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HEALTH & WELLBEING BOARD SUPPLEMENTARY AGENDA

29 March 2023

The following report is attached for consideration and is submitted with the agreement of the Chairman as an urgent matter pursuant to Section 100B (4) of the Local Government Act 1972

8 RELATIONSHIP BETWEEN HWBB AND HBPBP (Pages 1 - 54)

Updated cover report and appendices attached

9 ANNUAL REPORT (Pages 55 - 58)

Updated cover report attached

Zena Smith
Democratic and Election Services Manager

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HEALTH & WELLBEING BOARD

Subject Heading:	Working well with the Havering Place Based Partnership Board
Board Lead:	Mark Ansell, Director of Public Health
Report Author and contact details:	Mark Ansell – mark.ansell@havering.gov.uk

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

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

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SUMMARY

The paper proposes some initial priorities for the Health and Wellbeing Board (HWB) in the coming year and suggests how the HWB might choose to develop thereafter to ensure that it complements the Havering Place Based Partnership Board (HBPBP) and minimises duplication of effort. The proposals are informed by an analysis of the Terms of Reference and Mutual Accountability Framework for place based partnerships in North East London which are provided as background papers.

RECOMMENDATIONS

The Health and Wellbeing Board is asked to endorse the following recommendations regarding its 23/24 work programme:

- Refresh the Havering Joint Local Health and Wellbeing Strategy and clearly identify any local priorities for the HPBPB not covered by national or ICS concerns.
- Periodically receive reports from the HPBPB regarding progress with action to address local priorities and / or obstacles to implementation that the HWB is asked to help resolve.
- Continue to develop the Joint Strategic Needs Assessment, improving insight about professional and residents perspectives gained via the HBPBP.
- Receive and comment on draft Council policy / strategy likely to have significant impact on health outcomes and inequality.

In the longer term, the HWB is asked to consider:

- whether the agendas of the HWB and HBPBP are sufficiently close to allow for still greater alignment e.g. by adopting a 'Committees in common' arrangement. Alternatively, the HWB may wish to focus more on a wider determinants agenda at population level and expand its membership accordingly; while the HPBPB focuses on improving health and care services for individual residents.
- Whether it recommends that the Council delegate additional responsibilities to the HWB beyond the minimum stated in the Health and Care Act.

REPORT DETAIL

Working well with the Havering Place Based Partnership Board

Context

The role of the Health and Wellbeing Board

Since 2012, all upper-tier local authorities in England have hosted a HWB – statutory committees responsible for fostering partnership between health and

social care; assessing local health and care needs and agreeing a health and wellbeing strategy.
The Health and Care Act 2022 maintained the role of Health and Wellbeing Boards (HWBs) with very modest changes in response to the creation of integrated care systems e.g. HWBs must now consider the integrated care strategy published by the Integrated Care Partnership when developing its strategy now named a Joint Local Health and Wellbeing Strategy (JLHWS).

The role of place based partnerships

The Health and Care Act 2022 put integrated care systems (ICSs) on a statutory footing. Typically, they consist of-

- The 'system' tier, covering a population of 1 – 2 million and comprising the Integrated Care Board (ICB) and Integrated Care Partnership (ICP). The former is responsible for statutory NHS functions and the latter fostering collaboration and collective action between the NHS, local authorities and the VCS to improve health and reduce inequalities. Together, the ICS leads on strategic planning, oversees overall resources and performance, and drives strategic improvements in policy areas such as workforce planning, digital infrastructure and estates that benefit from solutions at scale.
- Place based partnerships, for a population of 250-500K, responsible for delivering tangible improvement, particularly in relation to community services, social care and primary care, and action to tackle the wider determinants of health; informed, shaped and in partnership with the local community; making the best use of the full range of resources available in the NHS, local authorities and elsewhere to improve outcomes for local people.
- Neighbourhoods, covering a population of 30-50K where groups of GP practices work with NHS community services, social care and other providers to deliver more co-ordinated and proactive care.

The relationship between HWB and Place Based Partnership

Unlike ICSs, place-based partnerships are not statutory bodies. The Health and Care Act 2022 did not create any legal requirements for place-based partnerships, leaving flexibility for local areas to determine their form and functions.

Within the North East London ICS, place-based partnerships operate at borough level and are coterminous the relevant HWB.

Arrangements at place level mirror those at system level, with the Havering Place Based Partnership Board bringing together a wide variety of statutory and non-statutory partners to collectively agree and deliver plans to improve health and health and care services and an ICB Sub-Committee responsible for NHS functions delegated to place.

The Havering HWB and Havering Place Based Partnership Board (HPBPB) have previously agreed that the former will continue to lead the development of the Joint Strategic Needs Assessment and use the resulting insight to set the strategic

priorities for the borough regarding health and wellbeing, and health and care services. Whereas, the HPBPB will develop plans to address these priorities (amongst others, see below) and oversee their delivery, reporting to the HWB on progress periodically.

This relationship is consistent with the Health and Care Act 2022, which requires Integrated Care Boards – and by extension, place-based partnerships – to pay regard to local health and wellbeing strategies in developing their plans.
More recently, NEL ICS has shared Terms of Reference (ToR) and Mutual Accountability Framework (MAF) for place based partnerships in North East London (see background papers). These were considered and endorsed by Havering ICB Sub-Committee on 8th March 2023.

A brief summary and suggested implications for the HWB (shown in *italics*) is set out below:-

The vision in the ToR, notwithstanding the emphasis on prevention, inequalities and the wider determinants, focuses on improving access, experience and outcomes achieved by local health and care services.

The HWB could complement the HBPBP by focusing on wider policy opportunities to improve the wider determinants of health at population level e.g. to improve incomes and access to 'good' employment; the availability of affordable, high quality housing; educational attainment; sustainability and air quality etc. which will be crucial to securing good health for longer for more residents in the long term.

The ToR require each place based partnership to develop a local system vision and strategy that should reflect priorities determined by:

- local residents – *suggesting much more direct engagement with residents than that attempted by the HWB. The insight gained would strengthen the JSNA and improve the selection of local priorities for inclusion in the JLHWS.*
- the contribution of Place to the NEL ICS,
- and relevant system plans including the JLHWS - *consistent with the previously proposed relationship between HWB and HPBPB.*

Moreover, the HBPPB is expected to:

- develop a Place-Based Partnership Plan for Havering to deliver these priorities;
- oversee delivery (e.g. through task and finish groups) and performance at Place against national, ICS and place priorities. *This would include priorities in the JLHWS, so it is reasonable to expect the HPBPB to update the HWB periodically regarding progress.*
- Oversee the use of resources and promote financial sustainability.

The ToR makes specific references to Health and Wellbeing Boards stating that:

The Partnership Board will work in close partnership with HWB and shall ensure that the Place-Based Partnership Plan is appropriately aligned with the JLHWS

The Health and Wellbeing Board will assist the Partnership Board, where required, by addressing issues and obstacles that prevent implementation of the Health and Wellbeing Board's joint local health and wellbeing strategy.

The HPBPB must have the means to escalate issues to the HWB and the HWB should consider how it might assist e.g. by using democratic mandate of elected members to advocate on behalf of the HBPBP; mobilising wider Council assets; engaging other statutory partners e.g. the police or other stakeholders e.g. the local business community.

The Partnership Board and the Health and Wellbeing Board will provide reports to each other, as appropriate, so as to inform their respective work. The reports the Partnership Board receives from the Health and Wellbeing Board will include the Health and Wellbeing Board's recommendations to the Partnership Board on matters concerning delivery of the Place objectives and priorities and delivery of the associated outcomes framework. The Health and Wellbeing Board will continue to have statutory responsibility for the joint strategic needs assessment and joint local health and wellbeing strategy.

An early priority for the HWB should be a refresh of the JLHWS and any priorities that the HBPBP is best placed to lead on. Working together to address local priorities would seem most likely to engage local partners and release the full value of HBPBP. However, the ToR and MAF detail a considerable programme of work regarding the contribution of place to the achievement of national and ICS priorities. Hence, care will be needed when selecting additional local priorities that meet the unique needs of Havering and yet ensure that the HPBPB is not overburdened.

The membership of the HPBPB and Integrated Care Board Sub Committee are detailed drawing on representation from the NHS, Council, CVS and social care providers. There is considerable overlap with the membership of the HWB.

The HWB could consider advocating for still greater alignment with the HBPBP e.g. through a "Committees in Common" arrangement. Alternatively, the HWB might wish to expand its membership to better address the wider determinants and create a more different but complementary agenda to that of the HPBPB.

Based on this analysis, suggested priorities for the HWB in relation to the HPBPB are outlined in the table overleaf.

NB. Although a sub-committee of the Council, currently no additional functions are delegated to the HWB by the Council beyond those described in the Health and Social Care Act. Havering Council has begun a process to review its constitution and the HWB might wish to recommend that the Council consider delegating additional responsibilities to it e.g.

- Formal adoption of relevant Council policy e.g. regarding the Council's Public Health responsibilities including obesity, drug and alcohol, sexual health
- Approval of an annual spending plan against the public health grant, currently delegated to the Council Leader and Lead member for Adults and Health (who are both members of the HWB).
- Other functions consistent with the remit of the HWB.

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Function	HPBPB	HWB	Implications for HWB work programme
Set / deliver priorities	Develop and oversee implementation of plans to address priorities identified in JLHWS	Identify priorities regarding health and wellbeing and health and care services	Update JLHWS and clearly identify priorities for the HBPBP. Receive HBPBP Plan and reports on progress.
Information and insight	Encourage adoption of population health management approach; monitor and manage performance.	Maintain and improve Joint strategic needs assessment (JSNA) to inform identification of high-level priorities for HBPBP and ICS.	Continuously refresh JSNA
understanding and working with communities	Through direct engagement with patients and residents; the HBPBP will identify and remove obstacles to engagement with local services; understand and take steps to improve user experience; identify problems that require a system / provider collaborative response.	Democratic accountability - HWBs enable elected members to influence the direction of local health and care services reflecting the expressed needs of their constituents.	Ensure understanding of professional and residents' perspectives gained by HBPBP is captured in JSNA and informs priorities in JLHWS
joining up and co-ordinating services	Encourage and facilitate PCNs/ NHS community services, social care and other providers to deliver co-ordinated and proactive care at neighbourhood level.	Help HBPBP remove obstacles / escalate issues e.g. to NEL system level; by mobilising wider Council assets, making use of relationships with other stakeholders etc;	Develop and apply understanding of how best to represent Havering perspective at system level.
tackle the wider determinants of health	Identify and proactively support residents and / or communities who are more likely to be disadvantaged due to their health and care needs; ensure provision of health and care services is proportionate to needs of population served	Ensure wider Council policy serves to improve health and reduce health inequalities. Strengthen links to other statutory partners e.g. through links to the community safety partnership; to business sector etc. to make health a concern for a wider pool of stakeholders	HWB to receive relevant policy with robust health impact assessment before adoption by Council. HWB to consider expanding membership to make health and concern for wider pool of stakeholders.
quality and sustainability of local services	Develop and implement plans to improve quality and sustainability of local issues.	Help HBPBP to escalate issues e.g. to ICB and to provider collaboratives;	Receive reports from HBPBP and escalate issues as required

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IMPLICATIONS AND RISKS
There are no immediate risks arising from this paper. However failure to ensure that the HWB and HPBPB have an effective and complementary working relationship will slow progress and waste limited officer / clinician time.
BACKGROUND PAPERS
Terms of Reference (ToR) and Mutual Accountability Framework (MAF) for place based partnerships in North East London

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HAVERING

PLACE-BASED PARTNERSHIP

TERMS OF REFERENCE

Contents

INTRODUCTION

1. The following health and care partner organisations, which are part of the North East London Integrated Care System have come together as a Place-Based Partnership to enable the improvement of health, wellbeing and equity in the Havering area:

   (a) Barking, Havering and Redbridge University Hospitals Health NHS Trust

   (b) The North East London NHS Foundation Trust

   (c) London Borough of Havering

   (d) The NHS North East London Integrated Care Board

   (e) Havering Health

   (f) Havering Compact

   (g) Havering's Primary Care Networks[1]

   (h) Healthwatch Havering

   (i) Havering Care Association

   (j) Partnership of East London Cooperatives

2. 'Place' for the purpose of these terms of reference means the geographical area which is coterminous with the administrative boundaries of the London Borough of Havering.

3. These terms of reference for the Place-Based Partnership incorporate:

   (a) As Section 1, terms of reference for the Havering Place-Based Partnership Board (the '**Partnership Board**'), which is the collective governance vehicle established by the partner organisations to collaborate on strategic policy matters and oversee joint programmes of work relevant to Place.

   (b) As Section 2, terms of reference for any committees/sub-committees or other governance structures established by the partner organisations at Place for the purposes of enabling statutory decision-making. Section 2 currently includes terms of reference for:

   - The Havering Sub-Committee of the North East London Integrated Care Board (the '**Place ICB Sub-Committee'**), which is a sub-committee of the Integrated Care Board's Population Health & Integration Committee.

4. As far as possible, the partner organisations will aim to exercise their relevant statutory functions within the Place-Based Partnership governance structure, including as part of meetings of the Partnership Board. This will be enabled (i) through delegations by the partner organisations to specific individuals; or (ii) through specific committees/sub-

[1] A graphic showing Havering's Primary Care Networks is included set out at Figure 1 at the end of this document.

committees established by the partner organisations meeting as part of, or in parallel with, the Partnership Board.

5. Section 2 contains arrangements that apply where a formal decision needs to be taken solely by a partner organisation acting in its statutory capacity. Where a committee/sub-committee has been established by a partner organisation to take such statutory decisions at Place, the terms of reference for that statutory structure will be contained in Section 2 below. Any such structure will have been granted delegated authority by the partner organisation which established it, in order to make binding decisions at Place on the partner organisation's behalf. The Place ICB Sub-Committee is one such structure and, as described in Section 2, it has delegated authority to exercise certain functions of the Integrated Care Board at Place.

6. There is overlap in the membership of the Partnership Board and the governance structures described in Section 2. In the case of the Partnership Board and the Place ICB Sub-Committee, the overlap is significant because each structure is striving to operate in an integrated way and hold meetings in tandem.

7. Where a member of the Partnership Board is not also a member of a structure described in Section 2, it is expected that the Partnership Board member will receive a standing invitation to meetings of those structures (which may be held in tandem with Partnership Board meetings) and, where appropriate, will be permitted to contribute to discussions at such meetings to help inform decision-making. This is, however, subject to any specific legal restrictions applying to the functions or partner organisations and subject to conflict of interest management.

8. All members of the Partnership Board or a structure whose terms of reference are contained at Section 2 shall follow the Seven Principles of Public Life (also commonly referred to as the Nolan Principles), which are: selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

Section 1
Terms of reference for the Havering Place-Based Partnership Board

Status of the Partnership Board	1. The Partnership Board is a non-statutory partnership forum, which commenced its operation on 1 July 2022. It brings together representatives from across Place, who have the necessary authority from the partner organisation they represent to consider strategic policy matters and oversee joint programmes of work relevant to Place. 2. Where applicable, the Partnership Board may also make recommendations on matters a partner organisation asks the Partnership Board to consider on its behalf.
Geographical coverage	3. The geographical area covered will be Place, which for the purpose of these terms of reference is the area which is coterminous with the administrative boundaries of the London Borough of Havering.
Vision and ways of working	4. The vision of the Partnership Board is to create person-centred, seamless care and support that is designed around the needs of local people throughout their life course, with a strong focus on prevention, addressing inequalities and the wider determinants of health by: (a) Developing joined up support and services that prevent people becoming ill; (b) Ensuring that when people do need advice it is easy to access and seamless between different agencies; (c) Ensuring that services for people who are ill are high quality and can be accessed without delay. 5. The Partnership Board will work in a way which: (a) Promotes positive cross-system conversations and collaboration at Place; (b) Communicates key messaging across organisations at Place, encouraging broader involvement when required; (c) Listens to the voice of patients, service users and residents at Place, and advocates for the issues they experience within the system. 6. The Partnership Board has agreed the following principles to guide its work, and the participation of its members: (a) Start from purpose, with a shared local vision;

(b) Build a new relationship with communities;

(c) Invest in building multi-agency partnerships;

(d) Build up from what already exists locally;

(e) Focus on relationships between systems, places and neighbourhoods;

(f) Nurture joined-up resource management;

(g) Strengthen the role of providers at Place;

(h) Embed effective place-based leadership.

Role of the Partnership Board

7. The overall purpose of the Partnership Board is to bring together partners across Place with the aims of:

(a) Improving how our residents experience support and services, in accordance with our vision set out above;

(b) Working together to continually improve the partnership in the interest of Havering residents/patients;

(c) Resolving issues that may be preventing the successful delivery of integrated services and collaborative partnership working.

8. This will be done by:

(a) Identifying problems experienced within the system at Place, and resolving those problems or escalating them to the appropriate part of the North East London Integrated Care System, as appropriate;

(b) Identifying and testing solutions to problems experienced within the system at Place;

(c) Monitoring the impact of solutions delivered at Place, and realising the associated benefits;

(d) Preparing for the potential for further delegation to Place as national policy around health and social care integration develops, whilst maintaining a focus on tailoring service provision to meet the needs of the people of Havering;

(e) Building effective relationships across the system at Place and furthering the strategic development of health and social care integration.

9. The Partnership Board has the following core responsibilities:

(a) To set a local system vision and strategy, reflecting the priorities determined by local residents and communities at

Place, the contribution of Place to the North East London Integrated Care System, and relevant system plans including:

- the Integrated Care Strategy produced by the North East London Integrated Care Partnership;
- the 'Joint Forward Plan' prepared by the Integrated Care Board and its NHS Trust and Foundation Trust partners;
- the joint local health and wellbeing strategy produced by the Havering Health and Wellbeing Board, together with the needs assessment for the area;
- the Place Mutual Accountability Framework[2]

(b) To develop the Place-Based Partnership Plan for Havering, which shall be:

- aimed at ensuring delivery of relevant system plans, especially those listed above;
- developed in conjunction with the governance structures in Section 2 (e.g. the Place ICB Sub-Committee);
- agreed with the Board of the Integrated Care Board and the partner organisations;
- developed by drawing on population health management tools and in co-production with service users and residents of Havering.

(c) As part of the development of the Place-Based Partnership Plan, to develop the Place objectives and priorities and an associated outcomes framework for Place. A summary of these priorities and objectives can be found here.

(d) To oversee delivery and performance at Place against:

- national targets;
- targets and priorities set by the Integrated Care Board or the Integrated Care Partnership, or other commitments set at North East London level, including commitments to the NHS Long Term Plan;

[2] The Place Mutual Accountability Framework describes what NHS North East London ICB asks the seven Place ICB Subcommittees and wider Place Based Partnerships to have responsibility for and, in turn, what the Place Based Partnerships can expect the ICB to achieve for them. The framework needs to be read alongside the equivalent document that focuses on the role of the provider collaboratives which operate across the ICS area. The current versions of these frameworks are published in the ICB's Governance Handbook.

- the Place-Based Partnership Plan, the Place objectives and priorities and the associated outcomes framework.

(e) To oversee and monitor design or task and finish groups who will be responsible for the delivery of projects set out in the Place-Based Partnership Plan.

(f) To support innovation and engagement through task and finish or design groups.

(g) To ensure systems intelligence data is available to inform discussions on delivery of projects and identify new projects which may need to be delivered.

(h) To co-ordinate jointly funded programme allocation including project management office matters.

(i) To stay abreast of local and national developments relating to integration.

(j) To provide a forum at which the partner organisations operating across Place can routinely share insight and intelligence into local quality matters, identify opportunities for improvement and identify concerns and risk to quality, escalating such matters to the North East London Integrated Care System's System Quality Group as appropriate. Meetings of the Partnership Board will give Place and local leaders an opportunity to gain:

- understanding of quality issues at Place level, and the objectives and priorities needed to improve the quality of care for local people;
- timely insight into quality concerns/issues that need to be addressed, responded to and escalated within each partner organisation through appropriate governance structures or individuals, or to the System Quality Group;
- positive assurance that risks and issues have been effectively addressed;
- confidence about maintaining and continually improving both the equity, delivery and quality of their respective services, and the health and care system as a whole across Place.

(k) To oversee the use of resources and promote financial sustainability.

(l) To make recommendations about the exercise of any functions that a partner organisation asks the Partnership Board to consider on its behalf.

	(m) To support the North East London Integrated Care System with the achievement of the 'four core purposes' of Integrated Care Systems, namely to: • improve outcomes in population health and healthcare; • tackle inequalities in outcomes, experience and access; • enhance productivity and value for money; • help the NHS support broader social and economic development. (n) To support the North East London Integrated Care System to deliver against its strategic priorities and its operating principles, as set out here.
Statutory decision-making	10. In situations where any decision(s) needs to be taken which requires the exercise of statutory functions which have been delegated by a partner organisation to a governance structure in Section 2, then these shall be made by that governance structure in accordance with its terms of reference, and are not matters to be decided upon by the Partnership Board. 11. However, ordinarily, in accordance with their specific governance arrangements set out in Section 2, a decision made by a committee or other structure (for example a decision taken by the Place ICB Sub-Committee on behalf of the Integrated Care Board) will be with Partnership Board members in attendance and, where appropriate, contributing to the discussion to inform the statutory decision-making process. This is, however, subject to any specific legal restrictions applying to the functions of a partner organisation and subject to conflict of interest management.
Making recommendations	12. Where appropriate in light of the expertise of the Partnership Board, the Partnership Board may also be asked to consider matters and make recommendations to a partner organisation or a governance structure set out in Section 2, in order to inform their decision-making. 13. Note that where the Partnership Board is asked to consider matters on behalf of a partner organisation, that organisation will remain responsible for the exercise of its statutory functions and nothing that the Partnership Board does shall restrict or undermine that responsibility. However, when considering and making recommendations in relation to such functions, the Partnership Board will ensure that it has regard to the statutory duties which apply to the partner organisation. 14. Where a partner organisation needs to take a decision related to a statutory function, it shall do so in accordance with its terms of reference set out in Section 2, or the other applicable governance

	arrangements which the partner organisation has established in relation to that function.
Collaborative working	15. The Partnership Board and any governance structure set out in Section 2 shall work together collaboratively. It may also work with other governance structures established by the partner organisations or wider partners within the North East London Integrated Care System. This may include, where appropriate, aligning meetings or establishing joint working groups. 16. The Partnership Board may establish working groups or task and finish groups, to inform its work. Any working group established by the Partnership Board will report directly to it and shall operate in accordance with terms of reference which have been approved by the Partnership Board. *Collaboration with the Health and Wellbeing Board* 17. The Partnership Board will work in close partnership with the Health and Wellbeing Board and shall ensure that the Place-Based Partnership Plan is appropriately aligned with the joint local health and wellbeing strategy produced by the Health and Wellbeing Board and the associated needs assessment, as well as the overarching Integrated Care Strategy produced by the Integrated Care Partnership. 18. The Health and Wellbeing Board will assist the Partnership Board, where required, by addressing issues and obstacles that prevent implementation of the Health and Wellbeing Board's joint local health and wellbeing strategy. *Collaboration with Safeguarding Adults/Children's Boards* 19. The Partnership Board will also work in close partnership with the Havering Safeguarding Children Partnership and the Safeguarding Adults Board for Havering.
Chairing and executive lead arrangements	20. The Partnership Board will be chaired jointly by the following, who shall be known as the Co-Chairs: (a) The London Borough of Havering's Lead Member for Adult Social Care and Health; (b) A member of the Partnership Board who is from the primary care sector and who is appointed in accordance with paragraph 21 below. 21. At the beginning of each financial year, the Partnership Board will appoint one of the members who is from Havering Health or who is a Primary Care Network Director (as set out in paragraphs 25 (r) to (w) below) to co-chair the Partnership Board. By virtue of the

	appointment, the individual shall also be a member of the Place ICB Sub-Committee and one of its joint Deputy Chairs.[3] 22. It is expected that the Co-Chairs will chair meetings jointly and resolve issues between them but, where only one Co-Chair is present, that person will assume the joint responsibilities of the Co-Chairs. 23. The Chief Executive of the London Borough of Havering will be the Place Partnership Lead, and shall also be the Deputy Chair of the Partnership Board. 24. If for any reason the Co-Chairs and Deputy Chair are absent for some or all of a meeting, the members shall together select a person to chair the meeting.
Membership	25. There will be a total of 28 members of the Partnership Board, as follows: *Integrated Care Board* (a) Delivery Director for Havering; (b) Clinical Care Director for Havering; (c) Director of Finance or their nominated representative; (d) Director of Nursing/Quality or their nominated representative; *The London Borough of Havering* (e) Lead Member for Adult Social Care and Health; (f) Chief Executive (Place Partnership Lead); (g) Director of Adult Social Care & Health; (h) Director of Children's Social Care; (i) Director of Public Health; (j) Director of Housing; (k) Head of Commissioning; (l) Commissioning Programme Manager; (m) Head of Communities, Policy & Performance;

[3] Appointment to the Place ICB Sub-Committee, as a sub-committee of the ICB, will always be subject to the approval of the Chair of the Integrated Care Board, as required by the Integrated Care Board's Constitution.

	NHS Trusts/Foundation Trusts (n) Director, North East London NHS Foundation Trust; (o) Director, Barking, Havering and Redbridge University Hospitals Health NHS Trust; (p) Assistant Director, North East London NHS Foundation Trust; *Primary Care* (q) Place-Based Partnership Primary Care Development Clinical Lead; (r) Chair, Havering Health; (s) Chief Executive, Havering Health; (t) North Primary Care Network Clinical Director; (u) South Primary Care Network Clinical Director; (v) Marshall Primary Care Network Clinical Director; (w) Crest Primary Care Network Clinical Director; *Voluntary sector* (x) Chair of Havering Compact; *Healthwatch* (y) Chairman, Healthwatch Havering; *Others* (z) **Two** representatives, Havering Care Association; (aa) Representative, Partnership of East London Cooperatives. 26. Members, set out above, will attend meetings as many times as possible. However, with the permission of the Co-Chairs of the Partnership Board, the members may nominate a deputy to attend a meeting of the Partnership Board that they are unable to attend. Each member should have one named nominee to ensure consistency in group attendance. Where possible, members should notify the Co-Chairs of any apologies before papers are circulated.
Participants	27. The Partnership Board may invite others to attend meetings, where this would assist it in its role and in the discharge of its duties. This shall include other colleagues from the partner organisations or across the North East London Integrated Care System, professional advisors or others as appropriate at the discretion of the Co-Chairs. In particular, consideration will be given to inviting presenters and

	implementers as and when required in line with the delivery of the Place-Based Partnership Plan.
Meetings	28. The Partnership Board will operate in accordance with the evolving governance framework of the North East London Integrated Care System, including any policies, procedures and joint-working protocols that have been agreed by the partner organisations, except as otherwise provided below: *Quoracy* 29. For a meeting of the Partnership Board to be quorate, at least six members will be present and must include: (a) Two of the members from the Integrated Care Board; (b) Two of the members from the local authority; (c) One of the members from an NHS Trust or Foundation Trust; (d) One primary care member. 30. If any member of the Partnership Board has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. 31. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. *Scheduling meetings* 32. The Partnership Board will normally meet monthly. 33. On a bi-monthly basis, subject to a minimum of four occasions each year, the Partnership Board will hold its meetings in tandem with the Place ICB Sub-Committee.[4] 34. The expectation for such meetings to be held in tandem will not preclude the Partnership Board from holding its own more regular or additional meetings. 35. Changes to meeting dates or calling of additional meetings will be convened as required in negotiation with the Co-Chairs. 36. Where a meeting is held in tandem with the Place ICB Sub-Committee, the Co-Chairs of the Partnership Board and the Chair of the Sub-Committee, shall agree which of them shall lead and facilitate the discussion at the meeting.

[4] ~~In the first financial year of operation the Place ICB Sub-Committee is only expected to meet on three occasions.~~

Papers and notice

37. A minimum of seven clear working days' notice is required. Notice of all meetings shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed. Supporting papers must be distributed at least five clear working days ahead of the meeting.

38. On occasions it may be necessary to arrange urgent meetings at shorter notice. In these circumstances the Chair will give as much notice as possible to members. Urgent papers shall be permitted in exceptional circumstances at the discretion of the Chair.

39. Where a meeting is to be held in tandem with the Place ICB Sub-Committee, the Co-Chairs of the Partnership Board will liaise with the Chair of the Sub-Committee, in order to agree the meeting agenda in advance of the meeting. The Co-Chairs will also need to reach agreement with the Chair of the Sub-Committee about other matters falling within paragraphs 40 (virtual attendance) and 42 (recordings of meetings).

Virtual attendance

40. It is for the Co-Chairs to decide whether or not the Partnership Board will meet virtually by means of telephone, video or other electronic means. Where a meeting is not held virtually, the Co-Chairs may nevertheless agree that individual members may attend virtually. Participation in a meeting in this manner shall be deemed to constitute presence in person at such meeting. How a person has attended a meeting shall be specified in the meeting minutes.

Admission of the public

41. Where the Partnership Board meets jointly with the Place ICB Sub-Committee in accordance with paragraph 33, its meetings shall be held in accordance with the Place ICB Sub-Committee's terms of reference in Section 2. Otherwise, whether a meeting of the Partnership Board is to be held in public or private is a matter for the Co-Chairs.

Recordings of meetings

42. Except with the permission of the Co-Chairs, no person admitted to a meeting of the Partnership Board shall be permitted to record the proceedings in any manner whatsoever, other than in writing.

Minutes

43. The minutes of a meeting will be formally taken in the form of key points of debate, actions and decisions and a draft copy circulated to the members of the Partnership Board, together with the action log as soon after the meeting as practicable. The minutes shall be submitted for agreement at the next meeting where they shall be signed by the Co-Chairs.

	44. Where it would promote efficient administration, meeting minutes, action logs and any work plan may be combined with those of the Place ICB Sub-Committee and/or other place governance structures in Section 2. *Governance support* 45. Governance support to the Partnership Board will be provided by the Integrated Care Board's governance team. *Confidential information* 46. Where confidential information is presented to the Partnership Board, those present will ensure that they treat that information appropriately in light of any confidentiality requirements and information governance principles.
Decision-making	47. The Partnership Board is the primary forum within the Havering Place-Based Partnership for bringing a wide range of partners across Place together for the purposes of determining and taking forward matters relating to the improvement of health, wellbeing and equity across the borough. It brings together representatives from across Place, who have the necessary authority from the partner organisation they represent to consider strategic policy matters and oversee joint programmes of work relevant to Place. 48. The Partnership Board does not hold delegated functions from the partner organisations, but each member shall have appropriate delegated responsibility from the partner organisation they represent to make decisions for their organisation on matters within the Partnership Board's remit or, at least, will have sufficient responsibility and be ready to move programmes of work forwards by holding discussions in their own organisation and escalating matters of importance. 49. Members should come to each meeting ready and prepared to discuss the items on the agenda, particularly those that are most relevant to their role/work stream/service. 50. Members will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view and reach agreement by consensus. 51. In the event that the Partnership Board is unable to agree a consensus position on a matter it is considering, this will not prevent any or all of the statutory committees/sub-committees in Section 2 taking any applicable decisions they are required to take. To the extent permitted by their individual terms of reference, statutory committees may utilise voting on matters they are required to take decisions on.

Conflicts of Interest	52. Conflicts of interests will be managed in accordance with relevant policies, procedures and joint protocols developed by the North East London Integrated Care System, which shall be consistent with partner organisations' respective statutory duties and applicable national guidance.
Accountability and Reporting	53. The Partnership Board shall comply with any reporting requirements that are specifically required by a partner organisation for the purposes of its constitutional or other internal governance arrangements. The Partnership Board will also report to the Integrated Care Partnership. 54. Members of the Partnership Board shall disseminate information back to their respective areas of work as appropriate, and feed back to the group as needed. 55. The Partnership Board and the Health and Wellbeing Board will provide reports to each other, as appropriate, so as to inform their respective work. The reports the Partnership Board receives from the Health and Wellbeing Board will include the Health and Wellbeing Board's recommendations to the Partnership Board on matters concerning delivery of the Place objectives and priorities (see here) and delivery of the associated outcomes framework. The Health and Wellbeing Board will continue to have statutory responsibility for the joint strategic needs assessment and joint local health and wellbeing strategy. 56. Given its purposes at paragraph 9(j) above, the Partnership Board will regularly report upon, and comply with any request of the North East London Integrated Care System's System Quality Group for information or updates on matters relating to quality which effect the Integrated Care System and bears on the group's remit.
Monitoring Effectiveness and Compliance with Terms of Reference	57. The Partnership Board will carry out an annual review of its effectiveness and provide an annual report to the Integrated Care Partnership and to the partner organisations. This report will outline and evaluate the Partnership Board's work in discharging its responsibilities, delivering its objectives and complying with its terms of reference. As part of this, the Partnership Board will review its terms of reference and agree any changes it considers necessary.

Section 2
Terms of reference for the Havering Sub-Committee of the North East London Integrated Care Board

Status of the Sub-Committee	1. The Havering Sub-Committee of the North East London Integrated Care Board ('**the Place ICB Sub-Committee**') is established by the Population Health & Integration Committee as one of its sub-committees. 2. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Sub-Committee and may only be changed with the approval of the Board of the Integrated Care Board. Additionally, the membership of the Sub-Committee must be approved by the Chair of the Board of the Integrated Care Board. 3. The Sub-Committee and all of its members are bound by the Integrated Care Board's Constitution, Standing Orders, Standing Financial Instructions, policies and procedures of the Integrated Care Board. 4. These terms of reference should be read as part of the suite of terms of reference for the Havering Place-Based Partnership, including the terms of reference for the Havering Place-Based Partnership Board ('**the Partnership Board**') in Section 1, which define a number of the terms used in these Place ICB Sub-Committee terms of reference.
Geographical coverage	5. The geographical area covered will be Place, as defined in the Partnership Board's terms of reference in Section 1.
Purpose	6. The Place ICB Sub-Committee has been established in order to: (a) Enable the Integrated Care Board to exercise the Delegated Functions at Place in a lawful, simple and efficient way, to the extent permitted by the Integrated Care Board's Constitution and as part of the wider collaborative arrangements which form the Place-Based Partnership; (b) Support the development of collaborative arrangements at Place, in particular the development of the Place-Based Partnership. 7. The Delegated Functions which the Place ICB Sub-Committee will exercise are set out at **Annex 1**~~.~~ and described in further detail in the Place Mutual Accountability Framework which the annex refers to. 8. The Place ICB Sub-Committee, through its members, is authorised by the Integrated Care Board to take decisions in relation to the Delegated Functions. 9. Further functions may be delegated to the Place ICB Sub-Committee over time, in which case Annex 1 ~~will~~may ~~~~be updated with the approval of the Board of the Integrated Care Board, on the recommendation of the Population Health & Integration Committee. The remit of the Place ICB Sub-Committee is also described in the Place Mutual Accountability Framework,

which may be updated by the Board taking into account the views of the Population Health & Integration Committee.

10. The Delegated Functions shall be exercised with particular regard to the Place objectives and priorities, described in the plan for Place-Based Partnership Plan, which has been agreed with the Population Health & Integration Committee and the partner organisations represented on the Partnership Board. A summary of the Place-Based Partnership's priorities and objectives can be found here.

11. In addition, the Place ICB Sub-Committee will support the wider Integrated Care Board to achieve its agreed deliverables, and to achieve the aims and the ambitions of:

    (a) The Joint Forward Plan;

    (b) The Joint Capital Resource Use Plan;

    (c) The Integrated Care Strategy prepared by the North East London Integrated Care Partnership;

    (d) The Health and Wellbeing Board's joint local health and wellbeing strategy with its needs assessment for the area;

    (e) The Place Mutual Accountability Framework and the NHS North East London Financial Strategy and developing ICS Financial Framework;

    ~~(d)~~(f) The Place-Based Partnership Plan.

12. The Place ICB Sub-Committee will also prioritise delivery against the strategic priorities of the North East London Integrated Care System (see here) and its design and operating principles set out here.

13. In supporting the Integrated Care Board to discharge its statutory functions and deliver the strategic priorities of the North East London Integrated Care System at Place, the Place ICB Sub-Committee will, in turn, be supporting the Integrated Care System with the achievement of the 'four core purposes' of Integrated Care Systems, namely to:

    (a) Improve outcomes in population health and healthcare;

    (b) Tackle inequalities in outcomes, experience and access;

    (c) Enhance productivity and value for money;

    (d) Help the NHS support broader social and economic development.

14. The Place ICB Sub-Committee is a key component of the North East London Integrated Care System, enabling it to meet the 'triple aim' of better health for everyone, better care for all and efficient use of NHS resources.

Key duties relating to the exercise of the

15. When exercising any Delegated Functions, the Place ICB Sub-Committee will ensure that it acts in accordance with, and that its decisions are informed

Delegated Functions	by, the guidance, policies and procedures of the Integrated Care Board or which apply to the Integrated Care Board. 16. The Sub-Committee must have particular regard to the statutory obligations that the Integrated Care Board is subject to, including, but not limited to, the statutory duties set out in the National Health Service Act 2006 and listed in the Constitution. In particular, the Place ICB Sub-Committee will also have due regard to the public sector equality duty under section 149 of the Equality Act 2010.
Collaborative working	17. In exercising its responsibilities, the Place ICB Sub-Committee may work with other Place ICB Sub-Committees, provider collaboratives, joint committees, committees, or sub-committees which have been established by the Integrated Care Board or wider partners of the North East London Integrated Care System. This may include, where appropriate, aligning meetings or establishing joint working groups. *Collaboratives* 18. In particular, in addition to an expectation that the Place ICB Sub-Committee and the Partnership Board shall collaborate with each other as part of the Place-Based Partnership, the Place ICB Sub-Committee will, as appropriate, work with the following provider collaborative governance structures within the area of the North East London Integrated Care System: (a) The North East London Mental Health, Learning Disability & Autism Collaborative; (b) The Combined Primary Care Provider Collaborative; (c) The North East London Acute Provider Collaborative; (d) The North East London Community Collaborative. (e) The evolving Voluntary, Community and Social Enterprise Sector Alliance/Collaborative. 19. Some members of the Place ICB Sub-Committee may simultaneously be members of the above collaborative structures, to further support collaboration across the system. *Health & Wellbeing Board and Safeguarding* 20. The Place ICB Sub-Committee will also work in close partnership with: (a) The Health and Wellbeing Board and shall ensure that plans agreed by the Place ICB Sub-Committee are appropriately aligned with, and have regard to, the joint local health and wellbeing strategy and the assessment of needs, together with the Integrated Care Strategy as applies to Place; and (b) The Safeguarding Adults Board for the Place established by the local authority under section 43 of the Care Act 2014; and

	(c) The Safeguarding Children's Partnership established by the local authority, Integrated Care Board and Chief Officer of Police, under section 16E of the Children Act 2001~~4~~4. *Establishing working groups* 21. The Place ICB Sub-Committee does not have the authority to delegate any functions delegated to it by the Integrated Care Board. However, the Place ICB Sub-Committee may establish working groups or task and finish groups. These do not have any decision-making powers but may inform the work of the Place ICB Sub-Committee and the Place-Based Partnership. Such groups must operate under the Integrated Care Board's procedures and policies and have due regard to the statutory duties which apply to the Integrated Care Board.
Chairing and executive lead arrangements	22. The Place ICB Sub-Committee will be chaired by the Chief Executive of the London Borough of Havering, who is appointed on account of their specific knowledge, skills and experiences making them suitable to chair the Sub-Committee. 23. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference. 24. The Co-Chairs of the Partnership Board will be the joint Deputy Chairs of the Place ICB Sub-Committee. 25. If the Chair has a conflict of interest then the joint Deputy Chairs or, if necessary, another member of the Sub-Committee will be responsible for deciding the appropriate course of action. 26. The Chief Executive of the London Borough of Havering is also the Place Partnership Lead.
Membership	27. The Place ICB Sub-Committee members will be appointed by the Board of the Integrated Care Board in accordance with the Integrated Care Board's Constitution and the Chair of the Integrated Care Board will approve the membership of the Sub-Committee. 28. The Place ICB Sub-Committee has a broad membership, including those from organisations other than the Integrated Care Board. This is permitted by the Integrated Care Board's Constitution and amendments made to the National Health Service Act 2006 by the Health and Care Act 2022. 29. The membership of the Place ICB Sub-Committee includes members drawn from the following partner organisations which operate at Place: (a) The Integrated Care Board; (b) Barking, Havering and Redbridge University Hospitals Health NHS Trust; (c) North East London NHS Foundation Trust;

(d) The London Borough of Havering;

(e) Havering Health;

(f) Primary Care Networks.

30. There will be a total of 13 members of the Place ICB Sub-Committee, as follows:

Integrated Care Board

(a) Delivery Director for Havering;

(b) Clinical Care Director for Havering;

(c) Director of Finance or their nominated representative;

(d) Director of Nursing/Quality or their nominated representative;

The London Borough of Havering

(e) Chief Executive (**Place Partnership Lead and Chair**);

(f) Lead Member for Adult Social Care and Health;

(g) Director Adult Social Care & Health;

(h) Director Children's Social Care;

(i) Director of Public Health;

NHS Trusts/Foundation Trusts

(j) Director, North East London NHS Foundation Trust;

(k) Director, Barking, Havering and Redbridge University Hospitals Health NHS Trust;

Primary Care

(l) Place-Based Partnership Primary Care Development Clinical Lead;

(m) The member of the Partnership Board from the primary care sector who is appointed to be its Co-Chair.

31. With the permission of the Chair of the Place ICB Sub-Committee, the members, set out above, may nominate a deputy to attend a meeting of the Place ICB Sub-Committee that they are unable to attend. However, members will be expected not to miss more than two consecutive meetings. The deputy may speak and vote on their behalf. The decision of the Chair regarding authorisation of nominated deputies is final.

32. When determining the membership of the Sub-Committee, active consideration will be made to diversity and equality.

Participants	33. Only members of the Sub-Committee have the right to attend Sub-Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Sub-Committee. 34. Meetings of the Sub-Committee may also be attended by the following for all or part of a meeting as and when appropriate: (a) Any members of the Partnership Board (i.e. in Section 1). 35. The Chair may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion on particular matters.
Resource and financial management	36. The Integrated Care Board has made arrangements to support the Place ICB Sub-Committee in its exercise of the Delegated Functions. Financial responsibilities of the Place ICB Sub-Committee are contained in the list of Delegated Functions in Annex 1, and further information about resource allocation within the Integrated Care Board is contained in the Integrated Care Board's Standing Financial Instructions and associated policies and procedures~~.~~, which includes the NHS North East London Financial Strategy and developing ICS Financial Framework. ~~36.~~37. The Chair will be invited to attend the Finance Performance and Investment Committee where the Committee is considering any issue relating to the resources allocated in relation to the Delegated Functions.
Meetings, Quoracy and Decisions	~~37.~~38. The Place ICB Sub-Committee will operate in accordance with the Integrated Care Board's governance framework, as set out in its Constitution and Governance Handbook and its wider policies and procedures, except as otherwise provided below: *Scheduling meetings* ~~38.~~39. The Place ICB Sub-Committee will aim to meet on a bi-monthly basis and, as a minimum, shall meet on four occasions each year. [5] ~~–~~Additional meetings may be convened on an exceptional basis at the discretion of the Chair. ~~39.~~40. The Place ICB Sub-Committee will usually hold its meetings together with the Partnership Board, as part of an aligned meeting of the Place-Based Partnership. Although the Place ICB Sub-Committee may meet on its own at the discretion of its Chair, it is expected that such circumstances would be rare. ~~40.~~41. The Place ICB Sub-Committee acknowledges that the Partnership Board may convene its own more regular meetings, for instance where agenda items do not require a statutory decision of the Place ICB Sub-Committee.

~~[5] In the first financial year of operation the Place ICB Sub-Committee is only expected to meet on three occasions.~~

~~41.~~42. The Board, Chair of the Integrated Care Board or its Chief Executive may ask the Sub-Committee to convene further meetings to discuss particular issues on which they want the Sub-Committee's advice.

~~42.~~43. Where a meeting is held in tandem with the Partnership Board, the Co-Chairs of the Partnership Board and the Chair of the Sub-Committee shall agree which of them shall lead and facilitate the discussion at the meeting.

Quoracy

~~43.~~44. The quoracy for the Place ICB Sub-Committee will be six and must include the following of which one must be a care or clinical professional:

(a) Two of the members from the Integrated Care Board;

(b) Two of the members from the local authority;

(c) One of the members from an NHS Trust or Foundation Trust;

(d) One primary care member.

~~44.~~45. If any member of the Sub-Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

~~45.~~46. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Voting

~~46.~~47. Decisions will be taken in accordance with the Standing Orders. The Sub-Committee will ordinarily reach conclusions by consensus. When this is not possible, the Chair may call a vote. Only members of the Sub-Committee may vote. Each member is allowed one vote and a simple majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Sub-Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

Papers and notice

~~47.~~48. A minimum of seven clear working days' notice is required. Notice of all meetings shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed. Supporting papers must be distributed at least five clear working days ahead of the meeting.

~~48.~~49. On occasions it may be necessary to arrange urgent meetings at shorter notice. In these circumstances the Chair will give as much notice as possible to members. Urgent papers shall be permitted in exceptional circumstances at the discretion of the Chair.

~~49.~~50. Where a meeting is to be held in tandem with the Partnership Board, the Chair of the Sub-Committee will liaise with the Co-Chairs of the Partnership Board, in order to agree the meeting agenda in advance of the meeting. The Chair will also need to reach agreement with the Co-Chairs about other

matters falling within paragraphs 5150 (virtual attendance) and 5756 (recordings of meetings).

Virtual attendance

50.51. It is for the Chair to decide whether or not the Place ICB Sub-Committee will meet virtually by means of telephone, video or other electronic means. Where a meeting is not held virtually, the Chair may nevertheless agree that individual members may attend virtually. Participation in a meeting in this manner shall be deemed to constitute presence in person at such meeting. How a person has attended a meeting shall be specified in the meeting minutes.

Admission of the public

51.52. Meetings at which public functions of the Integrated Care Board are exercised will usually be open to the public, unless the Chair determines, at his or her discretion, that it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for some other good reason.

52.53. The Chair shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the business shall be conducted without interruption and disruption.

53.54. A person may be invited by the Chair to contribute their views on a particular item or to ask questions in relation to agenda items. However, attendance shall not confer a right to speak at the meeting.

54.55. Matters to be dealt with by a meeting following the exclusion of representatives of the press and other members of the public shall be confidential to the members of the Place ICB Sub-Committee and others in attendance.

55.56. There shall be a section on the agenda for public questions to the Sub-Committee, which shall be in line with the Integrated Care Board's agreed procedure as set out on our website here.

Recordings of meetings

56.57. Except with the permission of the Chair, no person admitted to a meeting of the Place ICB Sub-Committee shall be permitted to record the proceedings in any manner whatsoever, other than in writing.

Confidential information

57.58. Where confidential information is presented to the Place ICB Sub-Committee, all those who are present will ensure that they treat that information appropriately in light of any confidentiality requirements and information governance principles.

Meeting Minutes

~~58.~~59. The minutes of a meeting will be formally taken in the form of key points of debate, actions and decisions and a draft copy circulated to the members of the Place ICB Sub-Committee, together with the action log as soon after the meeting as practicable. The minutes shall be submitted for agreement at the next meeting where they shall be signed by the Chair.

~~59.~~60. Where it would promote efficient administration, meeting minutes and/or action logs may be combined with those of the Partnership Board.

Legal or professional advice

~~60.~~61. Where outside legal or other independent professional advice is required, it shall be secured by or with the approval of the Director who is responsible for governance within the Integrated Care Board.

Governance support

~~61.~~62. Governance support to the Place ICB Sub-Committee will be provided by the Integrated Care Board's governance team.

Conflicts of Interest

~~62.~~63. Conflicts of interest will be managed in accordance with the policies and procedures of the Integrated Care Board and those contained in the Handbook and shall be consistent with the statutory duties contained in the National Health Service Act 2006 and any statutory guidance issued by NHS England.

Behaviours and Conduct

~~63.~~64. Members will be expected to behave and conduct business in accordance with:

(a) The Integrated Care Board's policies and procedures including its Constitution, Standing Orders and Standards of Business Conduct Policy which includes the Code of Conduct which sets out the expected behaviours that all members of the Board of the Integrated Care Board and its committees will uphold whilst undertaking the Integrated Care Board's business;

(b) The NHS Constitution;

(c) The Nolan Principles.

~~64.~~65. Members must demonstrably consider equality, diversity and inclusion implications of the decisions they make.

Disputes

~~65.~~66. Where there is any uncertainty about whether a matter relating to a Delegated Function is within the remit of the Place ICB Sub-Committee in its capacity as a decision-making body within the Integrated Care Board's governance structure, including uncertainty about whether the matter relates to:

(a) a matter for wider determination within the North East London Integrated Care System; or

(b) determination by another place-based committee of the Integrated Care Board or other forum, such as a provider collaborative,

then the matter will be referred to the Director who is responsible for governance within the Integrated Care Board for consideration about where the matter should be determined.

Referral to the Population Health & Integration Committee

~~66.~~67. Where any decision before the Place ICB Sub-Committee is 'novel, contentious or repercussive' across the Integrated Care Board's area and/or is a decision which would have an impact across the area, then the Place ICB Sub-Committee shall give due consideration to whether the decision should be referred to the Population Health & Integration Committee.

~~67.~~68. With regard to determining whether a decision falling within the paragraph above shall be referred to the Population Health & Integration Committee for consideration then the following apply:

(a) The Chair of the Place ICB Sub-Committee, at his or her discretion, may determine that such a referral should be made;

(b) Two or more members of the Place ICB Sub-Committee, acting together, may request that a matter for determination should be considered by the Population Health & Integration Committee.

~~68.~~69. Where a matter is referred to the Population Health & Integration Committee under paragraph ~~66~~ 67, the Population Health & Integration Committee (at an appropriate meeting) shall consider and determine whether to accept the referral and make a decision on the matter. Alternatively, the Population Health & Integration Committee may decide to refer the matter to the Board of the Integrated Care Board or to another of the Integrated Care Board's committees/subcommittees for determination.

~~69.~~70. In addition to the Place ICB Sub-Committee's ability to refer a matter to the Population Health & Integration Committee as set out in paragraph 67~~66~~67:

(a) The Population Health & Integration Committee, or its Chair and Deputy Chair (acting together), may determine that any decision falling with paragraph ~~66~~67 should be referred to the Population Health & Integration Committee for determination; or

(b) The Board of the Integrated Care Board, or its Chair and the Chief Executive (acting together), may require a decision related to any of the Integrated Care Board's delegated functions to be referred to the Board of the Integrated Care Board.

Accountability and Reporting

~~70.~~71. The Place ICB Sub-Committee shall be directly accountable to the Population Health & Integration Committee, and ultimately the Board of the Integrated Care Board.

	~~71.~~72. The Place ICB Sub-Committee will report to: (a) **Population Health & Integration Committee.** The Population Health & Integration Committee, following each meeting of the Place ICB Sub-Committee. A copy of the meeting minutes along with a summary report shall be shared with the Committee for information and assurance. The report shall set out matters discussed and pertinent issues, together with any recommendations and any matters which require disclosure, escalation, action or approval. And will report matters of relevance to the following: (b) **Finance, Performance and Investment Committee.** Such formal reporting into the Integrated Care Board's Finance, Performance and Investment Committee will be on an exception basis. Other reporting will take place via Finance and via North East London wide financial management reports. (c) **Quality, Safety and Improvement Committee.** Reports will be made to the Quality, Safety and Improvement Committee in respect of matters which are relevant to that Committee and in relation to the exercise of the quality functions set out here. ~~72.~~73. In the event that the Chair of the Integrated Care Board, its Chief Executive, the Board of the Integrated Care Board or the Population Health & Integration Committee requests information from the Place ICB Sub-Committee, the Place ICB Sub-Committee will ensure that it responds promptly to such a request. *Shared learning and raising concerns* ~~73.~~74. Where the Place ICB Sub-Committee considers an issue, or its learning from or experience of a matter, to be of importance or value to the North East London health and care system as a whole, or part of it, it may bring that matter to the attention of the Director who is responsible for governance within the Integrated Care Board for onward referral to the Population Health & Integration Committee, the Chair or Chief Executive of the Integrated Care Board, the Board of the Integrated Care Board, the Integrated Care Partnership or to one or more of Integrated Care Board's committees or subcommittees, as appropriate.
Review	~~74.~~75. The Place ICB Sub-Committee will review its effectiveness at least annually. ~~75.~~76. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board of the Integrated Care Board for approval.

Date of approval: 14 September 2022 (Initial version by ICB Board on 1 July 2022)

Version: 2.0

Date of review: 1 April 2023

Annex 1 – Functions delegated to the Place ICB Committee by the North East London Integrated Care Board

Commissioning functions

In addition to the specific activities set out in this Annex 1 below, ~~T~~The Place ICB Sub-Committee will have delegated responsibility for exercising the ~~Integrated Care Board's commissioning functions at Place in relation to the following specified services (the '**Specified Services**'), in line with Integrated Care Board policy~~ functions described in the Place Mutual Accountability Framework at Place. These functions are referred to below as 'the **Place Commissioning Functions**.'

The Place Mutual Accountability is contained in the ICB's Governance Handbook and should be read alongside the equivalent accountability framework which describes the role of the provider collaboratives.

Where Place Commissioning Functions relate to a particular service they must be exercised in line with the ICB's relevant commissioning policy for that service.

~~[section to be completed by end of 2022 following confirmation]~~

Health and care needs planning

The Place ICB Sub-Committee will undertake the following specific activities in relation to health and care needs planning, through embedding population health management:

1. Making recommendations to the Population Health & Integration Committee in relation to, and contributing to, the Joint Forward Plan and other system plans, in so far as relates to the exercise of the Integrated Care Board's functions at Place.

2. Overseeing, and providing assurance to the Population Health & Integration Committee regarding the implementation and delivery at Place of the Joint Forward Plan, the Integrated Care Strategy and other system plans, in so far as they require the exercise of the Integrated Care Board's functions.

3. Overseeing the development of service specification standards needed ~~at Place~~ in connection with the exercise of the Place Commissioning Functions and~~for the Specified Services~~, in line with relevant Integrated Care Board policy.

4. Working with the Partnership Board on behalf of the Integrated Care Board, to develop the Place-Based Partnership Plan including the Place objectives and priorities and a Place outcomes framework.

   The Place-Based Partnership Plan shall be developed by drawing on data and intelligence, and in co-production with service users and residents of Havering. It is aimed at ensuring delivery of the Joint Forward Plan, the Integrated Care Strategy, the Health and Wellbeing Board's joint local health and wellbeing strategy and associated needs assessment, and other system plans.

   In particular, this shall include developing the Place priorities and objectives set out in the Place-Based Partnership Plan, and summarised here, and an associated outcomes framework developed by the Place-Based Partnership.

The Place-Based Partnership Plan shall be tailored to meet local needs, whilst maintaining ICB-wide operational, quality and financial performance standards. It shall also be consistent with, and aimed at delivery of, the Place Mutual Accountability Framework at Place.

5. Overseeing, and providing assurance to the Population Health & Integration Committee regarding, the implementation and delivery of the Place-Based Partnership Plan, in so far as the plan requires the exercise of Integrated Care Board functions.

6. Overseeing, and providing assurance to the Population Health & Integration Committee regarding, the implementation and delivery of the Place objectives and priorities, contained within the Place-Based Partnership Plan and summarised here, in so far as they require the exercise of Integrated Care Board functions.

7. Overseeing the implementation and delivery of the Health and Wellbeing Board's joint local health and wellbeing strategy, in so far as the strategy requires the exercise of Integrated Care Board functions.

Market management, planning and delivery

The Place ICB Sub-Committee will undertake the following specific activities in relation to market management, planning and delivery:

1. Making recommendations to the [Board of the Integrated Care Board / Population Health & Integration Committee in relation] to health service change decisions (whether these involve commissioning or de-commissioning).

2. Approving commissioning policies ~~in relation to the Specified Services,~~ connected with the exercise of the Place Commissioning Functions, in line with Integrated Care Board policy.

3. Approving demographic, service use and workforce modelling and planning, where these relate to ~~the Integrated Care Board's commissioning functions being exercised at Place~~ the Place Commissioning Functions.

Finance

~~The Place ICB Sub-Committee will undertake the following specific activities in relation to financial control and contracting:~~

The Place ICB Sub-Committee will have delegated financial management and control, as detailed below and within the ICB's Standing Financial Instructions. The Finance, Performance and Investment Committee will continue to have oversight of NEL wide financial decisions, including where coordination/planning for the services concerned is best undertaken over a larger footprint. However, there will be ongoing dialogue in order to ensure a joined up approach, ensure financial sustainability, and as the NHS North East London Financial Strategy and ICS Financial Framework develop.

1. Plan and monitor the budgets delegated to the Place ICB Sub-Committee and take action to ensure they are delivered within the financial envelope.

2. The Sub-Committee will take shared responsibility, along with partners, for the health outcomes of their population, and will work with those partners to develop a shared plan for improving health outcomes and maintaining collective financial control.

3. Review and understand any variations to plan within the delegated budget and take appropriate action to mitigate these.

4. Oversee any required recovery plans in order to ensure financial balance is achieved at Place.

5. Ensure financial plans are triangulated with performance and quality.

6. Ensure any known financial risks are escalated to the Integrated Care Board's Finance, Performance and Investment Committee and to the [North East London Integrated Care System Executive], as appropriate.

7. Review performance of the contracts within Place ~~[in relation to the Specified Services,]~~ to ensure services and activity are being delivered in line with contractual arrangements.

8. Review and understand the financial implications of new investments and transformation schemes,~~.~~ and ensure there is sufficient funding across the life of the investment.

9. Oversee implementation of investments/transformation schemes, ensuring financial activity, Key Performance Indicators and required outcomes are delivered.

10. Review and agree any procurement decisions in relation to ~~the Specified~~ services connected with the Place Commissioning Functions, as appropriate, in line with the Integrated Care Board's Standing Financial Instructions and Procurement Policy.

11. Ensure financial decisions are taken in line with the Integrated Care Board's Standing Financial Instructions~~.~~ and NHS North East London Financial Strategy and developing ICS Financial Framework.

~~11.~~12. In relation to financial risk share arrangements (including but not limited to section 75, 76 and section 256 agreements), the Place ICB Sub-Committee shall:

- Review any current in-year arrangements applicable to Place, ensuring that funding is spent appropriately in line with contractual agreements;
- Review the risks and benefits of the allocation of funding and approve spend on pooled budgets based on recommendations from those leading the work and where all parties are in agreement;
- Receive reports on the schemes funded through this mechanism to ensure it is delivering the expected outcomes and benefits;
- Review the funding and arrangements for the subsequent financial year and ensure there are adequate governance and arrangements in Place that are consistent with other places across the Integrated Care Board's area;
- Review and make recommendations in relation to proposals for the Integrated Care Board to enter into new agreements under section 75 of the National Health Service Act 2006 with the local authority at Place. In accordance with the Constitution, any such arrangements must be authorised by the Board of the Integrated Care Board.

Quality

The Place ICB Sub-Committee will undertake the following specific activities in relation to quality:

1. Providing assurance that health outcomes, access to healthcare services and continuous quality improvement are being delivered at Place, and escalate specific issues to the Population Health & Integration Committee, the Quality Safety and Improvement Committee and/or other governance structures across the North East London Integrated Care System as appropriate.

2. Complying with statutory reporting requirements relating to the exercise of the Place Commissioning Functions~~Specified Services~~, in particular as relates to quality and improvement ~~of those services~~.

3. In addition, the Place ICB Sub-Committee will have the following responsibilities on behalf of the Integrated Care Board at Place, in relation to quality:

    - Gain timely evidence of provider and place-based quality performance, in relation to the ~~Specified Services;~~ exercise of the Place Commissioning Functions at Place.

    - Ensure the delivery of quality objectives by providers and partners within Place, including North East London Integrated Care System programmes that relate to the place portfolio;

    - Identify, manage and escalate where necessary, risks that materially threaten the delivery of the Integrated Care Board's objectives at Place and any local objectives and priorities for Place;

    - Identify themes in local triangulated intelligence that require local improvement plans for immediate or future delivery;

    - Gain evidence that staff have the right skills and capacity to effectively deliver their role, creating succession plans for any key roles within the services being delivered at Place;

    - Hold system partners to account for performance and the creation and delivery of remedial action/improvement plans where necessary;

    - Share good practice and learning with providers and across neighbourhoods.

4. Ensure key objectives and updates are shared consistently within the Integrated Care Board, and more widely with North East London Integrated Care System and senior leaders via the North East London Integrated Care System's System Quality Group and other established governance structures.

Primary Care

The Place ICB Sub-Committee will undertake the following specific activities in relation to primary care:

1. To develop arrangements for integrated services, including primary care, through local neighbourhoods

Communication and engagement with stakeholders

The Place ICB Sub-Committee will undertake the following specific activities in relation to communications and engagement:

1. Overseeing and approving any stakeholder involvement exercises proposed specifically in Place, consistent with the Integrated Care Board's statutory duties in this context and the

Integrated Care Board's relevant policies and procedures. Such stakeholder engagement shall include political engagement, clinical and professional engagement, strategic partnership management and public and community engagement.

2. Overseeing the development and delivery of patient and public involvement activities, as part of any service change process occurring specifically at Place.

Population health management

The Place ICB Sub-Committee will undertake the following specific activities in relation to population health management:

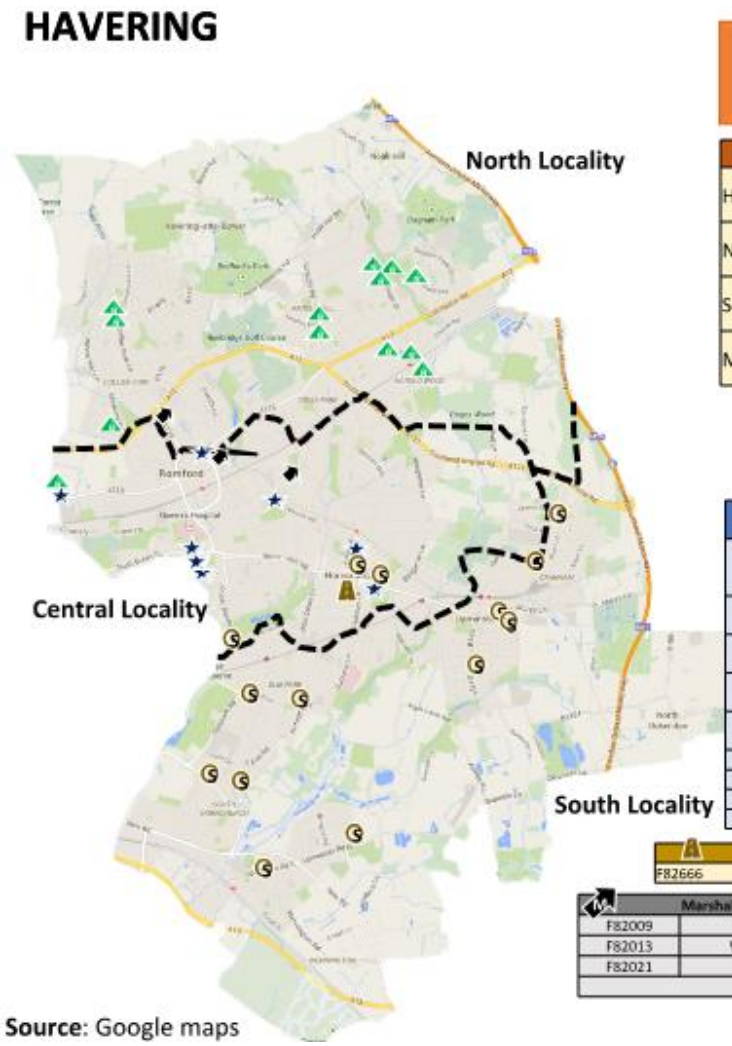
1. Ensuring there are appropriate arrangements at Place to support the Integrated Care Board to carry out predictive modelling and trend analysis.

Emergency planning and resilience

The Place ICB Sub-Committee will undertake the following specific activities in relation to emergency planning:

1. At the request of the any of the Population Health & Integration Committee or the Board of the Integrated Care Board, in relation to a local or national emergency, prepare or contribute to an emergency response plan for implementation at Place, coordinating with local partners as necessary.

Figure 1 - Havering's Primary Care Networks



GP Federation: Havering Health Limited
Chair: Dr Dan Weaver

Havering PCN Clinical Directors	
Havering Crest	Dr A Imran
	Dr N Kullar
North	Dr J Gupta
	Dr. G Singh
South	Dr J O Moore
	Dr N Rao
Marshall's	Dr Yasmin Heerah
	Dr S Symon

North PCN - 13 Practices List size: 80,617		
F82007	The Greenwood Practice	11830
F82010	Petersfield Surgery	7856
F82014	The Health Centre (Dr Kuchhal)	7117
F82016	Central Park Surgery (Dr Kakad)	6901
F82030	Lynwood Medical Centre	13087
F82045	Oak Tree Surgery	3648
F82610	Dr Gupta	2856
F82630	Chase Cross Medical Centre	6455
F82648	Ingrebourne Medical Centre	3335
F82670	AbbaMoor Surgery (Harold Hill Health Centre)	2763
F82686	Chadwell Heath Health Centre (Dr A Patel)	2855
Y00312	Robins Surgery	4640
Y02973	Kings Park Surgery (Previously Harold Wood Polyclinic)	7273
		80617

Havering Crest - 8 Practices List Size : 41,016		
F82011	St Edwards Medical Centre (Previously Mawney Medical Centre)	10373
F82019	The Upstairs Surgery (Previously Dr Hamilton-Smith)	6269
F82023	High Street Surgery (Dr Pervez)	3395
F82031	Rush Green Medical Centre (Dr Sanomi)	4570
F82039	Rush Green Medical Centre (Dr Poolo & Partners)	3450
F82638	The Modern Medical Centre	6049
F82663	Dr Marks Practice	3453
F82675	Billet Lane Medical Centre	3459
		41016

South PCN - 14 Practices List Size : 95,848		
F82002	Haiderian Medical Centre	6349
F82006	Cranham Village Surgery (Dr Dahs & Partners)	12294
F82008	Maylands Health Care	14093
F82022	Rosewood Medical Centre	12467
F82028	Wood Lane Surgery	9185
F82053	Upminster Medical Centre	3403
F82055	Hornchurch Healthcare	7402
F82607	South Hornchurch Medical Practice (Spring Farm Surgery)	4891
F82609	Suttons Avenue Surgery (Dr P M Patel)	4525
F82619	Harlow Road Surgery	3505
F82624	Upminister Bridge Surgery (Dr John O'Moore)	3645
F82627	Rainham Health Centre (Dr Abdullah)	4649
F82649	Berwick Surgery	4765
F82674	Avon Road Surgery	4675
		95848

Not Aligned to Network		
F82666	Dr Rahman & Tsoi	4320

Marshalls PCN - 3 Practices List Size : 44,594		
F82009	North Street Medical Care	19476
F82013	Western Road Medical Centre	16155
F82021	The New Medical Centre	8962
		44594

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FINAL DRAFT, FOLLOWING FEEDBACK

North East London Health & Care Partnership

A framework for mutual accountability between north east London's place partnerships and NHS North East London

Introduction

North east London's place partnerships are uniquely placed to drive the integration between health and care that will improve residents' wellbeing, through co-produced approaches that build on community assets. As partnerships, they understand their communities and the inequalities that residents face. Reshaping north east London's health and care system so that it is equitable, delivers improved wellbeing for everyone, and is financially sustainable, will happen only if we work together to deliver at neighbourhood, place, collaborative, and system. Each element of the system needs to be accountable for its part of our improvement journey and to work together alongside residents and communities to effect change sustainably.

This draft document continues our discussion about what NHS North East London asks place partnerships to hold accountability for and, in turn, what the partnerships can expect NHS North East London to achieve for them. It will sit alongside an equivalent document that focuses on the role of provider collaboratives to help build our understanding of how the system overall will work best.

We recognise that our system is new and evolving, and much of this draft document seeks to outline the principles which will guide this evolution to support improved health and wellbeing for local residents.

Zina Etheridge – Chief Executive Officer, NHS North East London

Background

The North East London Health and Care Partnership (NELHCP) brings together the NHS, local authorities, and community organisations across north east London to work in partnership with local people to support them to live healthier, happier lives.

Our approach is built on an understanding that partnership, conversation, and collaboration underpin all that we do. We see that place shapes and strengthens system and that system enables and builds place, underlining our appreciation of the need for our workforce to participate through a range of inter-connecting networks (operating at neighbourhood, place, collaborative, system, region, and nation) in order to be most effective in improving outcomes for everyone. NHS North East London has adopted the principle of subsidiarity to encapsulate this approach as applied to governance, decision-making, strategy, and delivery of models of care. This means we will facilitate tasks being performed at the most local level, closest to those most likely to be directly affected, and only carry out tasks that cannot be carried out at that more local level.

As north east London's integrated care system, we are ambitious and actively draw on best practice locally and internationally. We are clear that we are moving beyond performance management to maximising value, and beyond our individual responsibilities to create a shared endeavour and mutual accountability for delivering benefit and opportunity for our residents. We are committed to continuous improvement and innovation across and with all partners, meaningful

co-production and resident participation, and working in integrated ways together to provide better health and care outcomes for our growing and diverse population of over two million people. At the heart of our partnership is a shared commitment to meaningful participation with residents and partners, a passion for equality and addressing health inequalities, and ensuring that system collaboration underpins continuous improvements to population health and the integrated delivery of health and care services. To operate effectively, we understand that our system needs to develop continually, to be resilient, and to respond coherently and in partnership to emergencies and emerging challenges.

Our seven place partnerships and our five provider collaboratives are crucial building blocks of North East London's integrated care system. Together they play distinct but crucially interdependent roles in driving the improvement of health, wellbeing, and equity for all residents. As we mature as a system, we will increasingly call on each other to support the achievement of outcomes and to enable the collaboration and partnership on which we all rely. We recognise that this support will look different for different pathways but we recognise the fundamental importance of building relationships, sharing perspectives and working alongside local residents to facilitate this support.

The places of north east London have a long history of successful pace-based working. Strengthening and spreading this across north east London is critical to our overall success because places are:

- where the NHS, local authorities, and the voluntary and community sector integrate delivery, supporting seamless and joined up care;
- where local authorities can seek partner input into, and support for, their work to improve the wider determinants of health, which extends into areas including housing, education, employment, food security, community safety, social inclusion and non-discrimination, leisure and open spaces, and air pollution;
- where we will most effectively tackle many health inequalities through prevention, early intervention, and community development, including at neighbourhood level;
- where diverse engagement networks generate rich insight into residents' views;
- where we can build detailed understandings of need and assets on a very local basis and respond with appropriate support; and
- where the NHS and local authorities as a partnership are held democratically accountable, through health and wellbeing boards and overview and scrutiny committees.

Aligned to this, our collaboratives play a critical role in bringing together NHS provider trusts, primary care networks, and VCSE organisations across the whole of north east London to make use of their combined resources and expertise. We have collaboratives for acute care; mental health, learning disabilities, and autism; community services; primary care; and the VCSE sector. Across these five collaboratives, partners are focused on:

- reducing unwarranted variation and inequality in health outcomes, access to services and experience;
- improving resilience by, for example, providing mutual aid;
- ensuring that specialisation and consolidation occur where this will provide better outcomes and value;
- spreading innovation and best practice; and
- ensuring a strong voice for users of their services and other provision in ICS decision-making.

Principles for working together as place, collaborative, and system

- Our approach is built on a shared understanding of subsidiarity: that decisions are best taken closest to those most affected by them. There is freedom to lead, innovate, experiment, and deliver through place partnerships, without non-value-adding interventions from NEL-wide structures.
- Subsidiarity will be enabled by financial and functional delegation to place sub-committees and to provider collaboratives where required.
- Aligned to this is a shared belief that the place partnerships created in our new arrangements are equal partnerships, with organisations, including collaboratives, coming to the table as equal partners to improve outcomes for local residents.
- Our model of working together sees place partnerships holding responsibility for the health and wellbeing of their local population, for key local outcomes, for improving care and support, and for reducing health inequalities, calling on collaboratives and NHS North East London to support.
- Our ambition is for system to support the journey towards greater integration strategically and operationally, building on best practice in places and recognising this might look different in each place.
- We are committed to working from existing arrangements in each place to develop the capacity and infrastructure that best supports place partnerships to respond to the specific and varied health and wellbeing needs of their local populations.
- NHS North East London will play a role in facilitating partners across the patch to enable effective place working, including problem-solving with and on behalf of place partnerships, advocating for the centrality of place, and organising teams and processes in ways that recognise the relevance of place.
- NHS North East London supports the approach that places shape the system and the system shapes places, and will address behaviours that promote the idea of it as an organisation standing apart from places rather than built from them, such as how its teams communicate and how north east London-wide work is described.
- Place partnerships and provider collaboratives are equal and co-dependent partners in the improvement of health, wellbeing, and equity. They will frequently rely on each other to achieve their objectives. For example, provider collaboratives will often depend on place partnerships for the insight required to ensure that north east London-wide programmes of work meet the varied needs of communities across north east London. Equally, place partnerships will rely on provider collaboratives to leverage the capacity and expertise that enables their residents to be cared for in the quickest and safest way possible. The links between place partnerships and provider collaboratives will come from the overlap of leaders, focused engagement on particular areas work, and formally through the population health and integration committee of the Integrated Care Board.
- Place partnerships will recognise their role within, and contribution to, the wider system in line with the principle of subsidiarity. This means that, whilst places work principally to respond to the needs and aspirations of their local residents and communities, they will also work in alignment with co-created wider approaches and, along with provider collaboratives, to deliver local elements of wider programmes. Whilst some such approaches and programmes may span north east London, some may cover identified geographies within this or dedicated communities for example.

Delivering care and support that improve health, wellbeing, and equity

Our shared work to improve health, wellbeing, and equity combines outcomes and priorities identified by each place partnership with north east London-wide programmes in which places play a critical strategic and delivery role alongside collaboratives and NHS North East London.

We are already identifying clear and quantifiable outcomes goals – co-produced with our residents – so that we can be clear about the impact we are making. Where these already exist, they will be at the front and centre of the outcomes model.

Area	Place partnership accountabilities
Overall ambition	Place partnerships will be responsible for the health and wellbeing of their local populations. In order to support this, a key role of place partnerships will be to convene a range of partners and enable their contribution to the delivery of integrated local care, based on smaller neighbourhoods and reflecting the system and community assets held locally. Each place will facilitate and co-ordinate the work necessary across collaboratives and geographies to ensure that all residents can access same-day urgent care when they need it and deliver continuity of care for agreed cohorts of residents in line with the Fuller Stocktake and any associated policy or legislative developments. Through prevention and earlier intervention, focused on the wider determinants of health and wellbeing, place partnerships will help to reduce the proportion of the population needing the most acute health and social care, including hospital stays and residential and nursing care, creating health and wellbeing for a wider range of residents for longer. Partners will also work together in integrated ways to minimise pressure on the social care front door, including by promoting earlier intervention and the use of community assets that support residents to avoid reaching crisis. In the context of a rapidly growing population, this approach is key to moderating the growth in demand for both NHS health provision and local authority social care, which is critical to our system's long-term sustainability.
Leadership and infrastructure	Places hold a number of key strategic functions for the integrated care system, including: • relationships with local authorities, local providers, community groups, and residents; • participation and co-production with residents; • the insight to understand and tackle local population health and inequalities; • supporting system financial sustainability; and • building integrated models of insight, planning, and delivery. In order to fulfil these functions, places will need the resources identified in the proposal for core place teams, as well as support from north east London-wide teams who will provide embedded teams or individuals working at place. Places will be supported by an effective financial strategy and the requisite delegations for decision making. We envisage the leadership role at place as a system leadership role that builds on the strengths and assets of local communities and of our system, actively convening conversations, facilitating different perspectives, hosting partners to share best practice and building collaborative approaches. We will need to remind ourselves constantly of our system gaze, scanning a range of elements to build the strengths-based system we need.

Neighbourhood working	The place partnership will facilitate strong connections within each neighbourhood, building integrated teams encompassing NHS and social care services, the wider local government offer, and community-led care and support. Along with a central role for primary care, including the primary care collaborative, this joined-up locality working will strengthen the integration of health and care and directly drive better local outcomes. ➢ *How NHS North East London will help* Where a lack of geographical coherence of primary care networks poses a challenge to neighbourhood working in a place, NHS North East London will work with the primary care collaborative and places to support and drive the alignment of footprints to maximise the impact of neighbourhood working.
Partnership working	The place partnership will promote and enable the widest possible view of partnership working. This means working beyond statutory health and care organisations and ensuring that representatives from (for example) the voluntary sector, housing, and police are actively involved in the work of the partnership. This wide view of partnership includes a default to meaningful engagement of, and co-production with, residents. The place partnership lead and NHS North East London will together support the development of the partnership as a high-functioning executive team. This includes the encouragement of peer collaboration and constructive debate between partners, along with transparency and candour about organisational challenges. The Place Partnership Lead, the Director of Partnerships, Impact and Delivery, the Clinical Lead, and the collaboratives' leads in each place will together manage the business of the partnership as well as leading co-production, innovation, and the sharing of best practice. On safeguarding specifically, there is an important opportunity to join up existing statutory forums with the work of the broader partnership. Statutory arrangements are not affected by the development of the place partnership or the sub-committee of NHS North East London. However, the place partnership can play a vital role in facilitating the contribution of safeguarding leads' expertise into the broader agenda of the place partnership, including care model and pathway design. Equally, the place partnership can help to facilitate all partners' contribution towards additional preventative work across the safeguarding agenda. ➢ *How NHS North East London will help* NHS North East London will connect place partnerships with each other, including robust mechanisms to share learning and leading practice across place partnership leads, clinical and care professional leaders, and staff from all levels in partner organisations. NHS North East London will also provide elements of development support across the seven places, by agreement with the place partnership leads.
Mental health and wellbeing	The place partnership, working closely with provider collaboratives at place, will develop and, through its partners, deliver integrated services that enable residents with mental ill-health to live well in the community. This will focus on agreed priority cohorts and prioritise prevention and more equitable access to services. The place partnership lead will ensure a strong focus on the wider mental wellness agenda, including access to employment and access to community-based care and support networks, rather than our collective historic default to focus on the acute end of mental health services.

Babies, children, and young people	Place partnerships, working closely with provider collaboratives at place, will make sure that north east London's places are the best places for babies, children and young people to develop and grow. Place partnerships will take an all-age approach, with parity between the needs of babies, children, young people, and adults, as the basis for sustainable long-term improvements to population health and wellbeing. The place partnership lead will drive creation of a coherent approach to early years, adolescents, and young people up to the age of 24, bringing in partners from across the NHS, local government (families, education, housing), and community organisations, working with parents and families and building holistic support for all babies, children and young people.
Workforce	The place partnerships will lead local design of more integrated workforce models, based around neighbourhoods and focused on community delivery by a broad range of clinical and care professionals alongside VCSE. Place partnerships will also enable local employment by forging effective links with local education and training institutions. The place partnership lead will sponsor this work whilst participating in, and facilitating broader place contributions to, NEL-wide work on broader systemic issues relating to recruitment, retention, design of new roles, and skills development across north east London.
Long-term conditions	Place partnerships have a significant role in ensuring a strong focus on prevention and early intervention, convening work across collaboratives, places and system and facilitating the creation of health-promoting communities and neighbourhoods. Partnerships will support the co-ordination of end-to-end pathway responses for residents at risk of and experiencing long-term conditions, working at different geographies to facilitate the best outcomes for local residents and communities. Please see the annex for further detail.
Community-based care	Place has a significant role in co-ordinating care in the community, ensuring a strong focus on prevention and early intervention, working across collaboratives, places and system and creating health-promoting communities and neighbourhoods for all. Much of the focus will be on a multi-agency approach to Ageing Well, ensuring that north east London is a good place to age, for example with dementia-friendly policies which could be met by the all-age approach supported by place partnerships. Place partnerships will seek to ensure residents can be supported at the end of their lives, dying with dignity in the place of their choice. This could include ensuring good information, advice, and guidance, palliative care at home, effective community support, and residential options are all available, reflecting the cultural and specific needs of our diverse populations. Place partnerships will ensure informal carers are well supported through the experience of end-of-life care for their loved ones. Please see the annex for further detail.
Learning disability and autism	Recognising the leadership role for local authorities in valuing people with learning disabilities and autism to lead fulfilling lives, place partnerships will bring together partners at a place level, including to improve the levels of employment, independent living, and quality of life for people with a learning disability. Place partnerships will enable good system working and ensure the

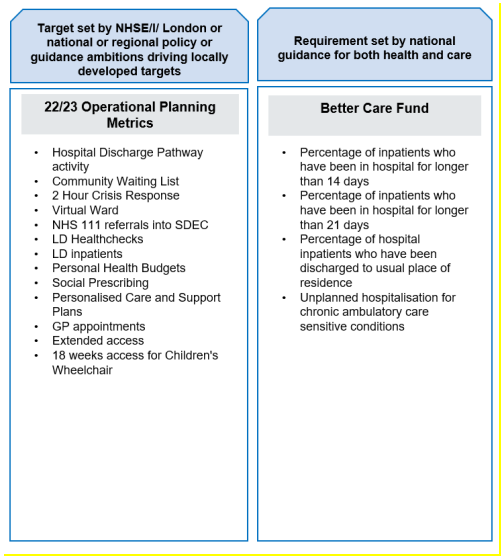
	needs of people with learning disabilities and autism are considered across all pathways. Place partnerships will work with all partners to seek to ensure people with learning disability and autism do not experience inequality of outcomes across any health or wellbeing domain, as reflected here and in performance and quality metrics. Place partnerships working across partners will be accountable for improving the rates of Learning Disability Health Checks carried out annually, and how the outcomes of these checks are followed through. Place partnerships will work with the Mental Health, Learning Disability and Autism Collaborative to ensure that Transforming Care responses are timely and support the principles of independent, community-based living for this cohort.
Carers	Place will play an active role in facilitating and joining up work across partners to ensure that carers are valued, supported to care, and able to enjoy fulfilling lives beyond their caring responsibilities. This will include developing a joint carers' strategy and action plan, as well as delivering on the NHSE metrics and deliver against specific targets on carer assessments, commissioning carer support agencies, etc. Place partnerships will work with local authority leads to ensure carers' strategies reflect wider system working and build awareness of the need for identification and support to carers to be system-wide. Place partnerships will deliver strengthened carers' offers that reflect the needs of their local communities and build best practice.
Homelessness	Recognising the leadership role of local authorities, place partnerships will be responsible for improving the health and wellbeing of those sleeping rough or facing homelessness by: • ensuring GP registration and primary care support to this cohort; • improving access to secondary and tertiary care as appropriate; • recognising the needs of the homeless population for all levels of support, care, and treatment across mental and physical health; and • co-ordinating local support to the street homeless population and participating in work led by local authorities work to improve their health and wellbeing outcomes.
Asylum seekers and refugees	Recognising the leadership role of local authorities, place partnerships will be responsible for improving the health and wellbeing of asylum seekers and refugees, including those accommodated in Home Office hotels, by: • ensuring GP registration and primary care support to this cohort; • improving access to secondary and tertiary care as appropriate; • recognising the needs of the asylum seekers for all levels of support, care, and treatment across mental and physical health; and • co-ordinating local health and wellbeing support to the asylum seeker and refugee population and participating in work led by local authorities to improve their health and wellbeing outcomes.
Person-centred care	Place partnerships will be held accountable for enabling person-centred care in their local area. This will include bringing together a range of initiatives that support residents and communities to be at the centre of decisions that are made around their care, reflecting the principle of 'Nothing about us, without us'. Ways of testing effectiveness in this area could include rates of

	satisfaction and levels of personal health budgets and direct payments in a specified area and for specific communities.
Health creation and primary prevention	Place partnerships will lead for ensuring that the wider determinants of health are effectively understood and influence approaches to all areas of accountability. Place partnerships will lead on the involvement of the whole local authority and wider partners to build an effective model for addressing wider determinants and their impacts on health and wellbeing. Place partnerships will be held accountable for supporting models to reduce health inequalities and improve health and wellbeing through a series of performance and quality metrics, attached.
Immunisations	Place partnerships are key in enabling uptake of immunisations across all communities in a local area. They will be accountable for the vaccination and immunisation rates of their local population, across children and adults and for routine and reactive vaccination programmes. Places will be required to ensure capacity for all vaccination and immunisations activity and to support take up with a focus on inequalities and ensuring equitable take up across all communities.
Local system flow	As the principal forum for local health, care and wellbeing partners, place partnerships have a critical role in addressing more immediate operational pressures whose resolution require input from multiple organisations. The place partnership lead will ensure that place-based mechanisms exist to convene relevant partners as required to maintain consistent and adequate system flow, as well as to respond to periodic additional pressures. This will be with the support of the relevant commissioning and transformation teams from within NHS North East London and will ensure the pressures on all parts of the system are paid equivalent attention.

Accountability for improving performance and quality at place

Many of the performance and quality metrics – and related outcomes for residents – that NHS North East London is required to deliver can be achieved only through effective collaboration in place partnerships. Each partnership is working on a performance and quality metrics framework that will set out in greater detail the metrics for which place partnerships are responsible and will be held accountable, whether the lead is with the NHS, the local authority, or other partners.

These metrics are a combination of performance and quality metrics contained in NHS North East London's operating plan, which is agreed each year with NHS England; the Better Care Fund Plans approved by Health and Wellbeing Boards in each local authority area; and in place partnership delivery plans, based on locally-identified priorities. The partnership will monitor performance and quality, identify trends and clusters of concern, agree and implement corrective action where necessary, and sense check data quality, with the support from the relevant local and north east London-wide commissioning and transformation teams from NHS North East London.



How NHS North East London will help

NHS North East London will direct its people to work with place partnerships to develop their approaches in each of the areas described above, specific to the local context. This includes offering the tools, capacity, and skills required. It will build up north east London-wide approaches from work done at place. These north east London-wide approaches will aim to remove systematic barriers which obstruct effective place-level work. It will also work with places to direct additional available financial resources to support work in these areas.

Additional commitments from NHS North East London:

Theme	Commitment
Localism and subsidiarity	• NHS North East London will operate, and shape the wider north east London health and care partnership, around a *default to place* – the assumption that places (and neighbourhoods within them) are the optimum organising footprint for our work unless there is a clear reason for operating at a larger scale • NHS North East London will provide its leaders at place with sufficient autonomy and flexibility to work in the ways required to deliver for their places, as well as encouraging and enabling this way of working in provider trusts • NHS North East London will ensure the ICB Board effectively delegates to Place Sub-Committees the functions and financial influence required to deliver its accountabilities – with an objective of this coming into place from 1 April 2023, with the requisite place-level engagement on new sub-committee terms of reference approvals happening in advance of this
Capacity to deliver	• NHS North East London will lead all partners across the health and care partnership to devise an integrated workforce strategy that sets out how the workforce needed in each place will be delivered • NHS North East London will organise its own workforce so that it supports the work of each place partnership, including through a core team based permanently in each place and an extended team at place drawn from colleagues working in NEL-wide structures • NHS North East London colleagues who are part of the extended team will spend time in the places to which they are aligned, building local knowledge and relationships

	• NHS North East London will encourage other partners who work across multiple places to align their structures and teams to place partnerships, where this supports delivery of place partnerships' objectives • NHS North East London will fund the substantial portion of clinical and care professional leadership roles operating at place
Money	• NHS North East London will lead the codesign of a system-wide financial strategy, including place partnerships, which will move investment into community health services and support the transformation required for place partnerships to deliver their objectives • This will include NHS NEL working with partners to agree the specific budgets for which place sub-committees hold responsibility, along with and the associated requirements (such as reporting and treatment of over/under-spends). NHS NEL's objective is that, subject to system agreement, place sub-committees take on these responsibilities during the 2023/24 financial year (potentially at different points in the year for different places), with all places responsible for delegated budgets ready for the 2024/25 planning round • An underpinning principle of the financial strategy will be that allocations are made to trusts and place sub-committees on the assumption of active and meaningful engagement with partners in how they are invested, through the place sub-committees and the broader place partnerships as well as through the provider collaboratives • NHS North East London will support the development of a strategic overview of all funding enabling health and wellbeing in each place – including money spent by the NHS, local government, the direct schools grant and other education spending, and other public services – to create the insight required for each place partnership to exert influence across a greater spread of relevant investment • NHS North East London's financial strategy will drive a levelling up agenda so that the money spent on health services in each place is increasingly in line with relative need and reflects the pressures of population growth
Data and insight	• NHS North East London will provide place partnerships with the shared data and insight collectively agreed to be required to improve local outcomes, focused on outcome measures, service performance, and the information needed to plan and evaluate local transformation work • This will be in the form of a defined data set agreed between NHS NEL and the place partnerships • As part of the financial development programme, NHS NEL will lead the co-design of a suite of reports and tools that support discussions between place partners within places about the best allocation of capacity. These will include benchmarking of finance and performance and operational data and support transparency within and between places. • NHS North East London will provide capacity for bespoke local analysis commissioned and directed by place partnerships

	• NHS North East London will also lead on working across partners to resolve issues that inhibit effective provision and sharing of data, including information governance, conflicting data sets, and unclear points of contact

Annex

We recognise that there are some specific areas where place partnerships and collaboratives working together will need to determine by pathway how we best enable population health and wellbeing.

Examples of areas where we may work to define roles in more detail include:

- **Long Term Conditions**
  - In addition to the roles and functions outlined above, places could be required to:
    - understand local needs, have insight into local communities and plan for future needs;
    - deliver engagement and outreach into our diverse communities to build awareness and community support;
    - innovate to deliver primary and secondary prevention;
    - identify and manage long-term conditions;
    - develop integrated teams that support people with rising and complex needs, which will encompass a lot of long-term conditions management (Fuller);
    - empower patients to manage their own health as far as possible;
    - support people to live independently and well at home, avoiding admission to hospital or long-term care;
    - develop out of hospital services that support people with long-term conditions;
    - implement a consistent community-based rehabilitation offer; and
    - share best practice, identifying opportunities to work on a cross-borough basis and making pathways into secondary care as simple as possible.
- **Ageing Well**
  - In addition to the roles and functions outlined above, places could be required to:
    - understand local needs, have insight into local communities and plan for future needs;
    - deliver engagement and outreach into our diverse communities to build awareness and community support;
    - innovate to deliver primary and secondary prevention for older residents and those in need of community-based care;
    - develop integrated teams that support people in need of community-based care, aligning with implementation of the Fuller Stocktake;
    - empower patients to manage their own health as far as possible;
    - support people to live independently and well at home, avoiding admission to hospital or long-term care;
    - develop out-of-hospital services that support and are accessible to local residents;
    - implement a consistent community-based rehabilitation offer; and

- share best practice, identifying opportunities to work on a cross-borough basis and making pathways into secondary care as simple as possible.

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HEALTH & WELLBEING BOARD

Subject Heading:	Annual Public Health Report 2022
Board Lead:	Mark Ansell, Director of Public Health
Report Author and contact details:	Mark Ansell, mark.ansell@havering.gov.uk

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

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

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SUMMARY

The Director of Public Health has a statutory duty to produce an annual public health report looking at the health of the community in which they work.

The 2022 Report focuses on the pandemic – from the perspective of the Council.

It describes the course of the pandemic in the form of a timeline highlighting key events in the national and local response. Local campaigns and comms messages are shown on the timeline to illustrate what was going on in Havering at that point. Brief articles written by colleagues involved in direct aspects of the response provide more detail.

The report acknowledges the contribution of a huge number of colleagues during the pandemic.

It also highlights learning that will help the Health and Wellbeing Board and the Havering Place Based Borough Partnership tackle the equally huge challenges ahead such as closing the 7 year difference in life expectancy between residents living in the most and least disadvantaged communities within the borough or reducing the proportion (2/3rd) of adults who are obese or overweight.

RECOMMENDATIONS

The HWB is asked to note the following learning from the pandemic:

1. What can be achieved if we succeed in mobilising the whole of civil society – the community and voluntary sector, local businesses, schools and colleges, other statutory partners, all elements of the Council, as well as health and social care.

2. If we are to reduce health inequalities we must continue with our existing strategy and
   - Address the wider determinants of health
   - The communities in which we live
   - Our Lifestyles and behaviours
   - As well as ensuring access to high quality health and care services

3. The same service offer to all communities will not achieve equality of outcomes. We must develop the means to allow residents to shape the delivery of services to meet their needs and preferences. To this end, investment in community engagement is essential.

4. The pandemic demonstrated how much more partners can achieve together if they are able to share information. The dispensation that

allowed information to be shared simply and quickly has since been withdrawn. Data sharing or the lack of it remains a significant barrier to the development of integrated health and care services.
REPORT DETAIL
A presentation will be made to the HWB and the full report will be published on line afterwards.
IMPLICATIONS AND RISKS
None directly arising from this report
BACKGROUND PAPERS
None

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