care services. This increased to around one in four aged over 85.

Most of the people we helped had physical needs although some had more complex conditions such as dementia or depression, We aim to support and help older people to remain living in their own homes and communities for as long as possible.

In 2014/15

- We helped more residents stay in their own home for longer, with 607 older people admitted to nursing or care homes – a 3.8 per cent reduction from 2013/14.

- Over 80 per cent of older people using our reablement service were able to remain living in their own home after leaving hospital.

- We helped over 190 carers of older people with services like respite or a temporary care home for the person they care for.

- We helped more older people remain more active with over 6,000 free swimming sessions in the Borough's leisure centres.

Our plans for the future

- Providing more joined-up health and social care services, sharing more resources with the NHS and providing a range of community services that help older people remain in the comfort of their own homes.

- In partnership with Family Mosaic, providing a new information and advice service to help people know what they can do to remain as independent as possible. The service will visit popular places and target elderly residents who are isolated or hard to reach.

- Providing more choice and control to older people. We know that those aged over 65 are traditionally reluctant to take-up a direct payment or personal budget. We are working to increase the take-up of self directed support among all age groups.

Case study 3 – integrated services helping Annie remain at home

Annie had been unable to get up after a fall in the night and used her pendant to raise the alarm. She was seen by the Doctor and diagnosed with severe bruising to her hip.

The occupational therapist from the Community Treatment Team (CTT) – a joint health and social care service with staff from the NHS and Council – suggested Annie use a walking frame to reduce the risk of future falls.

Her social worker recommended a package of reablement care and gave advice about other support so that she could return home. She also contacted Annie's family to make sure they were happy with the outcome.

The care package initially put in place consisted of three daily visits for six weeks and Annie's carers helped her with personal care and making meals. As she became stronger and more confident carers helped her manage these tasks herself and she has now regained her independence. Annie no longer requires support from social care but as a sensible precaution continues to wear her pendant alarm.

People with disabilities (physical, sensory and learning)

It is estimated that there are more than 14,000 adults of working age with a disability in Havering. Across the borough some 6,000 people cannot work because of their disability.[4]

Disabled people may be frail, have problems moving around or sensory needs because they are visually or hearing impaired, blind or deaf. In Havering we focus on supporting people through recovery and reablement so they can live independently without long-term support. This includes:

- Equipment and adaptations
- Blue Badges
- Freedom Passes
- Short term respite
- Professional support such as counselling or therapy
- Supported housing
- Day care
- Home care
- A range of day activities for adults living with a disability at Yew Tree Lodge in Romford

For those with sensory or learning disabilities and their carers, the Community Learning Disability Team - an integrated multi-disciplinary team managed in partnership with the North East London Foundation Trust (NELFT) - is responsible for assessment, care support planning and arranging care packages.

It also provides specialist health care to people with a learning disability, as well as advice and information and awareness training to GPs and other health professionals.

The Avelon Road Centre in Rainham also offers a choice of stimulating activities to help people with learning disabilities develop their abilities and skills.

In 2014/15

- Some 94 per cent of disabled people in Havering were supported in the community. During the year only 811 disabled people received services in residential or nursing care homes (624 with a physical disability, 165 with a learning disability and 22 with a sensory disability).

- We increased the proportion of adults with learning disabilities in paid employment from 8.3 to 8.6 per cent of service users.

- We increased the numbers of people with learning disabilities living in supported living rather than residential care, and 63 per cent of service users lived in their own home or with their family.

[4] Haveringdata.net

Our plans for the future

- Widening the range of accommodation available locally to people with learning disabilities, including supported housing.

- Establishing a Shared Lives Scheme with more people opening up their homes to those who need some form of support and assistance.

- Developing more services for people aged over 16 at the Avelon Centre in Rainham.

Case study 4: helping Jamie start afresh with supported living (with pic)

In 2015 Havering Council opened a new supported housing development for adults with learning disabilities or autism, to help them to live as independently as possible while still providing support.

Great Charter Close, based in South Hornchurch, has four self-contained bungalows and four flats. The Council allocated the properties to the local residents whose needs could be best met by the supported accommodation.

Among the residents is Jamie Bennett, who previously lived at a specialist assessment and treatment hospital unit. He said:

“When I moved into this supported accommodation, it was like my life had actually started afresh. I am very happy here, living in a very beautiful flat with very friendly neighbours and staff. I enjoy going to the local shops, park and pub, meeting up with members of my local community.

“I love how spacious my flat is with its beautiful garden where I can sit down and relax. My family lives close and they visit me frequently. This has completely changed my life.”

People with mental health needs

In Havering, the number of people with mental health conditions is increasing and the number of adults aged 18 to 64 with a common mental health disorder like anxiety or depression is projected to rise from 23,849 in 2015 to 26,493 in 2030.

Havering Council and the North East London Foundation Trust (NELFT) provide an integrated health and social care mental health service. This means teams of multi-disciplinary professionals from both organisations work with adults, their families and their carers both in the community and in hospital.

The service focuses care on supporting recovery and building the resilience of people with mental health problems, not just on treating or managing their symptoms. It aims to support healthy lifestyles, provide access to good quality information, advice and advocacy, reduce social isolation and increase the number of adults with mental health needs in paid employment.

During 2014/15

- Over 88 per cent of adults in contact with secondary mental health services – 405 people - lived independently.

- We increased the proportion of adults in contact with secondary mental health service in paid employment from 5.2 to 6.8 per cent.

- We also helped
  - 39 people into employment
  - 36 people sustain employment for 13 weeks or more
  - 121 people started a work placement
  - 129 people completed accredited training

Plans for the future

- Continuing to provide high quality care in the community by working with the families or networks of people experiencing a mental health crisis, not just the individuals themselves.

- Reviewing our arrangements for supported employment, enterprise and work experience.

Case Study: Helping Alan back into work

Alan has cerebral palsy and was diagnosed with mild depression when referred to the Work Independence Programme by his local job centre.

The Programme, which has built good relations with local employers, helped Alan manage his condition, build his confidence, learn new skills and be better prepared for work.

Sainsbury's agreed to interview Alan and he started a temporary role with their online shopping team. He was so successful that they offered him a permanent position.

As well as helping him to break down the barriers to finding a job, the project helped him with tax credits, which made it easier from him to stay in work, and he benefitted from a £2,000 back dated payment.

Alan said: “I’m really happy to be working now and can’t thank everyone enough.”

Carers

A carer is someone who looks after a relative or friend who because of age, physical or other disability cannot manage at home without help. This can range from personal care including toileting, washing and feeding to help with the shopping, housework or simply keeping them company.

According to the most recent Census some 25,200 Havering residents - around 11 per cent of Havering's population - provide unpaid care. Over 16,000 - 7 per cent - provide between one to 19 hours of unpaid care per week and over 5,800 - 3 per cent - provide over 50 hours unpaid care. These figures are higher than the average in both London and England.

In Havering carers are able to access a range of support to help them lead an independent life alongside the care they provide. This includes a carer's assessment and information on a wide range of services provided by Havering Council and its partners.

During 2014 / 15

- Some 1,936 carers had their needs assessed so we could support them.
- Nearly 800 carers were signed up to the Havering Carers' Register, connecting them to a number of services and a wealth of information.
- 418 carers got a break from caring when the person they care for received respite care.

Plans for the future

- Developing support for carers at doctor's surgeries including a pilot GP practice-based Carers' Support Group.
- Implementing a new Havering Carers' Strategy with Havering Clinical Commissioning Group and carers.
- Identifying more carers or former carers to help the Council and Havering Clinical Commissioning Group improve services.

Case study 6: helping carers carry on caring

Carer Vicky Pilditch from Collier Row was one of more than 200 people who attended an information event to raise awareness of services and support available for carers in Havering during Carers Week.

Vicky said: "It was really helpful to see all the services available and all the organisations that provide them under one roof and there were lots of friendly faces to speak to. *The Carers' Information Booklet,* which was given to everyone on the day is a particularly handy

guide to all that's going on in Havering to make caring a little easier."

You can download *The Carers' Information Booklet* on www.havering.gov.uk

Providing choice

Havering Council wants service users to have choice and control over the way care and support is provided.

Self directed support (SDS) covers personal budgets including Individual Service Funds, Voluntary Maintenance Allowance and direct payments. Anyone who is assessed as needing care services has the right to request a direct payment instead of having services provided by the Council.

There are some limited circumstances when direct payments are not awarded but the majority of people already receiving, or assessed as needing, services have a right to direct payments. This includes:

- older people who have been assessed as needing community care services
- disabled people aged 16 and over
- carers, in place of receiving carers' services
- families with disabled children
- disabled parents

During 2014 / 15

	Clients receiving some form of SDS	**Clients receiving a Direct Payment**
	Per cent of client base	**per cent of ASC client base**
18-64	67.77%	56.24%
65-74	66.97%	38.99%
75-84	75.97%	28.35%
85+	77.00%	25.58%
Total	72.86%	37.09%

Telecare is equipment that may be used to help people to live as independently as possible at home or to support people in their daily lives and routines.

The equipment can provide independence, safety and security - from simple alerts if someone needs emergency assistance, to devices designed to help people with dementia or memory loss.

For more information on Havering's telecare equipment and emergency alarms visit www.havering.gov.uk

In 2014/15

- Over 1,500 adults received some form of self directed support, giving them choice and flexibility over the services they receive
- Some 730 adults received a direct payment
- Over 1,300 people used assistive technology to help them remain independent with assistance only the touch of a button away

Plans for the future

- Increasing the proportion of service users who receive some form of self directed support to over 80 per cent.
- Providing more than 45 per cent of self directed support as a direct payment.
- Reviewing the voluntary sector and continue to commission services that help people remain independent
- Piloting a Social Isolation Project to help people who have become isolated and could require health and social care services as a result.

Case study 7: A personal budget for Alex

Alex is a profoundly deaf man in his thirties who uses British Sign Language to communicate. He had very little interaction with the deaf community and would only go out twice a week with his mum for shopping. He would spend most of his time at home reading, watching television or playing on his Xbox.

Alex told us he was bored and frustrated, and because of previous bad experiences, did not like to go out or be left alone.

Following an assessment with Alex and his mum, a personal budget was agreed with the aim of boosting his confidence, increasing his social skills, building friendships and helping him live more independently.

Alex's personal budget helped him use the services of a support worker fluent in British Sign Language and with their help Alex started volunteering in a charity shop. At first Alex worked one day a week for four hours. Now with increasing confidence he's working two days a week, travelling to the shop by himself and dealing with customers.

Preventing or delaying the need for health and social care

The Council and its partners provide a number of services to help people recover faster from illness, prevent unnecessary admission to hospital or premature admission to residential care, enable timely discharge from hospital and help people live independently.

Sometimes known as intermediate care, the services include:

Intensive Rehab Service
Provided by North East London Foundation Trust (NELFT)
Staff - nurses, occupational therapists, physiotherapists, rehab assistants
Services - Intensive rehab at home, alternative to inpatient or rehabilitation bed

Community Treatment Team
Provided by North East London Foundation Trust (NELFT) in hospital and at home
Staff – district nurses, occupational therapists, physiotherapists, social workers and support workers
Services – short term intensive care and support in the community, health and social care crisis and urgent response, community treatment

Reablement
Provided by Family Mosaic
Service – intensive, short term (six week) service to help people back into their own home and on the road to independent living once they leave hospital either at home or at a residential

Joint Assessment and Discharge Team
Provided by Havering Council, the London Borough of Barking and Dagenham and the local NHS
Service - single point of contact for all people who may require health or social care support after discharge from hospital. The services aims to get patients back to their homes as soon as they are fit and able
Staff - social workers, nurses, an occupational therapist and administrators

Help not hospital
Provided by British Red Cross
Services - support people through short term crises and in getting home and settled from hospital, keeping people away from hospital

In 2014/15

- We provided reablement to over 1,100 people at home and to over 170 people at our residential facility at Royal Jubilee Court in Romford.

- Only 4.4 per cent of services users - 28 people - who received reablement needed further care or support after 91 days.

- The Community Treatment Team helped over 5,900 patients - more than a tenfold increase on the previous bed based system

Plans for the future

- Locating health and social care teams around GP clusters**,** bringing integrated care to patients and ensuring coordination and ease of access for practices.

- Working in partnership with the NHS to provide the technology to share social care records.

- Improving the intermediate care pathway and reviewing the Community Treatment, Joint Assessment and Discharge Teams; Intensive Rehab and Reablement Services.

Case study 7: Reablement helped my Mum get back on her feet and return home

When she began reablement I did not think my Mum would ever return to any type of independent living. Although she was mentally capable, physically she was not able to look after herself. She was depressed and nervous and I thought I had lost that wonderful, vibrant person forever.

Havering's reablement service is amazing and the staff took a huge weight off of my shoulders when Mum arrived – working with us both to get her back on her feet and ready to return home.

In a very short period of time Havering's team proved me wrong. The lady that returned home was bright, confident and back to the wonderfully happy person she used to be. My family and friends are amazed at the difference in her. All down to the support and dedication of the staff.

Daughter of Mrs Y, aged 88

Improving and maintaining well-being

As people are now living longer and with a better quality of life, the care and support needs they have are different. The way care and support is provided has changed to reflect this.

In April 2015 the new Care Act came into force making care and support easier to access in Havering, and more consistent across the country.

Driving the landmark new legislation is the principle of individual well-being. Any decisions about care and support now consider individual well-being and what is important to people and their families so they can stay healthy and remain independent for longer.

In 2014/15

- We provided 9,849 care assessments including 5,063 under the new national assessment framework to date[5]
- We provided 82 deferred payment agreements so that people didn't have to sell their homes in their lifetime to pay for their care
- Our Better Care Fund plan was approved by the Government. Some £19m of existing funding will be invested by the Council and the local NHS to help improve services and the well-being of local people.
- Some 10,000 residents took part in our Active Living Programme.

Plans for the future

- Refreshing our adult social care website www.haveringcarepoint.org so it is easier for people to get the information they need to make informed care choices.
- Establishing an information and advice service that helps people remain independent in their own home and active within the local community.

[5] April to September 2015

Keeping people safe

An adult at risk is someone who finds it difficult to protect themselves from harm or abuse due to age, illness, disability or other impairment.

Harm can be physical, psychological, sexual or financial and can be caused by another person, a carer or an institution.

Protecting adults at risk is everyone's business and Havering's policies are designed so that all partners and individuals:

• Work together to protect people from harm
• Support them to make their own choices
• Uphold the person's needs, rights and interests

Together we:

• Investigate concerns
• Take timely and proportionate action
• Make people safe if they are at risk
• Act to prevent harm occurring in the first place

Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS), aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a care home, hospital or supported living arrangement only deprives someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them.

On 19 March 2014, the Supreme Court published its judgment in the case of P v Cheshire West and Chester Council and P and Q v Surrey County Council. The judgment clarified the test and definition for Deprivation of Liberty for adults who lack capacity to make decisions about whether to be accommodated in care. This means that a much greater number of service users and patients will now be subject to a deprivation of liberty and will come under the protection of the DOLS procedure.

As a result of this judgement the London Borough Of Havering has seen a dramatic increase in requests for DoLs authorisations. Prior to the Cheshire West judgement there were in the region of 20/30 requests per year , following the judgment the request increased to 230 a year and this year we have seen this request double. Form April 2015 to March 2016 the London Borough of Havering have had approximately 560 applications for Deprivation of Liberty authorisation. It is estimated that this figure is likely to increase to 800 for the coming year. As such the priorities for the coming year are;

- To ensure that we have sufficient Best Interest Assessors to meet the forecasted demands

- Raise awareness around the Deprivation of Liberty Safeguards and provide relevant training
- Support providers to recognise when a person is being deprived of their liberty and refer in for an authorisation as soon as possible
- Ensure that where a person is an unlawful deprived of their liberty immediate alternative options/solutions are explored.

During 2014/15

- We received 593 safeguarding alerts – a 25 per cent increase compared to 13/14. We formally investigated 70.2 per cent of the alerts we received.

- Most incidents - 184 - took place in the person's own home while 139 happened in care homes. Neglect is the most common type of abuse in Havering.

- We re-launched our safeguarding policies, introduced a local protocol and toolkit and established a Safeguarding Adults Senior Practitioners Forum.

- We highlighted how to raise safeguarding concerns with a campaign - Safeguarding is Everyone's Business.

Plans for the future

- Reviewing our integrated Multi Agency Safeguarding Hub and increasing partnership working for adults who do not meet the thresholds for Council intervention.

- Extending our safeguarding process and procedures into more general social care practice.

- Restructuring our Safeguarding Adults Team.

Case study 8: Safeguarding residents

Mrs X, 79, lives in a nursing home in Havering although she was originally from a neighbouring London borough. Her son and daughter contacted us to raise their concerns because they felt nursing staff were neglecting their Mum who needs help to eat, drink, wash, use the toilet and take her medication.

As a result of a safeguarding alert and investigation, Mrs X was allocated a social worker and a meeting was held where we put together a protection plan. A key worker sat with her during meal times to make sure she ate and drank.

We also asked the home to provide evidence that this was happening. Her GP agreed to

keep a close eye on Mrs X and support any plans to help with her nutrition.

The nursing home created a social stimulation plan to improve her mood and appetite. We also helped the nursing home to improve the way they communicated with her family.

Mrs X's family believe their Mum is a lot safer now.

Our achievements

Despite the 'perfect storm' of a swelling and ageing population, increasing demand for adult social care and funding reductions, we have lots of examples of good and award-winning practice.

Safeguarding approaches recognised

Havering's Multi Agency Safeguarding Hub (MASH) brings together the Council, police, health, and probation services and joins-up information that is already known within separate organisations to inform safeguarding decisions.

For those residents that don't meet the statutory thresholds for support, a Multi Agency Risk Assessment Conference (MARAC) enables information to be shared between different statutory and voluntary sector agencies.

The MASH and MARAC were recognised nationally as Havering was shortlisted in the Innovation in Social Care MJ Achievement Award 2015.

Dementia Friendly Community (with award)

Around 3,500 people aged over 65 live with Dementia in Havering and the Havering Dementia Action Alliance was developed with our partners to help those affected by the disease.

To date, over 2,000 organisations or teams have received dementia friendly training, 350 have completed it online and 1,965 clinicians who have been trained in dementia symptoms.

The Alliance, which has more than 75 member organisations, won the Best Dementia Friendly Community Initiative in the Dementia Friendly Awards, and the Community Organisation Award for Disability in The National Diversity Awards.

Improving health and well-being

Havering established a new partnership between health and social care in 2013 when our Health and Well-being Board was established. Since then it has gone from strength-to-strength working with Havering Clinical Commissioning Group, Barking, Havering, Redbridge University NHS Trust and the North East London Foundation Trust (NELFT) to improve the lives of local people.

The Board's work was shortlisted for the Best Health and Well-Being initiative at the 2015 APSE Awards.

Implementing the Care Act

The Care Act – the biggest change in adult social care legislation since the NHS was created – started to come into law in April 2015. With individual well-being the driving force, the Act heralded a new national care assessment framework, more rights for carers, new safeguarding responsibilities and a duty to shape the local care market. Havering has redesigned many of its services to meet our responsibilities.

Improving communication with social care providers

Havering has launched an online care network for the Borough's social care providers. The network enables care providers of all sizes – from large care homes to small voluntary organisations – discover what care is available, browse and book local training and events and, where appropriate, share service details and apply for tenders. The network connects care providers helping them get involved in discussion with the Council on how care is provided in the Borough. To get involved with the network visit www.carenetworkhavering.org.

The challenges ahead

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

With each generation in Havering living longer than the last it is important to ensure that people can enjoy these extra years in good health. Meeting the challenges ahead we will:

- **Be more ambitious** integrating services with our health partners to provide seamless care and support to residents. We need to provide more services that are joined up with health, provided by the NHS, and social care, provided by the council.

- **Provide more choice** and increase the take-up of personal budgets and direct payments. This is key to helping people manage their own care. We will also help shape Havering's care market to ensure real choice and control for everyone whether through a local authority managed budget, a direct payment, individual service fund or for those who self fund their own care.

- **Be more strategic in how we commission and contract services** not just across the council but with our health partners and with residents shaping the decisions we make.

- **Embrace our new responsibilities under the Care Act** fully modernising our services including how we assess people's needs, put together a support plan, provide choice and control, improve well-being and maximise independence. In Havering, care and support is changing for the better as a result.

- **Continue to strengthen our safeguarding arrangements** to make sure we are doing as much as we can to protect people from abuse – preventing it happening in the first place and in dealing with issues quickly.

- **Ensure our workforce has the right tools** to do the job and feels confident in meeting the challenges ahead. Our new Principal Social Worker will help us focus on outcomes for people rather than our processes, our senior management restructure will help us integrate services with our health partners, and our Assistant Chief Executive will ensure the needs of adults are always the priority.

- **We need to ensure we effectively manage the council's largest budget** in light of significant demographic pressures and increased demands.

Tell us what you think

We hope you have found this local account of adult social care informative.

The requirement to publish our Local Account comes from the Towards Excellence in Adult Social Care (TEASC) Programme and from the national Association of Directors of Adult Social Care. The TEASC programme helps councils perform to the highest standard in adult social care.

Let us know your thoughts. Please email your views to adultsocialcare@havering.gov.uk and help us improve future accounts and publications.

Keep informed

To keep up-to-date with the latest developments in adult social care in Havering, visit www.havering.gov.uk and subscribe to our email updates including Health and Well-being, Carers, Care Connect and Active Living.

Social care providers can sign-up to www.carenetworkhavering.org to connect with a range of information and training.

For further information on adult social care visit www.haveringcarepoint.org.uk

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Health Based Place of Safety
Board Lead:	Barbara Nicholls, AD Adults and Commissioning
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The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- ☐ Priority 1: Early help for vulnerable people
- ☐ Priority 2: Improved identification and support for people with dementia
- ☐ Priority 3: Earlier detection of cancer
- ☐ Priority 4: Tackling obesity
- ☐ Priority 5: Better integrated care for the 'frail elderly' population
- ☐ Priority 6: Better integrated care for vulnerable children
- ☐ Priority 7: Reducing avoidable hospital admissions
- ☒ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

Early in 2015 NHS England and London's thirty two CCGs and NHS England (London) launched a plan to make London the world's healthiest global city. The Healthy London Partnership was formed to improve health services and deliver changes to health in the capital.

The Healthy London Partnership is working to support improvements in mental health crisis care. This includes transforming the Urgent and Emergency Care pathway for individuals experiencing a mental health crisis in London, by introducing

clearer guidance to help London's Emergency Departments care for someone in crisis. It is also developing a specification for Health-Based Places of Safety and consistent care pathways for people under Section 136 and Section 135 of the Mental Health Act 1983.

The London crisis care subgroup has been asked to engage more widely on the Health Based Place of Safety (HBPoS) specification and London s136 pathway. The subgroup wants to engage with local authorities and particularly Health and Wellbeing Boards to obtain comments on the draft guidance and specification which are appendices to this report.

The Mental Health Crisis Care subgroup is leading on both pieces of work .The sub-group is consulting extensively across the whole system on the draft papers. Other parties consulted include mental health and acute provider trusts, commissioners, local partners (e.g. the police, London Ambulance Service, social care) and service users.

RECOMMENDATIONS

1) In general the guidelines appear to be of a comprehensive nature, indicating good practice. It is recommended that the Health and Wellbeing board agree to the Health Based Place of Safety (HBPoS) specification and London s136 pathway documents in principle. Points that the Health and Wellbeing Board may wish to consider are:

I. The guidance states that it is the responsibility of the NHS trust to ensure that an Approved Mental Health Professional (AMHP) is capable to carry out the functions of the role. However, it is the social services of local authorities who have the statutory responsibilities:

'AMHPs are critical to delivering better mental health services and outcomes, taking urgent decisions about the least restrictive options for people requiring care and treatment, protecting people's human rights and promoting the principles of the Mental Health Act: Code of Practice (2015). With AMHP services and individual AMHPs remaining the responsibility of local authorities, it is imperative that organisational arrangements are in place to support AMHP practice, including supervision and professional development, in line with our intentions for the new regulatory body for social work.' *(Local Authority responsibilities for the approved Mental Health Professional Role DoH letter to DASS and Chief Executives of Health Trusts Feb 2016)*

II. The guidance queries if the London Ambulance Service (LAS) should be part of local multi-agency group to consider ongoing practice issue, measure and analyse performance at the HBPoS. There presently exists such a group which is chaired by NELFT that meets bi-monthly. The attendance of LAS on a regular basis would be welcomed, as they are an integral part of the transportation process regarding people detained under the Mental Health Act, and the guidance should specify they should be a member.

III. The guidance states an AMHP should arrive at a Section 136 suite within two hours and start assessment within four hours. It is unclear in the guidance what attendance would achieve, and at the local 136 suite AMHPs have experienced difficulties regarding the use of mobile phones which could hinder the delay of the assessment. AMHPS, for example, require being easily contactable by the independent second doctor to coordinate a joint assessment.

IV. The starting of the assessment within four hours is supported. The Havering AMHPS undertaking the statutory assessment starts this on receipt of the request. The arrival and assessment times of AMHPs at the Section 136 Suite is monitored by a local multiagency forum to ensure that any delay is due to valid/clinical reasons.

V. The Guidance queries if there should be AMHPs to undertake assessments for children and for adult assessments. All the AMHPS within Havering receive training on all specialist groups. The AMHPS also ensure that appropriate specialists are involved in the assessments. For example, one of the mental healthcare professionals participating in an assessment of a child has child and adolescent mental health competencies. This is in line with the Mental Health Act Code of Practice. The AMHP would also work with healthcare professionals for other specialist groups e.g. people with learning disabilities.

REPORT DETAIL

1. Mental Health Act 1983

1.1 The Mental Health Act 1983 sections 135 and 136 is the law which can be used to admit an adult or young person to hospital for assessment and/ or treatment.

1.2 Section 135 has two parts; part 1 allows a magistrate to issue a warrant to the police allowing entry (by force if necessary) to a private place, for example someone's home, to remove a person who an Approved Mental Health Practitioner (AMHP) has reasonable grounds for suspecting is suffering from a mental disorder and not capable of caring for themselves, or is being mistreated/neglected or is not able to be controlled. The warrant has to specify the private place but does not have to name the person.

1.3 Part 2 covers the return of a person to hospital and other people liable to removal under the Act. A typical case might be when someone is absent without leave from hospital (where they are detained on a section of the act). The purpose of the warrant is to allow entry to a specified private place and then removal to the place where the person is meant to be (or a place of safety).

1.4 Section 136 provides a power for police officers to detain a person (adult or juvenile) found in a place to which the public has access, who appears to be suffering from a mental disorder and to be in immediate need of care or control and it is necessary in the interests of that person or for the protection of other persons. The legislation empowers an officer to take the detained person to a place of safety, so that ultimately health professionals would conduct a full Mental Health Act Assessment on the person with a view to determining whether or not they should be further detained under Section 2 (for further assessment) or Section 3 (for treatment) of the Mental Health Act.

1.5 Section 136 is an emergency power, providing a mechanism for non-mental health qualified police officers to take action to make a vulnerable person safe and assist them in accessing emergency assessment.

2. Draft Guidelines

2.1 The specifications in the draft guidelines do not stand alone but should be used in addition to the Mental Health Act Code of Practice (2015), London's Mental Health Crisis Commissioning Standards and the core principles set out in the Mental Health Crisis Care Concordat.

3. Health Based Places of Safety (HBPOS)

3.1 The document is a draft specification which sets out the minimum standard of care London's Health Based Places of Safety should offer. The specification applies to Health Based Places of Safety that care for children and young people as well as adults detained under section 135 and 136. It is aimed primarily at commissioners, referrers and providers of Health Based Place of Safety sites and should be used alongside the section 136 care pathway in order to provide a consistent pathway of care across London.

3.2 A HBPOS is used when an individual of any age has been detained under section 135 or 136 of the Mental Health Act 1983. In law, a 'place of safety' is not clearly defined and has no specific characteristics.

3.3 Technically anywhere can be a Place of Safety under the Mental Health Act as long as the occupier is temporarily willing to receive the patient, this is stated in s135(6) of the Mental Health Act. In practice psychiatric units and hospital emergency departments are most commonly used.

3.4 The Mental Health Act Code of Practice (2015) instructs a Place of Safety to be a hospital or other health based place of safety where mental health services are provided;

3.5 A Police station should not be used as a Place of Safety. A police station should only be considered as a last resort or when the patient is also suspected of having committed an offence.

4. London Section 136 Care Pathway

4.1 The Section 136 and Section 135 care pathway focuses on all ages and should sit alongside the Health Based Place of Safety specification in order to provide a consistent pathway of care across London.

4.2 Havering residents detained by the police under Section 136 are predominantly taken to the 136 Suite at Sunflowers Court, Goodmayes Hospital. The suite consists of two rooms for people to be assessed. The suite is to meet the needs of residents of Havering, Barking and Dagenham, Redbridge and Waltham forest.

4.3 Havering residents may on occasions be taken to A& E departments as they require medical intervention. This could be the Queens or King Georges hospital.

4.4 Nationally and across London there has been concern expressed that Police Stations have been used as places of safety. The draft guidelines indicate this should not happen. In reviewing the last two years statistics for Havering residents there is no record of the Romford Police station being used as a place of safety.

4.5 Havering AMHPS apply to Barkingside Magistrates' Court for warrants under Section 135, and coordinates the execution, assessment and if required the transportation of the person. Police involvement does this does not mean the person has committed a criminal offence

4.6 In the draft guidelines it has been decided to focus on the section 136 care pathways rather than section 135 as there are fewer section 135 detentions across London.

5. NELFT are considering the draft guidelines, in particular the HBPOS, and will be feeding back directly to the sub-group.

The numbers within Havering are demonstrated by the tables below:

Section 135 (1) 2014- 2015	
April	2
May	0
June	0
July	2
August	1
September	2
October	0
November	2
December	1
January	0
February	0
March	1
Total	**11**

Section 135 (1) 2015- 2016	
April	0
May	1
June	1
July	1
August	0
September	0
October	0
November	0
December	0
January	0
February	2
March	0
Total	**5**

Section 136 2014 - 2015	
April	5
May	6
June	2
July	11
August	24
September	18
October	10
November	8
December	7
January	7
February	6
March	6
Total	**110**

Section 136 2015 - 2016	
April	9
May	9
June	16
July	10
August	12
September	10
October	4
November	6
December	9
January	7
February	11
March	4
Total	**107**

IMPLICATIONS AND RISKS

Financial implications and risks:

There are no financial implications and risks as the London Borough of Havering already finance the provision of AMHPS, and are active members of multiagency groups reviewing the implementation of the Mental Health Act. Havering Adult Social Care financially contributes and are members of the North East London AMHP Training Consortium. This is to ensure there are sufficient AMHPS to meet the needs of people within Havering who are competent to undertake the role.

Havering ensure that AMHPS are available 24 hours a day, 365 days per year. To do this Havering has commission, with other boroughs, NELFT to provide Emergency Duty Services on behalf of Havering. This arrangement is under a section 75 agreement. There is a quarterly steering group to oversee this arrangement and measure and analysis current performance.

The London borough of Havering is also ensuring that legal indemnity is in place for all AMHPS.

Legal implications and risks:

The attached are guidelines and as such should be considered and followed. However the Mental Health Act and the Code of Practice are the legal requirements

and must be followed. The AMHP Borough wide does follow the statues and code of practice. The AMHPS also have access to legal advice if and when required.

Human Resources implications and risks:

To ensure AMHPS are appropriately supported the London Borough of Havering have established systems in place. These range from human resource policies to AMHP professional forum.

Equalities implications and risks:

The guidance and the related legal requirements will help to ensure that those persons experiencing mental ill health in the Borough are assessed and have access to services appropriate to their needs and requirements.

BACKGROUND PAPERS

London's Section 136 Care Pathway – draft guidance March 2016

Health Based Place of Safety Specification – draft March 2016

Local Authority responsibilities for the Approved Mental Health Professional role letter Feb 2016

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London's Section 136 Care Pathway

Draft guidance

March 2016

Introduction

This document is aimed primarily at stakeholders involved in the section 136 care pathway, specifically Police, London Ambulance Service, Approved Mental Health Practitioners and Acute and Mental Health Trusts. The section 136 care pathway focusses on all ages and should sit alongside the Health Based Place of Safety specification in order to provide a consistent pathway of care across London.

It has been decided to focus on the section 136 care pathway rather than section 135 as there are fewer section 135 detentions and they tend to be less problematic across London. Unlike s135 cases, where a warrant is required and an approved mental health professional is involved, section 136 can be more unpredictable, with the decision to detain a person relying on the individual police officer's judgement

It is recognised that whilst prevention of mental health crisis is a central goal of mental health services it is outside the scope of the s136 care pathway. The s136 care pathway starts from when the individual is detained until the Mental Health Act assessment is completed and follow up care arranged. However London's crisis care system is responsible for ensuring adequate preventative measures are in place within the local health economy to prevent people being detained under s136. Innovative practices such as street triage, crisis lines and Psychiatric Decision Unit's aim to improve access to crisis care and reduce detentions under section 136; these practices should be explored within London's wider crisis care system.

What is a section 136?

Section 136 is the power that allows a police officer to detain someone whom they believe to be mentally disordered and in need of urgent care and control. The individual must be in a public place, defined as a place to which the public have access, and can be taken to a place of safety to enable a mental health assessment to take place.

Section 136 of the Mental Health Act 1983

1 If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety.

2 A person removed to a place of safety under this section may be detained there for a period not exceeding 72 hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional and of making any necessary arrangements for his treatment or care.

The maximum duration of detention is 72 hours under section 136 so that the individual can be examined by a registered medial practitioner and interviewed by an approved mental health professional (AMHP), and to make any necessary arrangements for their treatment or care. **This will shortly be changed to 24 hours under new legislation. Information describing London's s136 care pathway is based on 24 hour maximum detainment.**

London's Section 136 Care Pathway

1. Initial detention and access to a Health Based Place of Safety

1.1 Local arrangements should be in place to ensure there is always a suitable health professional for the police to consult with prior to detaining the person under s136, if there is a care plan in place the instructions in the care plan for managing a mental health crisis should be followed to avoid detention under section 136;

1.2 The Ambulance service or other service transporting the individual will always go to the Health Based Place of Safety closest to where the individual was picked up. However crisis care plans which may include a preferred place of assessment should always be taken into account where feasible;

1.3 If there is no capacity at the local Health Based Place of Safety when Police make initial contact it is that site's responsibility to accommodate the individual through agreed escalation protocols or alternative arrangements, whether the individual is from that area or not. A capacity management tool should be available to support this process (need to include more detail – what does this look like?)

1.4 This role should fall to the Health Based Place of Safety s136 coordinator in liaison with the hospital bed manager. If necessary escalations should be made to the on-call suitability qualified doctor or service manager who should be available through the Trust's switchboard.

2. Transfers

Initial transfer to Health Based Place of Safety or Emergency Department

2.1 The possibility of conveyance by a family member, carer or friend should always be considered first if they are willing and able to do this. An individual should only be transferred by a private vehicle if a health care professional is satisfied that the individual and others will be safe from risk of harm and that this is the most appropriate method of transport. A medical escort should always accompany the vehicle in these situations – and the police?

2.2 If it is not possible or appropriate for the individual to be conveyed by a family member, carer or friend then an ambulance should be used to convey the individual with police support where appropriate. The ambulance should arrive within 30 minutes or 8 minutes if restraint is being used.

2.3 If there is concern that waiting for an ambulance will cause further distress to the individual, the level of risk is considered high or the individual is violent then police transport should be used as a last resort to convey the individual to the Health Based Place of Safety.

2.4 Where conveyance via a police vehicle is necessary because of the risk of violence, a qualified paramedic should accompany the individual in the police vehicle. In any case an ambulance should follow behind to provide additional support that may be required.

2.5 The time of arrival and admission to the Health Based Place of Safety should be clearly recorded; the time of arrival is the start of the 24 hour assessment period under Section 136.

2.6 Individuals detained under a section 136 but requiring physical health care should be transported to an Emergency Department by ambulance with police support. The police must remain with the detainee until s136 papers are transferred or ED staff assess there to be no mental health disorder, remove the 136 and are willing to accept the risk and management of the individual.

Intoxication pathway:

2.7 *The Association of Chief Police Officers and the Independent Police Complaints Commission (2012)* describes drunk and incapable as an individual that has consumed alcohol to the point of being unable to either walk unaided or stand unaided or is unaware of their own actions or unable to fully understand what is said to them.

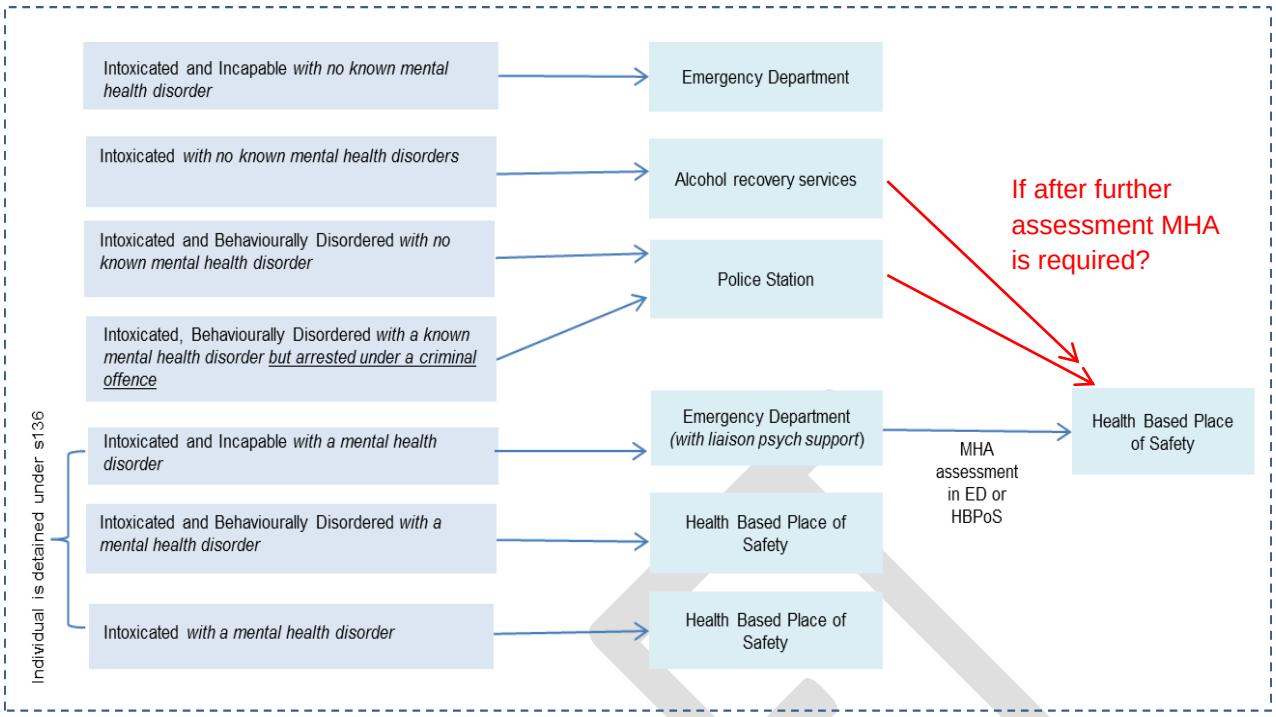
2.8 If someone appears to be drunk and showing any 'aspect' of incapability which is perceived to result from that drunkenness, then that person should be treated as drunk and incapable. A person found to be drunk and incapable should be treated as being in need of medical assistance at an Emergency Department. The same should occur for those who appear intoxicated by drugs.

2.9 A Health Based Place of Safety should not admit an individual that is 'drunk and incapable'. Where this occurs the person is too high a risk to the safety of the individual or staff and access to the Emergency Department should be arranged.

2.10 If the person is not adversely affected by intoxication and is fit for interview, they should be conveyed to the Health Based Place of Safety. The Health Based Place of Safety should not be conducting tests to determine intoxication as a reason for exclusion to the site; this should be based on clinical judgement. It is the clinical decision of the suitability qualified doctor at the Health Based Place of Safety to make the final call on where the individual is seen.

2.11 The following pathway for intoxicated individuals is proposed below; this includes intoxication by both alcohol and drugs. *Case studies will be developed to help define the different elements of the intoxication pathway.*

Intoxication pathway:



Transfers between hospital sites:

2.12 Trust boards are to be accountable for having and monitoring robust and cohesive policies for inter-hospital transfers;

2.13 All transfers should only take place when it is in the individual's best interests; relatives and/or carers are to be properly communicated with and informed where and when the individual is being transferred. The individuals privacy and dignity is to be maintained as far as possible throughout the transfer;

2.14 Unless it is an emergency, all transfers should be agreed by either an AMHP, S12 doctor or another mental health healthcare professional (who is competent to assess whether the transfer would put the person's or others' health or safety at risk) at both the sending and receiving hospitals;

2.15 A request to the Ambulance Service or a private transfer service is not to be made until agreement to transfer has been reached between hospitals with appropriate clinical involvement;

2.16 If the individual is conveyed and accepted into a Health Based Place of Safety and staff believe further treatment is required from the Emergency Department, transporting the individual is the responsibility of the Health Based Place of Safety. This should not be the Police's role unless there is mutual agreement between parties that it is in the best interest of the individual and the Police have capacity to support the transfer.

2.17 If an individual is in an Emergency Department for physical health treatment and a Mental Health Act assessment is required a needs assessment should be established to decide on

timely MHA assessment and the appropriate environment in which to conduct the assessment and provide on-going short term care.

2.18 Transporting individuals between Health Based Places of Safety and Emergency Departments and vice versa is the responsibility of Mental Health Trusts and Acute Trusts respectively, led by the s136 coordinator. This should not be the police's role unless there is mutual agreement between parties that it is in the best interest of the individual and there is capacity to provide support.

(Refer to ***Section 3: Expectations of Staff*** which details the expectation to conduct Mental Health Act assessments in Emergency Departments)

2.19 A person may be transferred before their assessment has begun, while it is in progress, or after it is completed and they are waiting for any necessary arrangements for their care or treatment to be put in place. The maximum period of detention cannot be extended if the person is transferred to another place of safety.

Can an individual be transferred to a HBPoS if the MHA assessment has been completed in the Emergency Department and they need somewhere until further care is arranged (but not wait in the ED)?

2.20 A person should never be moved from one place of safety to another unless it has been confirmed that the new place of safety is willing and able to accept them. The receiving hospital is to inform the sending hospital whether it can accept an individual within the agreed timeframes. An up-to-date Directory of Services should support transfers to alternative services.

2.21 If the individual is out of area and needs to be transferred to their local service the current Health Based Places of Safety is responsible for the individual's transfer. Transport should be arranged by this Trust and not delayed due to other external factors.

2.22 The sending hospital retains clinical responsibility for the individual until handover at the receiving hospital has taken place, handover should take place within 15 minutes of arrival;

2.23 The sending hospital is to ensure the individual is accompanied by an appropriate clinical escort(s) during the transfer, who is ready for transfer when the Ambulance service or private transport service arrives;

2.24 When the Ambulance service or a private transfer service agree to a transfer they are to dispatch or arrive at the hospital within the agreed times;

2.25 If Acute or Mental Health Trusts are unable to accept a transfer on clinical grounds clear reasons for the decision and targeted advice on further care must be provided to the sending hospital. The name of the staff member giving advice should be recorded in the individual's medical notes at the sending hospital;

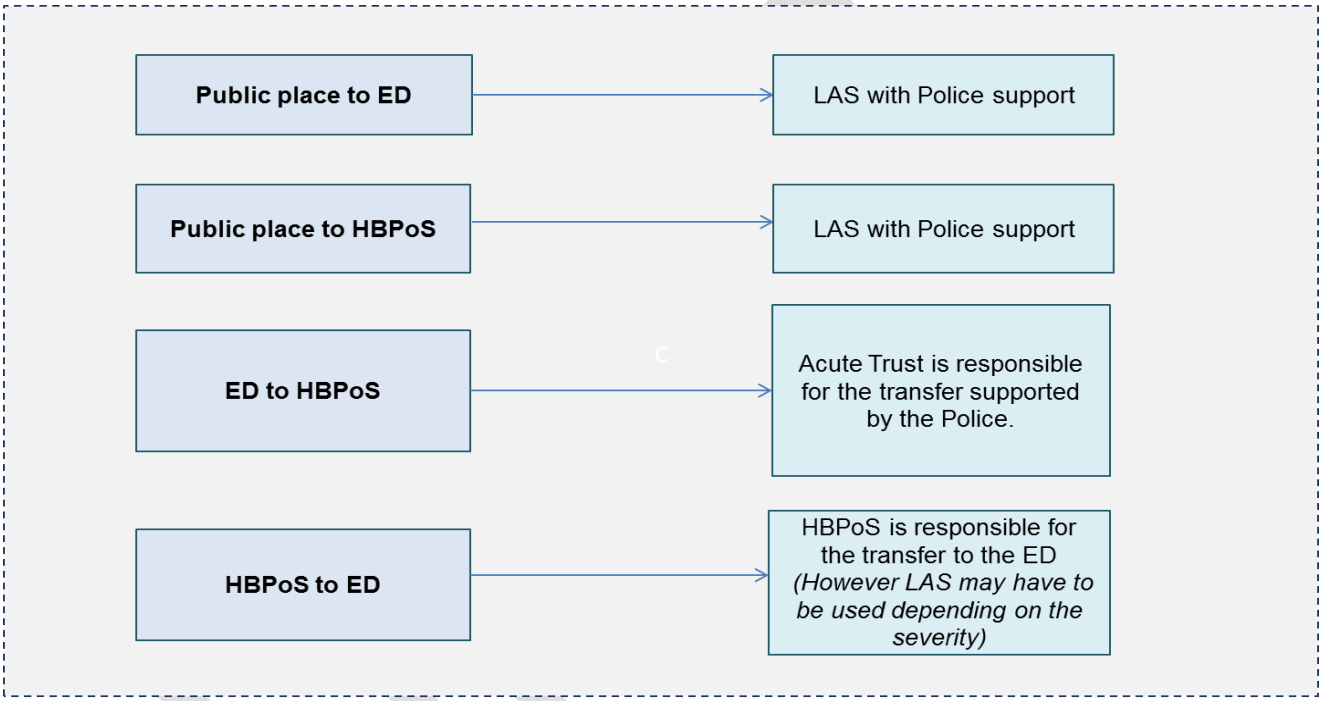
2.26 All transfers are to be carried out with appropriate clinical documentation. On arrival at the receiving hospital, an adequate structured handover to the receiving team is required;

2.27 All hospitals to have an escalation process in place which is instigated where timescales are not met for all transfers;

2.28 For all transfers, on arrival at the receiving hospital the individual must be seen by the receiving specialist team within the agreed timeframe (*refer to Section 4: Assessments in the Health Based Place of Safety specification);*

2.29 All individuals who have received rapid tranquillisation (in an Emergency Department or by the Ambulance Service) or been restrained for an extended period must always be transported in a fully equipped emergency ambulance because of the risk of rapid deterioration of their physical health.

Summary of transfer responsibilities across the s136 care pathway:



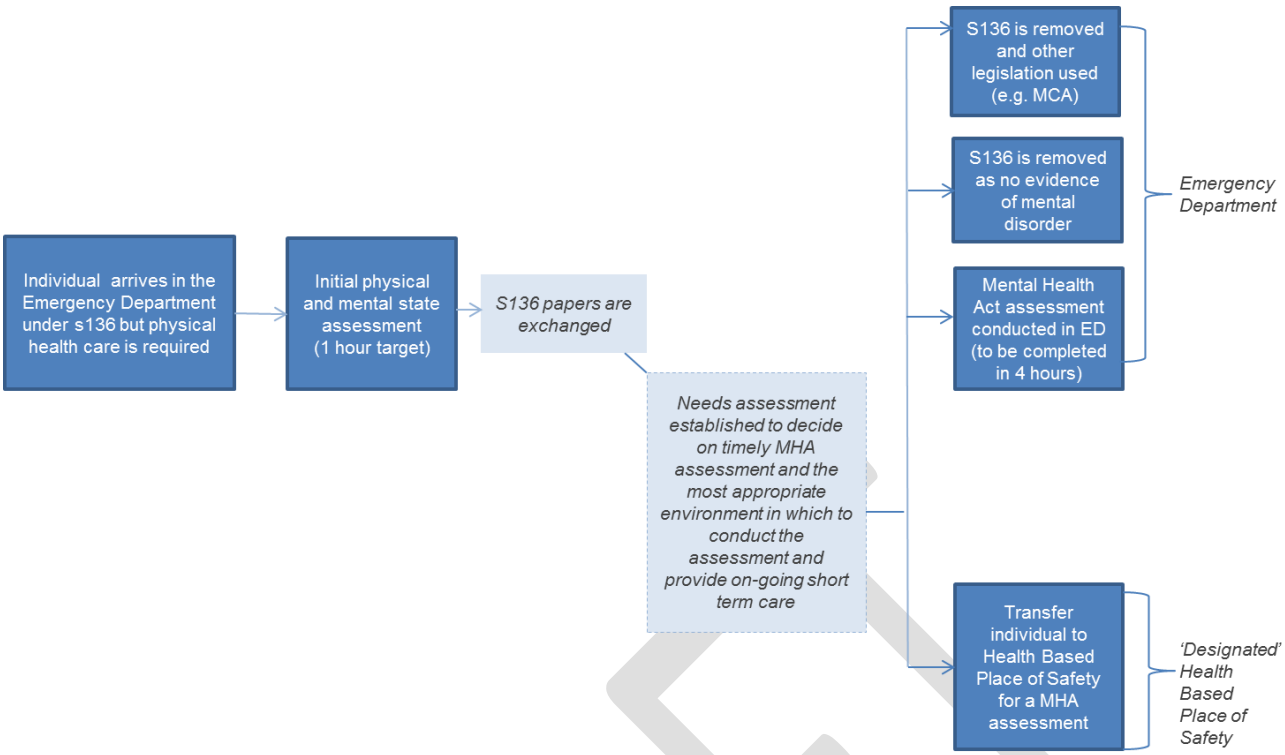
What does 'responsibility' mean – Booking transport, supplying RMN to accompany transfer?

3. Expectations of Staff

Emergency Departments

3.1 If individuals require a prolonged period in the Emergency Department or acute hospital admission, mental health services and the Emergency Department must respond in a timely way to support appropriate assessment and consideration of alternative legislation. This includes liaison psychiatry services seeing individuals within 1 hour of Emergency Department referral and Mental Health Act assessments being completed within 4 hours of the person's presentation to the Emergency Department.

See the proposed pathway below:



S136 is a police power – Are police are required to remain until 'assessment' is completed? If so there should be frequent reviews of police need and judgement calls made whilst the individual is in the healthcare setting.

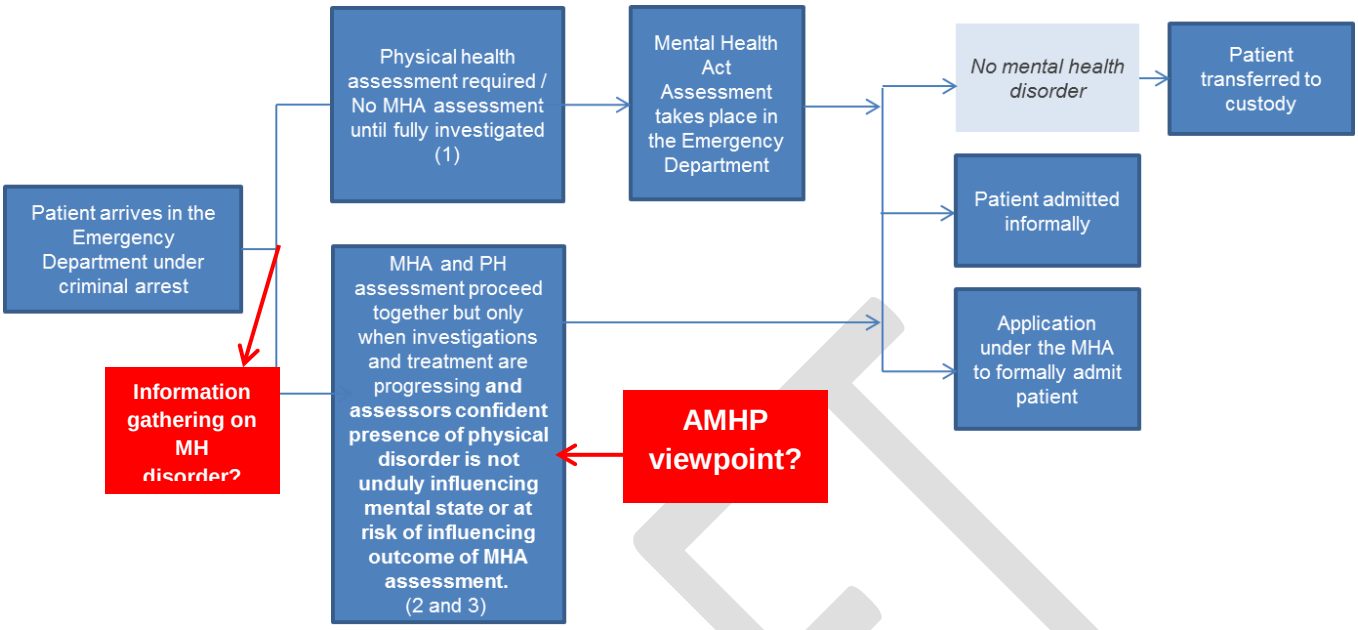
Who is the appropriate person to 'remove' a s136 – should this be a 'designated' person in the Emergency Department so this can be monitored.

3.2 When the detained individual is in an Emergency Department with an active mental health problem (either detained, voluntary with capacity or no capacity and under the Mental Health Capacity Act) and is being treated for their physical health, that individual is the Emergency Department's responsibility with support from medical and psychiatry specialities. The responsibility of that individual remains with the Emergency Department until they leave the Department, either discharged or transferred elsewhere.

3.3 If an individual in the Emergency Department is under criminal arrest, they are still entitled to a mental health assessment. The liaison psychiatry staff will not be expected to determine whether a person is 'fit to be detained in police custody' or 'fit to be interviewed'. However, as with any other patient, liaison psychiatry staff can make an assessment of mental health needs and arrangements for any necessary mental health treatment or aftercare, including whether a person needs Mental Health Act assessment or informal admission to a psychiatric ward. Close liaison with the police officers and ED staff to agree a joint approach is essential.

3.4 Information gained during the Mental Health Act assessment cannot be used in any way by Police in a criminal case. Reasonable consideration should be given where feasible to provide an alternative secure chaperon for the individual being assessed.

See the proposed pathway below:



1) *Presentation and disordered behaviour suspected to be directly due to physical pathology (e.g. post ictal, head injury, cerebral infection, organic psychosis) requiring immediate treatment.*

2) *Presence of additional co-morbid acute pathology that is compounding mental state presentation and presents acute risk to health requiring urgent treatment (e.g. infection, unstable medical condition, pain- surgical or medical aetiology).*

3) *Presence of additional unstable pathology with no overt impact on mental state (e.g. musculoskeletal injury, wounds)*

3.5 If an individual is under section 136 in the Emergency Department because physical health care is required but the individual has also committed a crime, the necessary care should continue and Mental Health Act assessment takes place if required.

Health Based Place of Safety

3.6 The Health Based Place of Safety should be provided at a level that allows for around the clock availability and meets the needs of the local population. In exceptional circumstances when the Police make contact with the Health Based Place of Safety and there is no capacity the place of safety is responsible for accommodating the individual through escalation protocols or alternative arrangements, this is for both local and out of area individuals.

Capacity management tools should be available to determine where capacity across London – need to engage further on this.

Acute Trust and Health Based Place of Safety Care Pathways

3.7 Acute and Mental Health Trusts should have local protocols in place that give specific attention to:

- Communication systems for clinical advice and handover;
- Triage systems for directing the referrer in a timely way to the appropriate service in the appropriate clinical timeframe with flexible assessment and treatment options (e.g. outreach or next day review)
- Clarity around the roles and responsibilities of individuals in delivering care and supporting safe transitions between care environments
- Clarity around transfer, escort and nursing support responsibilities

3.8 The principle components of the care pathways should include:

- Support and buy in from surgical, medical teams and the Emergency Department who understand and respond flexibly to the distinct clinical challenges presented by this populations' needs.
- Optimising available technology for example secure clinical picture transfer systems, shared notes systems and telemedicine facilities.
- Providing clarity and consistency over case ownership with clear agreed shared care arrangements.
- Optimising available clinical advice and triage systems including telephone consultation and advice between Trusts.
- Supporting flexible assessment and treatment arrangements including outreach and fast track care pathways.
- The requirement of direct telephone handovers between the referring and receiving medic on referral to and discharge from acute physical health care providers.
- Clear requirements for transfer of clinical information including specific systems to facilitate transfer (e.g. shared care records, location specific clinical communication templates)
- Referrals and discharge plans that include the name and contact number of clinicians who have responsibility for that individual's care and can be contacted to provide clinical information about the individual from both Mental Health and Acute Trust sites.

Examples of care pathways are include in Appendix 1

Expectations of Local Authority (AMHPs)

3.9 AMHPs to have separate responses for Adults and Children? Currently roles that cover both age groups contribute to the larger waiting times across London.

Appendix 1: Acute and Mental Health Trust Care Pathway Examples

Presentation and disordered behaviour suspected to be directly due to physical pathology (e.g. postictal, head injury, cerebral infection, organic psychosis) requiring immediate treatment

Actions:

Referrer (LAS, s136 coordinator or HBPoS medic)

Direct referral to ED + blue light ambulance transfer

Presence of additional co-morbid acute pathology that is compounding presentation in mental state and presents acute risk to health requiring urgent treatment (e.g. infection, pain- surgical or medical aetiology)

Actions:

Telephone triage advice from ED, Medical or Surgical registrar:

Referrer to provide medical summary, clinical findings, labs and bed side tests as appropriate / available

Transfer of required clinical information to be agreed during phone call. Name and number point of contact exchanged for referrer and clinician receiving and documented in both notes

Ambulance transfer if agreed to ED, SAU or MAU as appropriate

Liaison psychiatry to provide departmental mental health advice as required.

Presence of additional unstable pathology with no overt impact on mental state (e.g. musculoskeletal injury, wounds)

Actions:

Telephone Triage advice: HBPoS medic to ED Triage nurse or speciality registrar

Access to secure image transfer to support referral assessment

Fast track, in reach or outreach review including assessment appointment time (if next day review deemed appropriate) to be agreed during referral consultation

Risk factors for or presence of undiagnosed or treated stable pathology including chronic disease requiring further medical input (e.g. obesity, hypercholesterolaemia, hypertension, diabetes, COPD, liver disease, CCF)

Actions:

Health Based Place of Safety to arrange assessment and follow up with primary care provider

Health Based Place of Safety Specification

Draft guidance

March 2016

Introduction

This document is a draft specification which sets out the minimum standard of care London's Health Based Places of Safety should offer. This document is an initial draft and should be used to test and develop ideas further with stakeholders across London's crisis care system.

The specification applies to Health Based Places of Safety that care for children and young people as well as adults detained under section 135 and 136. It is aimed primarily at commissioners, referrers and providers of Health Based Place of Safety sites and should be used alongside the section 136 care pathway in order to provide a consistent pathway of care across London.

The specification should also be used in addition to the Mental Health Act Code of Practice (2015), London's Mental Health Crisis Commissioning Standards and the core principles set out in the Mental Health Crisis Care Concordat.

What is a Place of Safety?

A Place of Safety is used when an individual of any age has been detained under section 135 or 136 of the Mental Health Act 1983. In law, a 'place of safety' is not clearly defined and has no specific characteristics , technically anywhere can be a Place of Safety under the Mental Health Act as long as the occupier is temporarily willing to receive the patient, this is stated in s135(6) of the Mental Health Act.

In practice psychiatric units and hospital emergency departments are most commonly used, the Mental Health Act Code of Practice (2015) instructs a Place of Safety to be a hospital or other health based place of safety where mental health services are provided; a Police station should not be used as a Place of Safety.

The reason for a Health Based Place of Safety specification:

Recent engagement with key stakeholders from across the system as well as surveys and focus groups with service users have reiterated the issues that exist in relation to London's Health Based Place of Safety provision. Individuals are being refused admission to a Health Based Place of Safety because of intoxication, physical health problems, boundary issues or lack of space. There are many descriptions of police waiting with individuals in vans, and the resulting stress the situation is placing on the relationship between police and health services.

To support the system in improving current Health Based Place of Safety services and processes, the Healthy London Partnership crisis care programme is working in partnership with stakeholders across the crisis care system to develop a specification that will outline the minimum standard of care a HBPoS should offer, covering areas such as staffing models, assessments and governance arrangements. Alongside this document a London s136 care pathway is being developed to address inconsistencies in the broader pathway and clarify roles of the different stakeholders involved.

Health Based Place of Safety Specification

1. Governance and Monitoring

Strategic Governance: Urgent and Emergency Care Networks:

1.1 London's Urgent & Emergency Care (UEC) Networks have collective responsibility for the equitable provision of care and patient outcomes across their footprint, ensuring that the key standards of care are delivered.

1.2 As such the UEC networks will have responsibility for ensuring that the Health Based Place of Safety (HBPoS) within their area of London meets this specification.

Operational Governance - Local Multiagency Groups:

1.3 A local multiagency group led by the Trust providing the Health Based Place of Safety should exist for each Health Based Place of Safety across London and be overseen by the respective UEC network. The group must be attended by representatives from the Health Based Place of Safety, local Emergency Departments, Approved Mental Health Professionals (AMHP) and Police. LAS?

1.4 The group should perform the following roles:

- Measure and analyse current performance at the Health Based Place of Safety (specific measurements to be monitored are included in Appendix 1);
- Understand the contact s136 detainees have had with mental health services previously and what alternative pathways or interventions could have been applied in order to prevent escalation to a s136 detention.
- Facilitate training initiatives on local policies and protocols which include key partners and local Acute Trusts;
- Network with other local multiagency groups across London to ensure the consistency of service;
- Ensure the Directory of Service is regularly updated showing accurate up-to-date information regarding the Health Based Place of Safety site.

2. Location and Facilities

2.1 The Health Based Place of Safety should be a hospital or other health based facility where mental health services are provided. The Health Based Place of Safety for children and young people should be based in an adolescent mental health inpatient unit. Is the ward the best place or a separate area?

Should co-location with an Acute hospital be the preferable model?

2.3 Within the Health Based Place of Safety there must be assessment rooms with the following features:

- Large enough to accommodate six people, to be able to both assess and restrain where necessary;
- Well-lit and have an observation window;

- Have good exits, with consideration being given to there being two doors at opposite ends of the room; the doors should open outwards for the safety of staff;
- Have soft, comfortable chairs in a washable fabric; furniture and fittings should be chosen so they cannot be used to cause injury by offering a weapon of opportunity;
- Have a clock visible to both staff and the detained person;
- Have no ligature points;
- An intercom inside the assessment room for staff to use if the patient is too aroused;
- Have a panic alarm system;
- Be located near to other staff and be easily accessed by a team trained in physical intervention and the use of resuscitation equipment;
- Have CCTV to enhance staff protection;
- A mattress for sleeping or resting and to assist any necessary medical examination.

2.4 In close proximity to the assessment rooms the following should be available:

- Washing and toileting facilities with appropriate security protocols;
- Provision of beverages and light snacks;
- Telephone for staff to contact family, carers and other services;
- A place for writing up notes and briefing of assessment unit staff by those involved in the detention;
- A computer for staff linked to the electronic care system to identify relevant background information, current status under the Mental Health Act, crisis plans, advanced statements or decisions;
- Leaflets for patients on Mental Health Act rights, mental health conditions and treatments and local services on offer. Leaflets should be available in less commonly used languages and available electronically where they are not otherwise immediately available;
- Facilities for carers and legal representatives, including a separate waiting area.

3. Staffing

Section 136 coordinator

3.1 Every Health Based Place of Safety should have a designated section 136 coordinator available 24/7. The s136 coordinator must be assigned to the HBPoS at all times; adequate staff must be available to ensure staff do not come off inpatient wards.

Note – Staffing should be modelled off accurate and up-to-date activity data for that area, however contingency plans should be in place for responding to demand that exceeds average usage.

3.2 The s136 coordinator should be performed by the most senior person in the s136 team; it is recommended this is no less than a Band 6 ward nurse.

3.3 There should be a service manager available on call out of hours in addition to the clinical governance hierarchy. When complex issues arise a senior manager should be available above the s136 coordinator via the service manager.

3.4 The s136 coordinator should be the first contact by the Police or Ambulance Service. The s136 coordinator will assume immediate responsibility for:

- Accepting the individual to the Health Based Place of Safety or accommodating the individual through escalation processes or other alternative arrangements;
- Identifying an appropriate Emergency Department if physical health care is required and arranging transport from the Health Based Place of Safety to the Emergency Department;
- Informing the AMHP and Doctor (preferably Section 12 doctor) of arrival of the individual when the first contact has been made and liaising promptly with care partners, family or advocates where required.

Staffing requirements within a Health Based Place of Safety should include the following:

3.6 There should be a minimum of two mental healthcare professionals (minimum of at least one registered mental health nurse) immediately available to receive the individual from Ambulance Service and the Police. One of the two mental healthcare professionals should have CAMHS competencies or access to senior CAMHS advice – for a CYP specific HBPoS.

3.7 These two roles should provide support to the s136 coordinator as well as clinical staff when performing the initial patient safety and risk assessment.

3.8 Extra clinical staff must be available at short notice if required as there should be sufficient staff to cope with all but the most challenging behaviour, without recourse to ongoing police support.

3.9 All staff must have the competencies of all age inpatient staff including the administration of rapid tranquilisation medication. The Trust commissioned to provide the Health Based Place of Safety should ensure these competencies are up to date.

3.10 The use of physical restraint should follow NICE guidelines [NG10]: Violence and aggression: short-term management in mental health, health and community settings. There must be clear protocol about the circumstances when, very exceptionally police may be used to use physical restraint in a Health Based Place of Safety.

3.11 There should be sufficiently trained clinical staff that can take over the restraint if sedation is needed within a Health Based Place of Safety, Police Officers should not be restraining when sedation is administered.

Health Based Places of Safety accessible for children and young people should have the following minimum standard:

3.12 The Health Based Place of Safety should have sufficient staffing to safely manage the mental health needs and care of the young person. This includes a minimum of two nursing

staff (of which at least one should be registered) dedicated to the management of the young person, including line-of-sight supervision and access to additional staff for de-escalation and restraint if needed;

3.13 Staff responsible for the care of a young person must be enhanced DBS checked, have level 3 safeguarding training, an understanding of Children's Act and have developmentally appropriate training (staff trained in understanding the different ways that children and young people are at different stages of psychological development);

3.14 There should be access to on-call CAMHS trained doctors as well as access to general paediatric staff when a medical assessment is required.

Health Based Place of Safety staff physical health competencies:

3.15 Health Based Place of Safety staff (including both nursing and medical staff) should have the following physical health competencies; further detail is provided in Appendix 2.

- Be able to provide basic life support;
- Recognise and refer on the acutely deteriorating patient providing initial supportive treatment, including seizures, chest pain, breathlessness, lowering of consciousness;
- Provide monitoring and basic interventions e.g. hydration to support basic physical health status;
- Manage simple open wounds;
- Screen and respond to non-acute illness including management of non-septic co-morbid infection and identification and onward referral for chronic stable disease;
- Safely administer and monitor medication used or rapid tranquilisation;
- Perform basic lifestyle screen including assessment of risk factors for CVD;
- Screen for, prevent and manage mild alcohol or substance (including nicotine) withdrawal;
- Provide full medical examination and systems review (and if appropriate blood tests) to screen for co-morbid physical health conditions to support onward referral if appropriate.

4. Availability and Access

Initial pick up

4.1 Health Based Place of Safety sites should be open 24 hours a day, 7 days a week.

4.2 Local arrangements should be in place to ensure there is always a suitable health professional for the police to consult with prior to detaining an individual under s136. However the decision to detain and the responsibility of that decision rests with the Police.

4.3 If there is a care plan in place the instructions in the care plan for managing a mental health crisis should be followed to avoid detention under s136;

4.4 Trusts commissioned to provide the Health Based Place of Safety should have dedicated 24/7 telephone numbers in place, to enable the police, ambulance service and crisis teams to always phone ahead prior to the detained individual arriving on site.

4.5 It is the Trust's responsibility to ensure the numbers are available and communicated to key partners and regularly updated on the Directory of Service.

Note: A national access and waiting time standard is being developed for mental health emergency care. In the view of parity of esteem with physical health, it has been decided that a four hour timeline should be set to ensure that mental health emergencies are treated with the same urgency and seriousness as physical health emergencies. The ability of services to meet this standard will be monitored in 2017 and refined for implementation from 2018-19.

5. Assessment

Physical and mental state assessment:

5.1 Clinical staff should be present to meet the patient on arrival at the Health Based Place of Safety. They should conduct an initial patient safety and risk assessment and receive a verbal handover from the ambulance staff or the Police1.

5.2 Healthcare staff should take responsibility for the patient within 15 minutes of arrival, including preventing the person from absconding before the assessment can be carried out. The physical and mental state assessment should occur as soon as a person arrives, no later than 1 hour of the individual being in the HBPoS.

5.3 If the individual has arrived from the Emergency Department sufficient documentation should be provided to Health Based Place of Safety staff. If insufficient or incomplete written documentation has been provided, this should not obstruct the patients care. A serious incident form should be logged which should be fed back and reviewed by the local operational group.

5.4 Staff at the Health Based Place of Safety may request the Police to remain up to a maximum of 1 hour. Any further extension to this time will only be allowed if authorised by a Police supervising officer and is justified on the basis of the risks posed by the detainee. In most cases the Police should be free to leave within 30 minutes.

5.5 Health Based Place of Safety staff must be able to summon extra help at short notice from the Trust's emergency team.

5.6 When appropriate throughout the physical and mental state assessment collateral information should be gathered from the individual's locality mental health services as well as from family and/or carers.

Need to include here the opportunity for interventions to address alcohol use.

1 Handover should include physical health findings, clear detail of mental health presenting circumstances and evolution of patient presentation over time with ambulance staff or the Police.

Transfers to the Emergency Department:

5.7 Emergency physical health needs must always be prioritised over mental health assessment needs. If emergency physical health care needs are identified once the individual is accepted into the Health Based Place of Safety then a decision to transfer a person from the place of safety should be considered by the suitability trained medical professional. In making this decision, consideration must be given to the benefits and risks of the move, any delay and distress caused and any other relevant circumstances.

5.8 If the individual requires physical health treatment at the Emergency Department, once in the department they are the responsibility of Emergency Department staff and the liaison psychiatry team.

5.9 Transporting patients between Health Based Place of Safety and Emergency Departments and vice versa are the responsibility of Mental Health Trusts and Acute Trusts respectively, led by the s136 coordinator. This should not be the Police's role unless there is mutual agreement between parties that it is in the best interest of the patient and Police have capacity to provide support. *For further information on transfers see 'London's s136 care pathway.'*

5.10 A Health Based Place of Safety should not admit an individual that is 'drunk and incapable', where this occurs the person is too high a risk to the safety of the individual or staff and access to the Emergency Department should be arranged. *For further information on the intoxication pathway see 'London's s136 care pathway.'*

5.11 If the person is not adversely affected by intoxication and is fit for interview, they should be conveyed to the Health Based Place of Safety. The Health Based Place of Safety should not be conducting tests to determine intoxication as a reason for exclusion to the site; this should be based on clinical judgement. It is the clinical decision of the suitability qualified doctor at the Health Based Place of Safety to make the final call on where the patient is admitted.

> **Note:** Further detail and definitions in relation to the intoxication pathway is provided in 'London's s136 care pathway' document.

The Mental Health Act Assessment:

5.12 The Mental Health Act Assessment process should be arranged concurrently with the initial physical and mental state assessment and completed within four hours unless there are sound clinical reasons that this should not occur.

5.13 Mental Health Act assessments should not be delayed due to uncertainty regarding the availability of a suitable bed.

5.14 Medical staff at the Health Based Place of Safety should have a direct contact to the Approved Mental Health Professional (AMHP) serving the particular borough or Trust, particularly out of hours. It is the AMHP's responsibility to ensure this number is available to all Health Based Place of Safety staff.

5.15 The Mental Health Act Assessment should include a joint assessment between a doctor and an AMHP. Two doctors should be involved from the outset if the person is likely to require detention.

5.16 One doctor should be approved under Section 12(2) of the Mental Health Act for this role. In exceptional circumstances where Mental Health Act assessments are undertaken by core psychiatry trainees who are not approved under Section 12, a discussion with the senior Section 12 doctor must occur and their name and advice must be recorded in the notes.

5.17 Both the AMHP and the Section 12 doctor should be in attendance within 2 hours in all cases where there are not good clinical grounds to delay assessment.

5.18 Should a person be seen by a registered medical practitioner first and if there is no evidence of mental disorder the person can no longer be detained and must be immediately released, even if not seen by an AMHP.

5.19 The AMHP should be expected to commence the MHA assessment within 4 hours unless there are clinical grounds for delay, such as the person being significantly intoxicated, acutely unwell following self-harm or, after being clinically assessed by the team, is deemed to require more time for their mental state to settle.

5.20 If it is unavoidable, or it is in the person's interests, an assessment begun by one AMHP or doctor may be taken over and completed by another, either in the same location or at another place to which the person is transferred.

5.21 If the doctor sees the person first and concludes that they have a mental disorder and that compulsory admission to hospital is not necessary, but that they may still need treatment or care (whether in or out of hospital), the person should still be seen by an AMHP.

5.22 If the individual is under 18 years old or has recently been referred to adult services they should be taken to an appropriate HBPoS where there is a s12 approved CAMHS specialist doctor, a s12 approved clinician with experience in CAMHS and a AMHP with knowledge and experience of caring for this age group available to undertake the Mental Health Act assessment.

5.23 The Trust commissioned to provide the HBPoS should ensure assessing doctors and AMHPs have up to date knowledge and readily available information of local alternatives to admission, these should be considered as part of the assessment.

5.24 The AMHP and assessing doctors should also have prompt access to interpreting and signing services if required.

The Mental Health At assessment may result in one of five outcomes:

- Doctor concludes there is no mental disorder and the patient is discharged;
- Doctor and AMHP conclude that the mental disorder is not of a nature or degree to warrant admission to hospital for assessment or treatment but the individual may require arrangements for support from community based services;
- Doctor and AMHP conclude that there is a mental disorder, for which the patient agrees that informal admission to hospital is necessary (under section 131 of the Act);
- Doctor and AMHP conclude that there is a mental disorder, and the patient is refusing voluntary admission to hospital. A decision will be taken as to the suitability of an application under the MHA to detain the patient for a defined period of time in a hospital;
- Doctor and AMHP conclude that there is a mental disorder and the patient is refusing voluntary admission and they are subject to a Community Treatment Order (CTO) then…..need further clarification here.

5.25 The person may continue to be detained while these arrangements are being made, provided that the maximum period of detention under s136 (24 hours[2]) is not exceeded. The 24 hour period begins at the time of arrival at the first place of safety (including if the individual needs to be transferred between places of safety).

5.26 Where compulsory admission is indicated, the AMHP should arrange for a second doctor to examine the patient in accordance with the Act.

5.27 After the outcome is agreed, the person should be discharged or transferred to hospital as quickly as possible and the local policy should identify the transport arrangements. Failure to discharge promptly compromises the individual's care.

6. Equipment

6.1 Medical equipment on-site or within close proximity to the Health Based Place of Safety should include:

- ECG Machine
- Equipment for taking routine bloods
- Blood pressure machine (sphygmomanometer)
- Thermometer
- Stethoscope
- Equipment for measuring oxygen saturation levels
- Breathalyser
- Glucose meters (with ketone readings)
- Urine dip stick testing kits
- Weight and height measurement

2 The maximum period of detention is being reduced from 72 hours to 24 hours unless there are clinical/medical reasons for a delay.

- Carbon monoxide monitor
- Peak flow test
- Equipment for measuring respiratory rate
- Resuscitation equipment including a defibrillator
- Saliva substance misuse screening or drug urine testing kits
- Decontamination facilities to remove CS spray and other noxious substances
- Tendon hammer and sensory testing equipment
- Pregnancy testing equipment
- Equipment and dressing for simple open wounds.

7.2 Health Based Place of Safety staff should be able to use the equipment above, interpret test results or have working arrangements with Trust staff in other departments who can do so.

7. Staff Training

7.1 The provision of training should be covered in the jointly agreed policies and procedures developed by the multi-agency group (refer to section 1).

7.2 Healthcare staff who work in a Health Based Place of Safety should be trained in:

- Mental state and mental health assessments
- Risk assessment and management
- Observational skill including the level and manner of detail contained in written observations
- The use of the Mental Health Act, Mental Capacity Act and the Care Act
- The use of physical intervention and safe restraint
- The ability to use resuscitation equipment
- Assessment and management of substance misuse, intoxication and withdrawals and basic physical healthcare (refer to physical health competencies in Appendix 2)
- Rapid tranquillisation procedure
- CPR
- Age appropriate life support
- Liaison with families and carers
- Up to date mandatory training in Trust protocols (i.e. information governance, safeguarding)

7.3 All staff providing care to a young person should have appropriate training in Prevention and Management of Violence and Aggression, the Children's Act and training in developmental approaches to assessment and treatment.

7.4 The Trust commissioned to provide the Health Based Place of Safety is responsible for ensuring the training for staff is regularly available.

8. Patient Information

8.1 During patient handover it is essential that a copy of all information regarding the episode and patient information is transferred. Where available, this should include a copy of investigations undertaken, diagnosis made, discharge plan and any recommended follow up, signed by the medical staff responsible.

8.2 There should be access to appropriate records from all care providers under which the patient has received an episode of care or contact. If the patient is transferred it is the transferring team's responsibility to ensure records are handed over and the receiving team's responsibility to ensure they are uploaded on the clinical notes system.

8.3 The individual should be provided with information about section 136, both orally and in writing. This should be provided in alternative languages or the Health Based Place of Safety must ensure interpreters are available. Health Based Place of Safety staff must ensure the provisions of section 132 (the giving of information) are complied with and access to legal advice should be facilitated where possible.

8.4 The PACE (Police and Criminal Evidence) Code of Practice should be adhered to which requires an appropriate adult to be available for a person who appears to be mentally disordered or mentally vulnerable. This can be a relative, guardian or other person responsible for their care or custody, someone experienced in dealing with mentally disordered or mentally vulnerable people but who is not a police officer or employed by the police.

9. Follow up or discharge

9.1 Follow up care should be arranged for people in their area of residence when they are not admitted to hospital following a mental health act assessment.

9.2 It is the role of the s136 coordinator on that shift to ensure robust systems are in place to confirm onward referrals, discharge plans or discharge letters are received by the appropriate care provider within the next working day and onward services are provided with the information gathered throughout the assessment.

9.3 If patients decline follow up care there may be other issues that need following up (e.g. safeguarding). It is still that shift's s136 coordinator's responsibility to follow up with other local services within the appropriate timeframes; however the tasks may be performed by administrative staff.

9.4 For those discharged there must be ready access to funds to pay for an appropriate mode of transport, 24 hours a day.

Appendix 1: Measurements to be monitored by the local multiagency group

- Percentage of occasions that the police brought patients to the place of safety with no paper record / under the Mental Capacity Act (instead of S136);
- Occasions when S136 was refused access for whatever reason or when police have to wait longer than 15 mins to gain access to HBPoS (e.g. no space, condition of patient);
- Percentage of occasions that police / LAS did not communicate in advance;
- Percentage of occasions police conveyed the patient to the HBPoS without LAS;
- Percentage of occasions that AMHP took over 4 hours to attend where the delay is not clinically acceptable;
- Percentage of occasions that the first S12 doctor took over 4 hours to attend where the delay is not clinically acceptable;
- Percentage of occasions that more than 3 hours elapsed before the assessment began where the delay is not clinically acceptable;
- Percentage of occasions when the HBPoS is full to capacity and Police/LAS are forced to convey elsewhere (including ED);
- Percentage of occasions where the HBPoS transfers patients to ED for physical health treatment;
- Percentage of occasions where the HBPoS is closed due to staff shortages and Police / LAS are forced to wait or convey elsewhere;
- Percentage of occasions where a police cell is used for both adults and children and young people;

  (Legislation is being amended so children and young people aged under 18 are never taken to police cells if detained under S135 or S136, and ensuring that police cells can only be used as a place of safety for adults suffering a mental health crisis if the person's behaviour is so extreme they cannot otherwise be safely managed elsewhere).
- Percentage of occasions where police had to remain for over an hour before HBPoS staff were able to take over.

Appendix 2: Physical Health Care Medical and Nursing Competencies

**M refers to medics only*

Be trained and competent in delivery of intermediate life support including appropriate use of a defibrillator.

Be able to summarise and communicate acute physical health presentation including relevant investigations in a clear, structured and efficient manner to other health professionals.

Have received training in and be competent in early identification and management of the deteriorating patient. Be familiar with the presentation and acute management of infection, physical trauma, shortness of breath, chest pain, lowering of consciousness and aware of the need for rapid response and referral.

Be able to provide emergency assessment, support, interventions and referral in the event of a seizure.

Be able to assess shortness of breath including measurement of peak flow, respiratory rate and be able to administer acute medications for shortness of breath including inhaler, nebuliser and oxygen.

Be able to perform fluid status assessment.

Be able to assess, complete and evaluate documentation regarding include food and fluid intake and output and be able to respond appropriately and in a timely way to findings.

Be aware of the risk of deterioration in suspected infection and the importance of fluid management and rapid administration of antibiotics if prescribed.

Be able to conduct a risk assessment for DVT and escalate as appropriate.

Be aware of and be able to assess for hyper or hypoglycaemia.

Be able to provide acute emergency treatment for hyper or hypoglycaemia and refer onwards as appropriate.

Be able to complete, document and act upon basic physical observations (pulse, temperature, blood pressure, heart rate, capillary glucose levels). Be aware of cut offs indicating an abnormality and be able to respond appropriately to these in accordance with NEWS/ MEWS chart monitoring and escalation protocols.

Be able to perform an ECG and understand and act upon required governance protocols surrounding conducting medical investigations by ensuring an appropriately qualified professional is shown, interprets and as appropriate acts upon the ECG.

Be able to interpret an ECG and refer onwards for more specialist advice as appropriate. (M)

Be trained in phlebotomy and be able to safely take bloods. Be aware of governance protocols surrounding conducting medical investigations and ensuring an appropriately qualified professional is alerted that bloods have been taken and assumes responsibility for following up and acting on results.

Be able to interpret and act upon abnormalities in routinely conducted blood tests. (M)

Be able to safely assess for the presence of drug or alcohol intoxication. Be able to perform assessments including urine drug screens and breathalyser to broadly identify nature of substance intoxication and provide supportive management.

Be aware of the risks associated with acute withdrawal or intoxication in respect of both physical and mental health.

Be able to initiate a treatment plan to prevent deterioration or withdrawal from alcohol or substances. (M)

Be able to identify early signs of withdrawal and initiate appropriate treatment.

Be able to apply monitoring scales to monitor and quantify symptoms of withdrawal to guide treatment.

Be able to complete a body map.

Be able to perform basic wound assessment and communicate these findings.

Be able to appropriately change simple wound dressings maintaining a sterile field.

Be able to seek advice on wound management from appropriate professionals including transfer of consented secure images for advice as required.

Be able to assess a wound and perform basic wound closure. (M)

Be able to conduct a basic health and lifestyle screen including assessment of smoking, drug and alcohol intake, diet, exercise and engagement with health providers including dentist, optometrist, GP and allied health professionals.

Be able to perform a nutrition screen including documentation of height, weight and assessment of BMI. Be able to provide basic dietary advice.

Be able to conduct a full systems review and physical examination to screen for acute and chronic medical conditions. Be able to act upon or refer onwards these conditions as appropriate. (M)

Be able to take a smoking history and establish smoking status including use of carbon monoxide assessment. Be able to deliver basic smoking cessation advice, initiate nicotine replacement therapy and refer onwards to smoking cessation support as appropriate.

Be able to take a sexual health history including risk factors for blood born viruses. Be able to counsel and consent for relevant investigations. (M)

Be able to consent an individual for a pregnancy test and carry out and interpret the test.

Be able to assess for the requirement of rapid tranquilisation and initiate treatment if required. (M)

Be able to safely and appropriately monitor individuals according to protocol after the administration of medications for rapid tranquilisation.

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Department of Health

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1 February 2016

To: Directors of Adult Social Services

Copy to: Chief Executives of NHS Mental Health Trusts

For circulation to adult social service teams and appropriate partners

Local Authority responsibilities for the Approved Mental Health Professional role

We are writing to highlight issues in relation to the regulation and approval of the Approved Mental Health Professional (AMHP) role and the statutory responsibilities of the Director of Adult Social Services for the AMHP service in their local authority area. The quality and adequacy of mental health services is increasingly high profile and subject to considerable political and media attention.

AMHPs are critical to delivering better mental health services and outcomes, taking urgent decisions about the least restrictive options for people requiring care and treatment, protecting people's human rights and promoting the principles of the Mental Health Act: Code of Practice (2015). With AMHP services and individual AMHPs remaining the responsibility of local authorities, it is imperative that organisational arrangements are in place to support AMHP practice, including supervision and professional development, in line with our intentions for the new regulatory body for social work.

The Mental Health Act 2007 made changes to the Mental Health Act 1983 (1983 Act) to allow a broader range of professionals to be approved to carry out various functions under the Act, including the role of the AMHP, which was carried out previously by the Approved Social Worker (ASW). However, social workers continue to make up nearly 95% of all AMHPs[1] .

However, regardless of the professional background of the individual AMHP, the local authority has a number of key duties in relation to AMHPs undertaking assessments on

[1] Response *to FOI request from the lead AMHP in Manchester City Council (2014)*

their behalf, **whether or not they are on the payroll of or employed directly by the local authority on whose behalf they are acting as an AMHP** – these include:

- Ensuring that all AMHPs have access to professional supervision and support;
- Facilitate, support and encourage AMHP Leads to engage on a local and national level with the AMHP Lead Network;
- Provide a minimum of 18 hours refresher training relevant to the AMHP role every year, as determined by the local authority; and
- Responsibility for their professional competence in their AMHP role, including suspension or removal of their warrant as necessary.

Good practice guidance issued in October 2008 by the National Institute for Mental Health in England (NIMHE) [2]and ADASS and, more recently, the 2014 paper by Dr. Ruth Allen for the College of Social Work on the role of the social worker in adult mental health services, clearly state that local authorities should have robust arrangements in place to ensure a potential AMHP has undertaken the required professional training and has sufficient knowledge to be approved.

Following the 2014 paper, the Department has just published a suite of resources to help improve social work across the mental health sector and make sure the value of social work in improving mental wellbeing is recognised. These are part of the sector-led 'Social Work for Better Mental Health' initiative and are available from: https://www.gov.uk/government/publications/social-work-improving-adult-mental-health

These publications are of course, underpinned by "The Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008" which were made in April 2008 under section 114 of the 1983 Act. Schedule 1 lists the professional requirements for appointment as an AMHP. Schedule 2 lists the key competencies that AMHPs are expected to demonstrate, irrespective of their professional background. Given this is such a critical role in the mental health system, we wanted to particularly draw you attention to the following list of values at Key Competence Area 1, which reflect values that are grounded in social work:

a) the ability to identify, challenge and, where possible, redress discrimination and inequality in all its forms in relation to AMHP practice;
b) an understanding of and respect for individuals' qualities, abilities and diverse backgrounds, and is able to identify and counter any decision which may be based on unlawful discrimination;
c) the ability to promote the rights, dignity and self-determination of patients consistent with their own needs and wishes, to enable them to contribute to the decisions made affecting their quality of life and liberty, and
d) a sensitivity to individuals' needs for personal respect, confidentiality, choice, dignity and privacy while exercising the AMHP role.

[2] *http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106654.pdf*

Section 75 (s75) Agreements

Over the last few years, changes to the AMHP employing body in the 1983 Act, along with the move to greater integration of health and social care, has led some local authorities to transfer all of their mental health provision, including AMHPs, to health trusts under a section 75 of the NHS Act 2006 or similar agreement. While governance and accountability arrangements between the 'host' authority and relevant organisation should in theory provide continued accountability and oversight for social care and AMHP activity, feedback from AMHPs suggests that in many places, AMHPs are 'falling through the gaps,' with local authorities becoming distanced from their obligation to ensure AMHPs are properly supported, including with access to legal and professional advice, supervision and a development programme.

The response by some local authorities has been to take their AMHP service back 'in house,' resulting in a variance in the AMHP services according to their location in a health or social care setting. The absence in some local authorities of a senior manager with responsibility and knowledge of the AMHP role, has further diminished its status and standing, with the role often being held responsible for shortcomings in other parts of the system.

We believe this situation is further compounded by the lack of a national system for approving AMHPs, with local authorities free to set their own systems for approval leading to inconsistent quality. We are working with colleagues in the Department of Health and the Care Quality Commission (CQC) to look at how we can improve the current approach to monitoring AMHP provision, including whether there is a need for greater regulation of AMHP services.

Responsibilities for the AMHP service within Local Authorities

It is expected that social workers will continue to make up the largest proportion of the AMHP workforce and thus leadership roles are most likely to fall to people from a social work professional background. In your role as DASS, we would ask that, as part of your strategic leadership and planning for mental health services in your local authority, you ensure that the AMHP service is consistently supported –specifically by ensuring that:

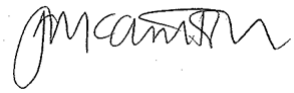
- the AMHP service is well led, with an identified AMHP service lead or manager in place to oversee availability of legal and professional advice, supervision and a development programme;
- the local authority is involved at senior (DASS/AD) level in strategic, multiagency planning for local mental health services;
- effective workforce management and succession planning, to enable on-going sufficiency of AMHPs and good workload management;
- forums for the sharing and resolution of systemic issues affecting AMHP practice, e.g. with other partners, such as the police and ambulance service; and
- collation of AMHP intelligence and data to inform practice and service improvement locally.

Social workers and other professionals undertaking the AMHP role do so in often difficult and challenging circumstances, to make sure that the needs and wishes of people subject to compulsion are heard and that the least restrictive options are considered. They

deserve the best support to be most effective and, in particular, they deserve explicit recognition of this role as part of a practice focused, career pathway progression.

We hope this is information is helpful. If you would like to discuss any of the issues raised in this letter, please contact us at the details below.

Yours sincerely,



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HEALTH & WELLBEING BOARD

Subject Heading:	Clinical Governance Assurance Report for services commissioned by Havering Public Health Service
Board Lead:	Susan Milner Interim Director of Public Health
Report Author and contact details:	Daren Mulley Public Health Commissioning Manager Dr J Lindo Consultant in Public Health (Interim) Jacqui.lindo@havering.gov.uk 01708431789

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

- ☐ Priority 1: Early help for vulnerable people
- ☐ Priority 2: Improved identification and support for people with dementia
- ☐ Priority 3: Earlier detection of cancer
- ☐ Priority 4: Tackling obesity
- ☐ Priority 5: Better integrated care for the 'frail elderly' population
- ☐ Priority 6: Better integrated care for vulnerable children
- ☐ Priority 7: Reducing avoidable hospital admissions
- ☒ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

This is the first report on clinical governance assurance to the HWBB. It provides an overview of the arrangements that are in place in order to assure the Council that the services commissioned by Public Health are safe and of good quality. The report covers the period April 1st 2015 to March 31st 2016.

RECOMMENDATIONS

The Health & Wellbeing Board is asked to note the report.

REPORT DETAIL

Please see attached report.

BACKGROUND PAPERS

Havering PH Service Clinical Governance Policy (Appendix 1)

Havering
LONDON BOROUGH

Clinical Governance Assurance Report for services commissioned by Havering Public Health Service 2015-2016

1. Background

The Health and Social Care Act 2012 transferred substantial health improvement duties to local authorities from April 2013 onwards. Local authorities receive a public health grant intended to improve outcomes for the health and wellbeing of their local populations.

Havering Council's Public Health Service (PHS) has commissioning responsibilities for a number of clinical services that are provided by NHS Trusts, General Practitioners, Pharmacists and 'third sector' providers.

Within the NHS there are well-established arrangements for the escalation of serious untoward incidents within Provider organisations including communication to Commissioners and national bodies and where appropriate the PHS liaises with Havering CCG to share relevant information.

2. Services

The Council's PHS has in place a clinical governance process that provides assurance of the safety, cost-effectiveness and quality of the following commissioned services;

Sexual Health Service
Brief description: The Integrated Sexual Health Service deliver level 1, 2 and 3 Sexual Health and Reproductive Health Services including specialist Genitourinary Medicine (GUM) services.
Provider: Barking, Havering & Redbridge University Hospital Trust
Target population: Aged 13 and over

Smoking Cessation Service
Brief description: The local service provides treatment and support to individual patients in pharmacies, dental practices, GP practices and specialist services including direct provision of individual / group support for appropriate patients.
Provider: North East London Foundation Trust
Target population: Aged 12 and over

Drug & Alcohol Treatment Service
Brief description: The local treatment and recovery services for alcohol and drug misusing adults including acute hospital alcohol liaison, community detoxification and needle exchange
Provider: WDP
Target population: Adults

Health Visiting Service
Brief description: The Health Visiting Service workforce consists of specialist community public health nurses and teams who provide expert information, assessments and interventions for babies, children and families including first time mothers and fathers and families with complex needs.

Provider: North East London Foundation Trust
Target population: 0-5 years of age

School Nursing Service
Brief description: The service promotes public health to children, young people and their families supporting schools, colleges, and pupil referral units to identify and respond to the health needs of their populations.
Provider: North East London Foundation Trust
Target population: 5-19

GP & Pharmacy Services
Brief description: Services with particular local GPs and Pharmacies including Long Acting Reversible Contraception, Chlamydia Treatment, Emergency Hormonal Contraception
Providers: GPs & Pharmacies
Target populations: Long Acting Reversible Contraception (15 years old-Adults), Chlamydia Treatment (15-24), and Emergency Hormonal Contraception Children (aged 15-24)

3. Overview for 15/16

Havering Council's Public Health Service (PHS), as commissioners of clinical and related services, has a duty to assure itself of the quality of the services it commissions. It is acknowledged that there is an element of inherent risk in the clinical services that the PHS commissions. The PHS's clinical governance process is therefore focused on gaining assurance that the clinical governance systems of those providers it contracts with are robust and promote safety, cost-effectiveness and quality. To achieve this level of assurance, contracts with providers include requirements that the providing organization has an effective clinical governance and quality assurance framework in place.

Providers are also required to demonstrate that they adhere to clinical and service standards set by relevant professional organisations. These requirements are evidenced to the commissioner at the point of procurement and commencement of each contract. In addition, these provider organisations are expected to disclose to the commissioner incidents, risks and compliance issues frequently (i.e. monthly or quarterly) as laid out in the PHS's Clinical Governance Policy (see Appendix 1).

The systems and processes for providing assurance to the Council that risk is being managed across key areas of patient safety, information governance, safeguarding, service user feedback, audits and inspections are managed appropriately and these are summarised in this section of the report below;

Patient Safety

Each Provider is required to share its organisational policies for incident reporting and investigation and a record of its CQC registration with the Council prior to the commencement of the contract. Each Provider is thus required to be CQC registered and comply with the requirements and arrangements for notification of deaths and other incidents to CQC in accordance with CQC Regulations. If the Provider gives a notification to the CQC or any other Regulatory Body which directly or indirectly concerns any service user, the Provider is required to send a copy to the PHS. Using the Clinical Governance Reporting Framework, each Provider is required to report, investigate and share the lessons learned from Serious Incidents, Patient Safety Incidents and non-Service User safety incidents. Escalation is proportionate to both the risk and the assurance that it is being appropriately managed by the provider but where necessary, clinical risks are escalated to the Director of Public Health.

Information Governance

The PHS contract has a number of clauses including reference to the Data Protection Act 1998 (DPA), Freedom of Information Act 2000, Records Management, Confidentiality and Caldicott Guardian. Regarding data protection, Providers are required to ensure that appropriate technical and organisational measures are in place to against any unauthorised or unlawful processing of personal data and against the accidental loss or destruction of or damage to such personal data. Using the Council's Clinical Governance Reporting Framework, Providers are required to provide the Authority that it is complying with its obligations under the DPA and promptly notify the Authority of any requests for disclosure of or access to the Personal Data of any breach of security measures. In addition to these local arrangements, where the Council works in partnership with other London Councils, the Council also receives external incident reports from the appropriate Council where patients residing in Havering are assessed as being at risk. A recent example was the breach of the DPA in a central London sexual health clinic whereby the commissioning Council informed each borough of the unauthorised disclosure of the personal data of patients.

Safeguarding

Each Provider is required to have child and adult safeguarding policies and these are submitted to the Council prior to the commencement of the contract. The Provider has a contractual obligation to implement robust recruitment and vetting procedures to help prevent unsuitable staff from working with service user whilst ensuring that staff understands their duty to record and report safeguarding concerns as well as knowing about the protocol for sharing of information and referral to local safeguarding systems (e.g. Multi-Agency Safeguarding Hub). The Provider must ensure that staff are adequately trained, supervised and monitored on safeguarding and promoting the welfare of service users. For example, the Council's contract with the North East London Foundation Trust for the delivery of the Health Child Programme states that all staff (90% threshold to account for staff turnover) has up to date training appropriate to their role and all staff are in receipt of regular supervision to support them in their role. The Provider is also required to implement robust procedures to ensure safeguarding allegations against a member of staff are

managed in accordance with relevant London wide safeguarding procedures. Where a provider falls short of this threshold a remedial action plan is put in place and monitored at contract meetings.

Audit & Inspections

Each contract stipulates that the Provider is required to comply with requests made by the CQC, the National Audit Office, the General Pharmaceutical Council and any authorised person for entry to the provider's premises for the purposes of auditing, viewing, observing or inspecting such premises and the provision of the Services and for information relating to the provision of the service. During such visits, the Provider is required to give reasonable assistance and provide all reasonable facilities to the authorised person. With regards to audits and inspections, the Provider is required to record the type of inspections and the results of any audit, evaluation, inspection, investigation or research in relation to the service on the PHS's Clinical Governance Reporting Framework.

Patient, staff and professional feedback & experience of the service

Each Provider is required by terms in the contract and through the PHS's Clinical Governance Reporting Framework to record and report on the numbers of concerns, complaints, compliments and comments received about the standard of the provision of the services. Frequency of reporting varies from monthly to quarterly. In relation to complaints, if a complaint is received the Council has the authority to investigate the complaint and discuss the complaint with the Provider, CQC and any regulatory body by patients, staff and professionals. The Provider is also required to conduct service user surveys with local commissioned services such as the sexual health and drug and alcohol services carrying out annual service user surveys. On completion of each survey, the Provider is required to present the findings of the survey to the Council identifying any learning and proposing recommendations and actions to improve services and patient care.

4. Conclusions

For the period 15/16 there has been no serious incidents in any of the PHS commissioned services. Providers have worked with the PHS to improve communication and embed the assurance process. Minor concerns have been readily dealt with at contract meetings and not required escalation.
The PHS has taken on board legal advice which states that local arrangements should be proportionate to the associated service risks and this is reflected in the PHS clinical governance assurance process.

Appendix 1

Governance Policy

For Clinical Services Commissioned by

Havering Public Health Service

VERSION CONTROL

Version	Reviewer	Issue Date	Summary of Changes
Draft 1	PH senior management team	08/03/2016	Reporting process amended; quality assurance of the PH team deleted to be captured in PDP/training policy.
Draft 2	DPH	08/03/2016	
Draft 3	JL	18/04/2016	Quality Monitoring Proforma included as Appx 1

Review Date: March 2017

1. Introduction

4.1. The Health and Social Care Act 2012 transferred substantial health improvement duties to local authorities from April 2013 onwards. Local authorities receive a ring-fenced public health grant intended to improve outcomes for the health and wellbeing of their local populations.

4.2. Local Authorities will commission a number of services in order to fulfil their duties. As such local authority Public Health (PH) departments need to ensure that they have robust systems in place to fulfil their obligations. Arrangements may differ from area to area depending on local circumstances but it is important for Local Authorities to note the specific requirements for clinical[1] services and make appropriate arrangements for these to be met.

4.3. Within the NHS there are well-established arrangements for the escalation of serious untoward incidents within Provider organisations including communication to Commissioners and national bodies where necessary.

4.4. Havering Council now has commissioning responsibilities for a number of clinical/patient care services that are provided by NHS Trusts, General Practitioners, Pharmacists and 'third sector' providers..

4.5. This policy describes the quality assurance process for clinical services commissioned by Havering PH.

4.6. It demonstrates an on-going commitment to the provision of high quality, safe, accountable care following transition of public health functions into local authority.

5. Principles of clinical governance

5.1. The *Health Act 1999* placed the corporate responsibility of 'the duty of quality' on organisations providing local healthcare, through systems and processes rather than on individuals. This duty of quality was articulated as clinical governance.

5.2. Clinical Governance has been defined as:

"the framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high

[1] Clinical services are services that are delivered by doctors, nurses, therapists, or pharmacists; and/or involve prescribing.; clinical - of or relating to the medical treatment that is given to patients in hospitals, clinics, etc.

standards of care by creating an environment in which excellence in clinical care will flourish." [2]

5.3. Quality is a fundamental goal in health care provision and the following 3 dimensions need to be in place in order to deliver high quality services[3]:

5.3.1. **Clinical effectiveness:** ensuring high quality services are commissioned according to the best evidence as to what is clinically effective in improving individual and population health outcomes, including National Institute for Health and Care Excellence(NICE) guidance;

5.3.2. **Safety:** commissioning so as to prevent all avoidable harm and risk to individual and population safety; and

5.3.3. **Patient experience:** commissioning that provides the individual with as positive an experience of services as possible, including being treated according to wants or needs, and with compassion, dignity and respect.

5.4. The principles of clinical governance apply to all who provide patient care services and are a core concern for relevant boards and the commissioners of these services. It is important to emphasise that clinical governance is a process and embedding clinical governance within the organisation should be viewed as a long-term developmental goal.

6. Objectives of the governance process

6.1. These are :

6.1.1. To use data and information to monitor the quality and safety of commissioned public health services.

6.1.2. To ensure quality improvement processes are in place in our commissioned services e.g. programme of clinical audit; and within the public health service e.g. taking action as a result of user feedback.

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[2] Scally G, Donaldson LJ. The NHS's 50 anniversary. Clinical governance and the drive for quality improvement in the new NHS in England. BMJ. 1998 Jul 4;317(7150):61–65. [PMC free article][PubMed]

[3] Secretary of State for Health .High Quality Care For All NHS Next Stage Review Final Report. London: Stationary Office; 2008. (CM 7432)

6.1.3. To ensure that within all commissioned services arrangements for clinical governance accountability and leadership are in place including the implementation of best practice and NICE guidance.

6.1.4. To ensure that learning from complaints, Monitor, Healthwatch, litigation and claims is systematically analysed and disseminated throughout the relevant organisations.

7. Accountability for clinical governance –

7.1. The Director of Public Health (DPH) will have the overall accountability for ensuring proper clinical governance arrangements are in place across all commissioned public health services.

7.2. The DPH will keep the Corporate Management Team (CMT) and the relevant HWBB subcommittees apprised of issues by exception reporting. An annual report will be taken to CMT for sign off and to the HWBB for information.

8. The process of clinical governance in Havering (see Fig 1)

8.1. The Public Health service will establish a process whereby quality and safety issues of the services that it commissions are routinely reviewed. The PH team will incorporate quality and risk management within the PH service plan by

- Ensuring that standards and performance indicators (qualitative and quantitative) are included in all public health contracts and service plans;
- Ensuring that standards and performance indicators are reported regularly in the corporate performance report;
- Ensuring that risks are identified and 'RAG' rated in the Public Health Risk Register and actions are clearly planned to mitigate and manage these;
- Leading on the investigation of serious incidents and complaints as appropriate supported by a time limited incident management team;
- Securing broader advice on clinical governance issues from clinicians, for example, on the safe and effective use of medicines, including the development and application of Patient Group Directions (PGDs).

8.2. Leads from the PH team will meet regularly with providers to seek assurance on the quality and safety of their services including :

- medicines management, prescribing and PGDs

- risk management and safety arrangements
- complaints, compliments, and serious incidents
- clinical audit and NICE compliance
- Infection prevention and control
- Results of 'Friends and Family' Test; Quality accounts; CQC registration/inspections; and staff turnover

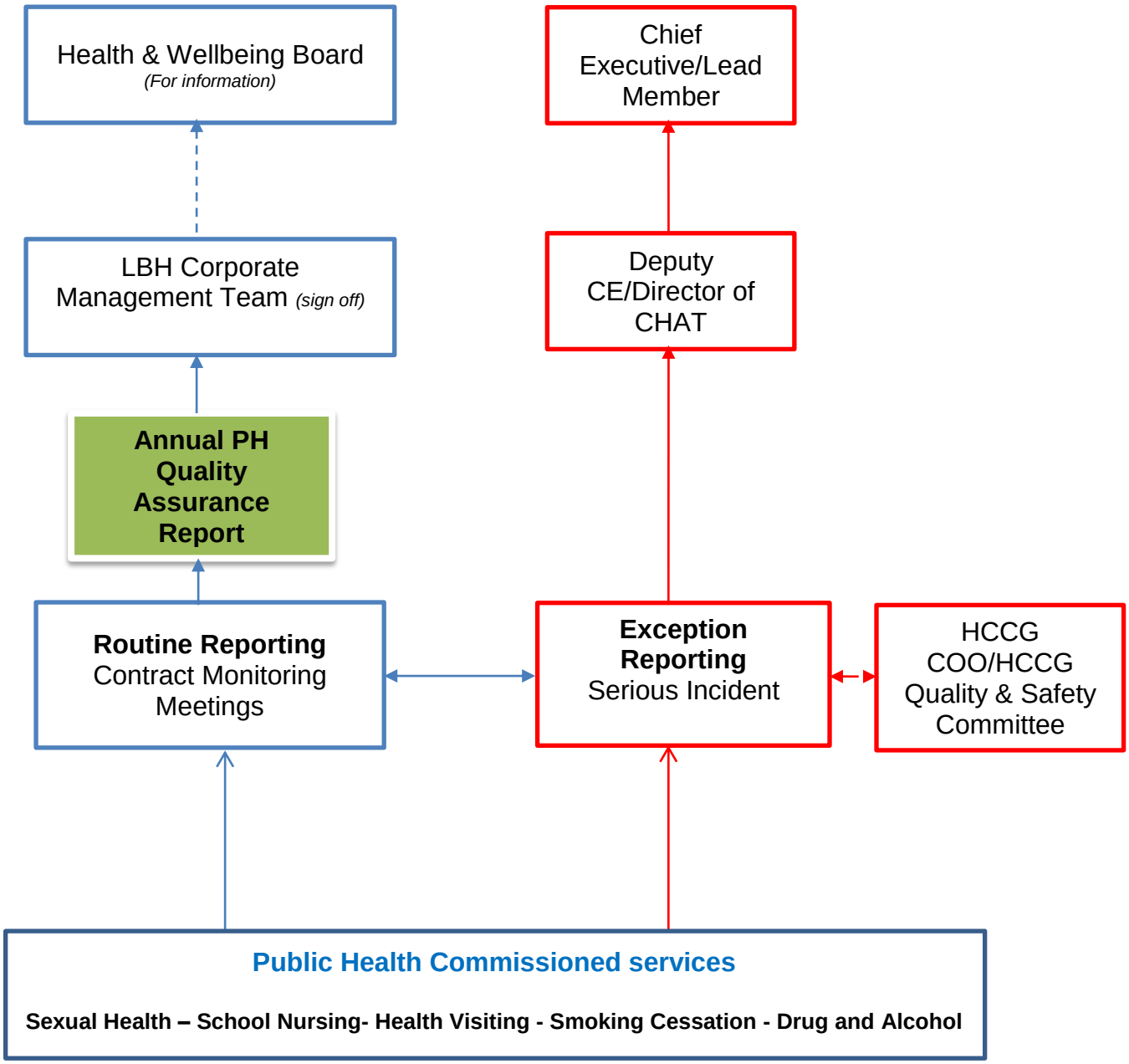
8.3. Quality assurance in partnership with Havering CCG

8.3.1. Havering CCG is the main commissioner of clinical services for Havering residents. It has a clinical governance process in place based on the NHSE Serious Incident Framework. The Quality and Safety Committee oversees this process.

8.3.2. The DPH is a member of Havering CCG governing body which receives reports from the Quality & Safety committee. This provides the ideal opportunity for Havering CCG and LBH to share information relating to clinical quality, particularly early warning signs of things that might be happening in providers that both organisations commission services from, e.g. BHRUT and NELFT.

8.3.3. In addition the CCG has responsibility for the quality of care provided by individual GP member practices.

Fig. 1 Reporting Structure for the Management of Clinical Governance and Risk



Routine reporting to include Friends and Family Test; Quality accounts; CQC registration/inspections; Staff turnover

Escalation process for serious incidents which in broad terms are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.[4]

[4] NHSE. Serious Incident Framework. 27 March 2015 accessed 7/3/2016 https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

Appendix A

Quality Monitoring Report

Summary

The Clinical Governance reporting requirements are set out in the report below. NELFT is required to report progress on their Clinical Governance arrangements monthly to the Council. The report will be used to provide assurance that commissioned services are safe, effective and meeting the needs of the patients. On completion, please submit with quarterly performance report.

Summary:	
Issues to be considered:	
Action required: (including any outstanding issues from previous reports)	
Accountable officer:	
Author of Report:	
Reporting Period:	
Date of report:	

1. Patient Safety –Serious Incidents, Other Incidents, Near misses (NELFT - School Nursing, Health Visiting, Oral Health , Smoking Cessation)				
	Issues/Themes Identified	**Lessons learned**	**Actions to address issues**	**Changes made to improve service**
Serious Incident				
Other Incident				

Near Miss				

2. Care Pathways (NELFT - School Nursing, Health Visiting, Oral Health, Smok		
Issue Identified	**Lessons learned**	**Actions to address issues**

3. Information Governance & Risk Management (NELFT - School Nursing, Hea Smoking Cessation)		
Issue Identified	**Lessons learned**	**Actions to address issues**

4. Safeguarding (NELFT - School Nursing, Health Visiting, Oral Health, Smokin		
Issue Identified	**Lessons learned**	**Actions to address issues**

5. Patient, staff and Professional feedback & experience of the service, complaints (NELFT - School Nursing, Health Visiting, Oral

Health, Smoking Cessation)				
	Issues/Themes Identified	**Lessons learned**	**Actions to address issues**	**Changes made to improve service**
No of new formal Complaints				
Other Incident (No of informal/concerns)				
Number of compliments				
5x5 reports				
Staff turnover (vacancy rate)				

6. Audits (NELFT - School Nursing, Health Visiting, Oral Health, Smoking Cessation)				
Audits carried out	**Issues identified/training needs identified**	**Lessons learned**	**Actions taken to address issues**	**Changes made to improve service**
CQC				
NICE				
Peer Reviews				

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