# 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

**6 HAVERING PLACED BASED BOROUGH PARTNERSHIP UPDATE** (Pages 1 - 38)

Updated cover report and appendices attached

**Zena Smith**
**Democratic and Election**
**Services Manager**

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Havering
LONDON BOROUGH

# HEALTH & WELLBEING BOARD

| | |
|---|---|
| **Subject Heading:** | Havering Placed based partnership development update |
| **Board Lead:** | Luke Burton, Director of Place based Partnership Development, Havering |
| **Report Author and contact details:** | Emily Plane, Head of Strategy and System Development, BHR |

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

☒ The wider determinants of health
- Increase employment of people with health problems or disabilities
- Develop the Council and NHS Trusts as anchor institutions that consciously seek to maximise the health and wellbeing benefit to residents of everything they do.
- Prevent homelessness and minimise the harm caused to those affected, particularly rough sleepers and consequent impacts on the health and social care system.

☒ Lifestyles and behaviours
- The prevention of obesity
- Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups
- Strengthen early years providers, schools and colleges as health improving settings

☒ The communities and places we live in
- Realising the benefits of regeneration for the health of local residents and the health and social care services available to them
- Targeted multidisciplinary working with people who, because of their life experiences, currently make frequent contact with a range of statutory services that are unable to fully resolve their underlying problem.

☒ Local health and social care services
- Development of integrated health, housing and social care services at locality level.

☒ BHR Integrated Care Partnership Board Transformation Board
- Older people and frailty and end of life
- Long term conditions
- Children and young people
- Mental health
- Planned Care
- Cancer
- Primary Care
- Accident and Emergency Delivery Board
- Transforming Care Programme Board

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## SUMMARY

Health, care and community and voluntary sector partners across Havering have come together to work in a more integrated way to deliver improved outcomes for local people, through the Havering Place based Partnership. The key focus of which is to:

- Understand and work with communities more closely
- Join up and coordinate services around the needs of local people
- Address social and economic factors that influence health and wellbeing
- Support improved quality and sustainability of local services

This Place-based Partnership approach builds on our strong history of collaboration and integration between organisations in Havering. The Havering Place based Partnership (PbP) is one of seven within the North East London Integrated Care System and reflects the ambition of our Integrated Care System to put decision making and resource closer to front line staff and local people, based on local needs.

The North East London Integrated Care System was formally established in July 2022, and since this date the Havering Place based Partnership has made significant progress to build strong local relationships, further integration, and respond to challenges such as the Wennington Fire and the cost of living crisis as a collective, to support local people.

This report provides Health and Wellbeing Board members with an update on the progress of the Partnership development in Havering, and how this is making progress to further integration.

## RECOMMENDATIONS

Havering Health and Wellbeing Board members are asked to:

- **note** the progress to date of the partnership development in Havering
- **discuss and comment** on the key priorities and progress, and our future plans to further support integration and closer working between health, care and the community and voluntary sector, with the ultimate goal of making care more seamless, improving outcomes for local people, and ensuring that they receive the right support at the right time with a greater emphasis on building resilience and embedding prevention.

## REPORT DETAIL

Since the establishment of Integrated Care Boards in July 2022, with a much greater focus on place, the Havering Place based Partnership has made significant progress to build on our history of local collaboration, and utilise the limited resources available to us to progress priorities and projects to further integration and improve outcomes for local people.

A strong brand for Havering is emerging, based on our vision of ensuring that support and resources are directed to the right places within the system, and building on our local ethos of partnership working based on openness and honesty. **Appendix 1** summarises the Havering vision and initial priorities that we're focusing on at place.

The partnership is developing within the context of a system that has constrained finances and resources; both the Local Authority and Health Teams are concurrently undertaking restructures that will see running and management costs reduced over the next two years, in line with the resources available to us. Despite this, partners are being innovative in their approach and are seeking to further integrate our work, and make best use of our resources by looking to establish a joint health and care team at place. We are currently seeking legal and Human Resources advice and will undergo engagement with staff to shape this proposal.

**Clinical and Care Leadership Team**

Whilst we await the formation of the core team of staff at place level, the Partnership has been given a budget to recruit sessional Clinical and Care Leads to drive forward our workstreams and projects. The Partnership has successfully recruited Clinical and Care leads from a range of backgrounds including; General Practitioners, Nurses, Speech and Language Therapists, Care home Providers, Domiciliary Care providers, those with a pharmacy background, and leads from the community and voluntary sector. We believe this fantastic team reflects our ethos of delivering truly integrated, joined up care, and also reflects the strength of our partnership working that so many high calibre candidates applied from such a varied range of backgrounds and disciplines. **Appendix 2** provides information on the current leads in post, and we will shortly be going out to recruit to the final vacant sessions that we have. These vacancies will be promoted widely across Havering.

**Our workstreams**

The Havering partnership have started to set out the foundation of our key workstreams, and are progressing our health inequalities projects as part of this. We will eventually shape our projects and programmes, supported by aligned teams, around a life course approach that will include:

- Start well
- Live well
- Age well
- Building resilience
- Enablers and Infrastructure

As a partnership we are looking to create and embed a population health approach to improving services and achieving better outcomes for local people, facilitated by innovative IT solutions.

Each of the workstreams that we are establishing is taking a complete partnership approach, with a focus on integrating services and service delivery to make best use of the resources that we have, and ensure that care delivery and access to care feels more joined up for local people.

Some progress on the initial key projects includes:

- **Establishment of Stop Smoking service**: Through our integrated working, Havering has been able to fund a Stop Smoking service for the

first time in 8 years. This service aims to support 368 people to quit smoking per annum. Partners are also looking to develop targeted smoking cessation support for those with a Learning Disability or mental health challenges.

- **Weight Management Service Pilot**: The prevalence of obesity is not evenly distributed across the borough, children from areas of highest deprivation are twice as likely to be obese than those from the lowest areas of deprivation, and obesity in children is also a significant challenge in Havering, as set out in our joint obesity strategy. This project is aimed at supporting healthier behaviours in the families the programme works with, and subsequently to see a reduced number and proportion of children that are of an unhealthy weight by year 6.
- **Development of a Multidisciplinary Team approach at a Primary Care Network Level**: This project aims to help local health, care and community and voluntary sector teams work in a more integrated way, around the needs of local people. The project is initially focussing on improvement of coordination of care for those with multiple and complex conditions.
- **Support for Housebound residents**: This project adopts a genuinely integrated approach to supporting those who are housebound, bringing together health, community and voluntary sector, and care partners to improve care and service delivery and support for those who are housebound. The project is extending beyond the traditional health and care partners to include housing officers and domiciliary care providers, as well as liaising with those who are housebound and their carers to improve their experiences and outcomes.
- **Support for those who are homeless and Mental Health outreach for those who are homeless/asylum seekers**: Through engagement with those who are homeless and asylum seekers, we have identified a number of challenges that they face which impact on their mental and physical wellbeing. A joint team of health, care and community and voluntary sector partners are working to address this, with investment in mental health outreach workers specifically for this group of people to support them. Wider work is underway to link this group with volunteering opportunities, and community and voluntary sector organisations that can support them to achieve the outcomes and life that they want.
- **Support for informal/unpaid carers**: Partners are developing an strategy for carers for the whole of Havering that will be owned by all, and is being co-developed with local people. Through our engagement on this, local arers have identified that information and advice is something that they would benefit from, and training is therefore being developed, which will be rolled out in the next few months, to carers to better equip them with the challenges that they face on a day to day basis. Through the wide engagement for this training (which will have provision for parent carers, child carers, and those who are caring for an adult with specialist needs),

we hope to reach a wider group of people than we have previously, and increase the number of people registered as carers, and therefore increase their access to the support to which they are entitled.

- **Self service Health Check offer:** established at three hubs across North, Central and South Havering. This aims to help case find 200 additional individuals with hypertension who might otherwise have not been diagnosed/identified. It supports the health inequalities agenda as point of care testing equipment being made available in most deprived parts of the borough at locations that are easily accessible to residents. This scheme has been led by Public Health Colleagues, working with Primary Care partners across the Borough.
- **Learning Disability Strategy**: Havering has not had a Learning Disability strategy for a number of years, and partners are working to not only address this, but ensure that the strategy is developed by local people with learning disabilities, and those who care for them. We intend to work closely with local groups and people to develop and shape a strategy that will work for them, with an action plan that will be owned and delivered by a joint Havering LD and Autism workstream.
- **Community Chest Funding**: : Fifteen community groups are currently receiving more than £80,000 in funding to help Havering residents with their health and wellbeing. The Community Chest gave small-to-medium-sized charities, voluntary, faith groups and social enterprises the chance to bid for up to £10,000 funding from money provided by the Havering Place-based Partnership, in collaboration with the NHS. The applications for funding were reviewed by an integrated panel of health, local authority and Healthwatch partners, will benefit a range of organisations whose proposals focused on tackling the cost of living and supporting people with learning difficulties and disabilities, long-term conditions and mental health.
- **St Georges development**: An integrated team of health, care and community and voluntary sector partners have come together to develop the proposals for the integrated wellbeing hub that is being built on the St Georges site in Hornchurch. This will include not only Primary Care provision, alongside community services delivered by NELFT, but will encompass an integrated way of working that will see all of the services housed at the site working as an integrated team, focussed on meeting the needs of the local population. Community and voluntary sector groups will have real ownership of the space, and will be able to deliver a range of wider wellbeing services to local people to truly tackle the underlying wider determinants of health.
- **Cost of Living support**: Health and Care partners have come together to jointly fund and deliver support to those who need it most relating to the impact of the cost of living increases across the borough. This has included working closely with the community and voluntary sector to establish a number of ‘warm hubs’ across the borough from which a number of wider

wellbeing activities are delivered. Our acute partners are also testing outreach into these hubs to deliver paediatric support and advice to families and children within the hubs. Partners have also innovatively used data to target those with life saving equipment at home, to enable them to apply for one off funding to help to pay for this.

- **Havering Integrated Care Coordination and Social Prescribing Network**: This multi partner group is chaired by Cllr Ford, our lead member for Health, and brings together the various roles that are aimed at supporting local people to access wider health and wellbeing services across the borough. We have a wide range of Community, Voluntary, Health and Care partners engaged in the group, sharing the work that is underway, and seeking to develop a common approach to the promotion and utilisation of these roles to ensure that as many local people as possible can benefit from them. This group will eventually oversee the development and roll out of the Joy app, including the 'marketplace' element of this, to ensure that local people, staff, and all of the roles aimed at connecting local people to support, are able to easily access a single version of the support services available.
- **Havering Core Connector Programme**: Havering is the pilot site in North East London For the 'Core Connector Programme' – a pilot aimed at supporting the most deprived populations within the borough to access health and care information. Initial feedback from the national team overseeing the pilots, is that the Havering service that is emerging, which has been overseen by an integrated team of health, care and community and voluntary sector partners, is significantly ahead of the other pilots in the country.
- **Infrastructure Planning and Population Growth**: The Place Based Partnership in Havering is working with colleagues from North East London and across Havering to develop a single public sector estate and infrastructure plan for Havering. This is in response to the predicted and current population changes in Havering as well as ensuring partners have a common vison for integrated health and care provision. A Local Infrastructure Group has been set up and is developing a joint plan for infrastructure and new models of care across Havering and North East London.

**Coproduction and engagement**

The Havering Place based Partnership sub-committee are working to embed an approach that will ensure that all of our work programmes and projects are shaped by the experiences, needs and suggestions of local people. This includes:

- For each one of our workstreams, we are embedding engagement with local people and service users as a first step – capturing and understanding their experiences, and then using these to shape our priorities and programmes of work. We believe that the experiences of local people are

the most powerful tool that we have to set out the case for change where this is needed, and will continue to embed this approach in all of our work going forward.

- A review of the way in which our Patient Engagement Forums operate, with a view to ensuring that these are supported by effective Patient Engagement Forums at a PCN level who are able to listen, and respond to feedback from local people on the things that need to improve within each network.
- Capturing qualitative feedback from local people on the impact of the changes that we are putting in place and using this to drive further service improvement.
- We have also launched a series of 'show case events' which are promoted widely across staff working in health, care and the Community and Voluntary sector in Havering, inviting them to come and hear more about the projects we're developing in more detail, and providing them with the opportunity to shape these projects, and get involved.
- Alongside this, as much as our limited resource will allow, we have been visiting and engaging with Community and Voluntary sector groups across the Borough, hearing out the fantastic work that they're doing, and understanding how we can better integrate the way that we work. Through this we were able to promote the Community Chest fund widely, and received a significant amount of high quality bids for this funding.

The Partnership has progressed significantly since its inception less than a year ago, primarily because of the fantastic relationships that already exist within Havering, and the culture of coming together to do what is in the best interests of local people. The Partnership will continue to foster and develop this culture, and we anticipate that we will be able to achieve significantly more when the restructures of the council and NHS teams are complete and we have a more comprehensive team at Place.

**IMPLICATIONS AND RISKS**

Our most immediate risks relate to funding and capacity:

- Our Local Authority partners have articulated clearly their financial deficit that they are working to address. As a partnership, there is a risk to our ability to deliver projects and programmes of work without access to funding to support this. We will also require finance and contacting support to enable the necessary joint commissioning arrangements to take place to make the best use of the resources that we have, and create joined up, seamless services for local people.
- The sub-committee, and Place team do not have the capacity to deliver our full ambition around our key workstreams, although we have made significant progress to get our workstreams mapped and the foundations of the work programmes in place. We are currently not able to progress some key projects that will be instrumental in improving the experiences of staff and local people, such as the full development and roll out of the Joy App to deliver a single database of services in Havering that all are able to access. We anticipate however than once the restructures of the NHS and Local

Authority are complete, we will have the necessary resource at place to take forward our identified priorities.

**BACKGROUND PAPERS**

**Appendix 1** Havering Place based Partnership vision and initial priorities at place
**Appendix 2**: introduction to the Havering Clinical and Care Leadership Team

North East London Health & Care Partnership

NHS North East London



# Havering Place based Partnership

Vision, principles and emerging priority areas

February 2023

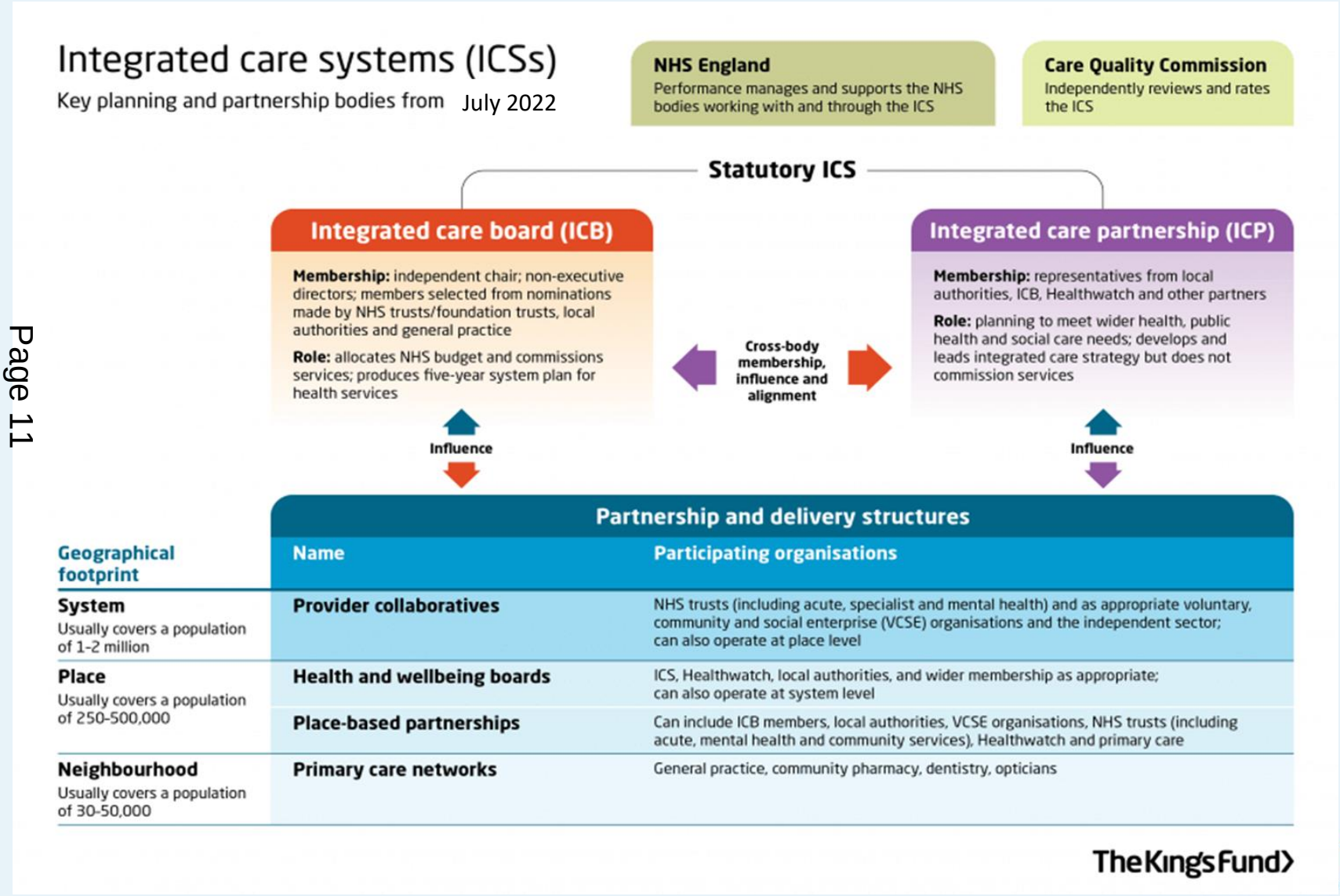
# Havering Place Partnership



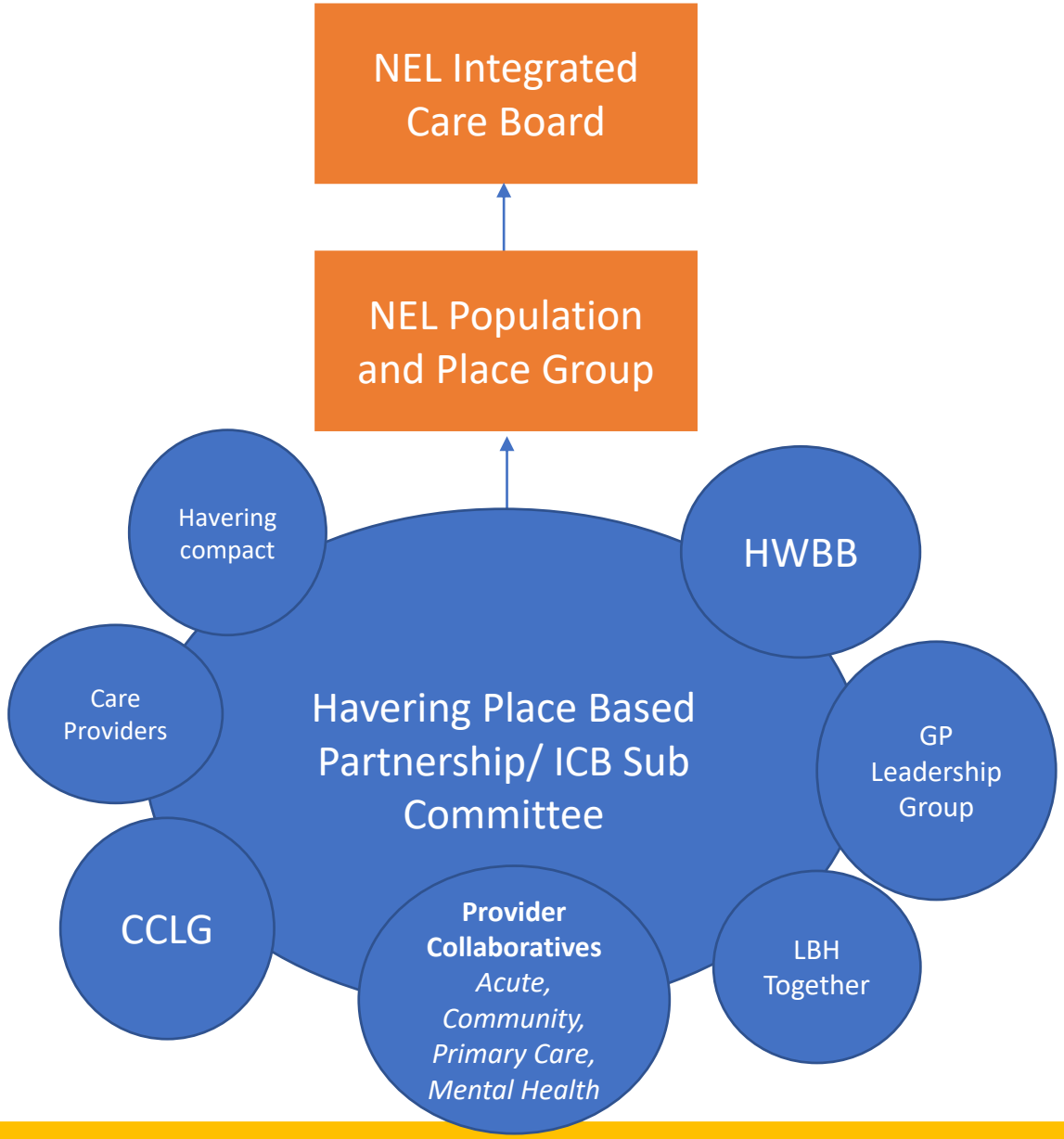





# Integrated Care Systems



# PROPOSED governance arrangements post July 2022 PHASE 1




Partnership Workstreams – Health Inequalities – LAC – Prevention – (more added one partnership develops) Elements of BHR work to be place based – Enabling Finance, Digital, Contracts

# Havering PbP – Priority Programmes on a page

**The infographic below illustrates the key priorities being taken forward by the Havering Place based Partnership currently within the resource available. There are a number of wider priorities that have been identified for us to progress once resource is more clear:**

## Aligning Social Prescribing

Progressing Care Connectors Pilot and aligning social prescribing work around Harold Hill Health Centre, including opportunities to build a local network and design training programmes

## Designing a new approach to Quality

Workshop held in July to design the local approach to Quality in Havering. Working group being established to take this forward.

## New approach to engagement

Designing a new approach to ongoing engagement with local people and staff that will embed experience based design in transformation.

## Joined up data/insights/ PHM

Joined up data and insights, supported by strong Information Governance and enabled by IT.


**The vision of the Havering Partnership is to pool our collective resources to create person centred, seamless care and support 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:**

## Addressing health inequalities

Tacking Health Inequalities and embedding prevention through a Population Health Management Approach, informed by local insights. Current key projects include:

- AF
- Mental Health
- Health Checks
- HTN
- MSK (BHR)
- Diabetes
- Healthy Havering Approach
- Community Chest funding targeted on local need
- Virtual clinics LTC support

## Leadership / workforce development

Leadership sessions with key partners, Setting up c o workforce development and projects with frontline staff

## Winter keeping people at home

Joined up community led approach to admission avoidance

## One Estate

## Cost of Livcing

Local partners working together around fuel poverty and cost of living

## Clinical and care leadership

Engaging with wider clinical and care Workforce

# Key functions of a place based partnership

- Understanding and working with communities
  - Developing  an in depth knowledge of local needs
  - Connecting with communities
- Joining up and coordinating services around people's needs
  - Jointly planning and coordinating services
  - Driving service transformation
- Addressing social and economic factors that influence health and well being
  - Collectively focusing on wider determinants of health
  - Mobilising local communities and building community leadership
- Supporting quality and sustainability of local services
  - Making best use of financial resources
  - Supporting local workforce development
  - Driving improvement through local oversight of quality and performance

**These functions are where there is greatest potential to add value over and above the contributions of individual organisations or entire systems.**

# Havering Place based Partnership - 8 key principles

A series of principles for local health and care leaders

1. **Start from purpose, with a shared local vision**
2. **Build a new relationship with communities**
3. **Invest in building multi-agency partnerships**
4. **Build up from what already exists locally**
5. **Focus on relationships between systems, places and neighbourhoods**
6. **Nurture joined-up resource management**
7. **Strengthen the role of providers at place**
8. **Embed effective place-based leadership**

# Our collective vision for the Havering Partnership

The vision of the Havering Partnership is to pool our collective resources to create person centred, seamless care and support 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:

1. Developing joined up support and services that prevent people becoming ill – this covers a whole range of activities aimed at building more resilient communities and better 'health literacy' which are largely undertaken by non-health partners, including school readiness, employment, housing etc
2. Ensuring that when people do need advice it is easy to access and seamless between different agencies – joining up services between the NHS and voluntary sector to enable a swift and comprehensive response
3. Ensuring that services for people who are ill are high quality and can be accessed without delay

# How we want to work together to deliver this vision

There needs to be urgent work on putting 'enablers' in place to help realise our vision and see real change delivered 'on the ground'. We have identified the following areas identified for early focus :

1. **Patient/resident voice** – we need to ensure the patient/resident voice is central to our discussions and decision-making and that, in 12 months' time residents feel included and involved, and we have a clear picture of how people experience services and are engaged (let's measure this from the beginning!). As part of this we can get input from local councilors and organisations such as HealthWatch.

2. **Good governance and accountability** – we need to set up robust governance and accountability structures to enable us to deliver this vision. This will not be a 'quick win'.

3. **Adequate resourcing** – the PMO support needs to be increased and we need to fund Clinical and Care Leadership time to increase professional  This also links into the ask of place around finance, quality, comms etc

4. **Good data and Insights** – we need good data to inform our decision-making and measure the impact of our work. As part of this we need to establish data sharing and systems access agreements.

5. **Shared accommodation** – practically, we should work swiftly to identify accommodation to support the colocation of services through shared accommodation wherever possible, as this offers huge benefits to staff and patients.

6. **A culture of collaboration and change supported at the most senior level** – we need to be setting the right culture across Havering where people are encouraged to collaborate rather than compete and where opportunities to create joint services and joint posts are sought out and supported.

7. **Practical arrangements** – we need clarity on the meeting schedule and membership of the Partnership and links to the wider system e.g. fire service/education etc.

# How we want to work together Clinical and Care Leadership

As part of the Clinical and Care Leadership development sessions the working group developed and agreed the key ways to work

Population health management

Prevention

Anticipatory care

Understanding the population needs

- Data driven
- Listening to local people

Support and develop the community capacity and capability

JSNA – build in more value through clinical and care professional engagement

We should not reinvent the wheel but build from where we are

Organise around the person and community:

- Strength based
- Asset based
- Person centred
- Holistic

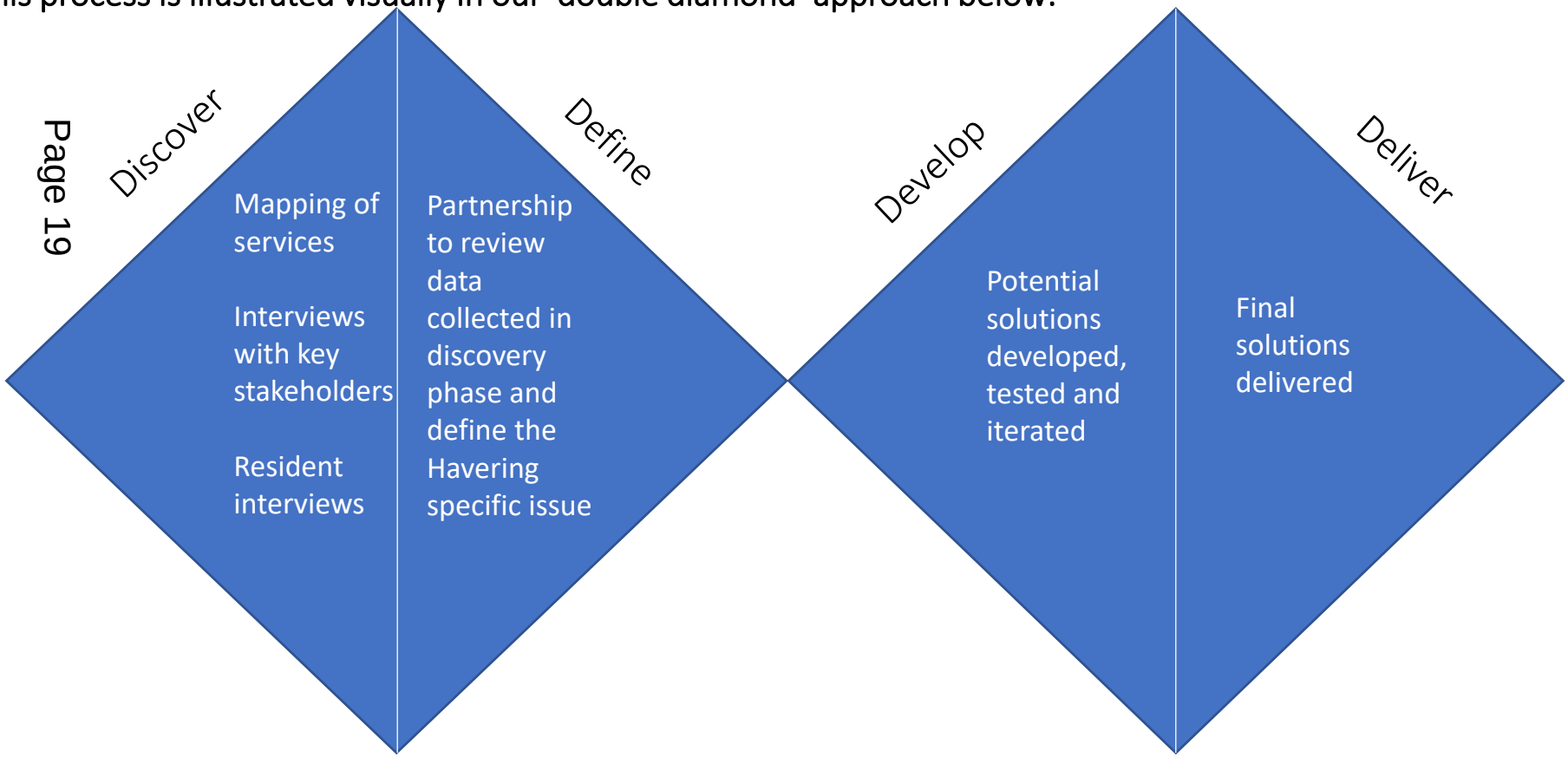
Integrated and collaborative approach to avoid duplication and make the best use of resources and breaks down organisational barriers to focus on the system

Partners have an equal voice and all need to contribute to CPL development

# Our approach to transformation

The Havering Place based partnership will take a comprehensive and systematic approach to transformation; following identification of a key challenge, we will assess and map the current situation including discussion with stakeholders, review the outputs of this as a partnership, developing options to address. Following review of the options, we will collectively as a partnership agree the next steps / course of action to address issues, bearing in mind our aspirations of adding value with our work as a partnership, not duplicating what is already underway, and improving outcomes for local people. We will take a continuous Quality Improvement approach, ensuring that our transformation is flexible, and able to respond to changing needs.

This process is illustrated visually in our 'double diamond' approach below:



# Havering PbP Matrix Team – Core Leads

| Area | Lead | Role title |
|---|---|---|
| **Place Lead** | Andrew Blake-Herbert | Chief Executive, LBH |
| **Place Director** | Luke Burton | Director of Place based Partnership development |
| **Place Clinical Care Lead** | Dr Kullar | Clinical Care Director |
| **Lead Member for Health** | Cllr Gillian Ford | Lead member for Health, Havering Council |
| **Communications** | Jackie McMillan | BHR Head of Comms and Engagement |
| **Engagement** | Annie Robertson | Senior Engagement and Community Communications Manager (BHR) |
| **PMO** | Matt Henry | Programme Manager / PMO |
| | Shibbir Ahmed | Project Support |
| | Jenny King | Project Support |
| | VACANT | Senior Commissioning Manager (LBH) |
| | Sandy Foskett | Commissioning Manager (LBH) |
| | Emily Plane | Head of Strategy and System Development – BHR |
| | Judith Smy | Business Manager |
| **Quality Leads** | Sandra Moore | Head of Quality |
| | Rosie Eadon | Havering Quality Lead |
| **CVS lead** | Paul Rose | Chair of Havering Compact |
| **Finance** | Julia Summers | Head of CCG finance |
| **Estates** | Carolyn BotField / Dean Musk | Director of Estates / Head of Estates and Capital Programmes |
| **Analytics (BI)** | tbc | |
| **Digital** | tbc | |

North East London Health & Care Partnership

# Havering Place based Partnership Clinical and Care Leadership Team

Version 2

**March 2023**

# Havering Place based Partnership Clinical and Care Leadership Team

**Place Clinical Director**
**Dr Narinderjit Kullar**

Oversight and direction of all clinical and care
Programs of work involving the Partnership
Working with the Delivery Director and partner organisations to develop and enact
The Borough Health and Care strategy
Oversight of Clinical and Care Leadership team and workstreams
Represent Havering at NEL ICS and Engagement with wider related organisations

6

**Primary Care Lead**
**Curerently Dr Ben Molyneux**

Primary Care Improvement
Supporting development of PCNs
Delivery of the recommendations of the Fuller review
Workforce Education Immunisation
Patient Engagement (working with PCNs)

4

**Planned Care**
**VACANT**

ENT
Urology
Opthalmology
General Surgery
Gynae
Breast
MSK
Gastroenterology
Dermatology
Diagnostics

2

**Long Term Conditions**
**Lead TBC shortly**

CVD Prevention
Cardiac, Diabetes
Respiratory, Stroke, Renal
Work with NEL LTC Team
Work with PCNs and primary care on LISs and equalisation
Support roll out of Edenbridge development working with including prevalence data exercise with Primary Care

2

**Babies Children and Young People**
**Dr Richard Burack**

Maternity LTCs
CAMHS
Paediatrics
NeonatalCYP - Weight Management Service - Pilot
Childrens Health & Wellbeing Pathway Development
BHR CYP Transformation Board;
Peads integrated nursing service
SEND
ASD/ADJD Challenging behavior
BCYP NEL strategy development;

2

**Urgent & Emergency Care**
**Dr Mary Burtenshaw**

Urgent Care
End of Life
Discharge
Work with Kirsty Boetter on existing urgent and emergency care work and projects
Supporting people to stay well at home - winter planning prep and action plan

2

**Mental Health**
**VACANT**

Mental Health
Dementia
SMI
1. Mental Health Board / Havering Mental Health Workstream
2. Refresh of Havering Community Mental Health Strategy
3. Development of Integrated MH services
4. Supporting recruitment to Mental Health ARRs roles in primary care working with partners

2

**LDand Autism**
**Dr Jyoti Sood**

NEL Autism and LD strategy focussed on autism diagnostic pathway, prevalence and annual health check and improving quality LEDOR implementation - gap
Home not hospital agenda - supported living and places in the community
Autism diagnostic pathway
CTR and dynamic risk registers to support at home
Oliver McGowan training

1

**Cancer**
**VACANT**

1. Representation at NEL Cancer board
2. Improving end-to-end pathways to timed and operational standards
3. Development of community Cancer care services
4. Public Health campaigns and initiatives

1

**St Georges development**
**Dr Atul Aggarwal**

Development of an integrated model of care for the St Georges Wellbeing Hub

3

**Frail Older People**
**Mike Armstrong (2 pw)**
**Dr Uzma Haque (2 pw)**

Housebound model development
Ageing well projects
Care Homes, Falls, Dementia, EoL
Health inequalities
Anticipatory Care MDTs / Working with Care Homes / CVS
Dementia care
Access to IAPT / Depression - large population of LD in older adults

4

**Prevention**
**Dr Ann Baldwin**

Whole systems approach to obesity
. Self-service health check offer
Launch of Universal Stop Smoking Service including with Mental Health and/or a Learning Disability
Working with UCLP to support LTC Proactive care for all PCNs
NDPP with PCNs

2

**Population Health Management**
**Vicki Kong**

Imbedding an MDT approach
Work closely with Public Health / HWBB
Personalised Care including LAC
PCN MDT / Anticipatory Care Pilot
Health Inequalities & PHM
Inclusion Health
Prevention champion
Weight Management
Data and insights for PHM

2

**IT/Digital**
**VACANT**

Work with partners to develop integrated IT, Digital and Data services/enabled projects
Development of Digital and IT strategy for Havering
Representation at, and engagement with, Digital First Programme Board
Imbedding QI approach and tracking outcomes
Work with PCN IT leads to develop primary care IT/Digital capability

1

**Community Connections**
**Shelley Hart and Rebecca Mazrreku**

Increase 50+ uptake of benefits. Unpaid/informal Carers strategy development and HI project to support Carers
Core Connector programme
Working to develop the Community and Voluntary Sector
Community Chest Project
Development of a single database for Havering
Havering Social Prescribing/ Core Connector Network development

2

**Flexible Lead**
**John Timbs**

implementation of Significant Seven training for Dom Care providers
Developing a vision for what enhanced homecare can be within Havering
Development of ongoing comms with Care providers to ensure two way comms
Improvements in workforce recruitment and retention

1

**Flexible Lead**
**Rhiannon Haaq**

MDT model and approach (PCN and Housebound MDTs)
Development of the Joy app across Havering

2

**Dr Narinderjit Kullar**
Clinical Director

**Dr Ben Molyneux**
Primary Care

**Dr Ann Baldwin**
Prevention

**Dr Atul Aggarwal**
St Georges

**Dr Mary Burtenshaw**
Urgent and Emergency Care

**John Timbs**
Flexible

**TBC shortly**
Long Term Conditions

**Vicki Kong**
Population Health Management



# Team Havering Clinical and Care Leads

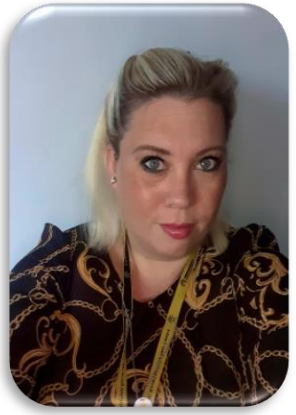
**Dr Richard Burack**
Babies, Children, Young People, and maternity

**Dr Jyoti Sood**
Learning Disabilities and Autism

**Dr Uzma Haque**
Older People and Frailty

**Michael Armstrong**
Older People and Frailty

**Shelley Hart**
Community Connections



**Rebecca Mazrreku**
Community Connections

**Rhiannon Haag**
Flexible

# Dr Narinderjit Kullar

Dr Narinderjit Kullar qualified from Barts and The London School of Medicine in 1997 and since then has developed a broad range of experience encompassing a variety of roles across the NHS. Having initially pursued  a career in surgery, he spent a period of time in research examining the use of technology in Medical Education; this work was recognised by the London Deanery with an "Excellence in Education" Innovation award. During this time period, he also completed a  Masters Degree in Medical Education and maintains an active interest in the field.

In 2012, Dr Kullar became a qualified GP and since 2017, has been a partner at St Edwards Medical Centre in Romford. In 2019, Dr Kullar became a Clinical Director for the then newly formed Havering Crest Primary Care Network, a position that he held for three years. In developing the network, he has established a strong MDT approach through a range of allied healthcare professionals and supported the ongoing development of PCN staff. The PCN also delivered a very successful vaccination programme during the pandemic, adopting innovative ways to engage staff, local people and the underserved population to improve uptake and coverage across Havering.

Dr Kullar has consistently worked in successful collaboration with partner organisations and is committed to improving integration and supporting health and care staff. He is driven by a real passion to improve outcomes for local people and a desire to address and tackle inequalities.

Dr Kullar is married with three children.

# Dr Ben Molyneux

Dr Ben Molyneux is an experienced GP having worked across North East London since 2008. Ben has recently joined the Havering place-based team as the new Clinical Director for Primary Care and intends to use his experience working across all 7 boroughs and 4 Trusts to good use. He has an urgent care interest and continues to work in both General Practice and supporting 111.

Ben has significant local clinical leadership experience across a number of domains. He continues to be a clinical sponsor for the NEL Digital First programme and recently stepped down as NEL personalisation clinical lead. He has also been clinical lead for urgent and end of life clinical at City and Hackney for 5 years.



Ben also has experience working with the GMC and CQC as well as holding senior positions at the BMA, most recently as Chair of the UK Sessional GP Committee representing GPs at national level.

‘I’m excited to begin this new role as Havering place-based partnership gets into gear. The system is under immense strain and I intend to support my primary care colleagues to deliver the very best care with our limited resources. I want to continue building relationships across PCNs and neighbourhoods and working closely with dentistry, pharmacy and optometry colleagues.’

# Dr Ann Baldwin

Dr Ann Baldwin has been a General Practitioner in Havering for over 15 years, with a particular interest in Diabetes and Rheumatology.

Dr Baldwin has worked to develop primary care at scale for a number of years; having held system level roles as the integrated care lead for Havering North PCN, Clinical Director for Havering Clinical Commissioning Group, and as Chair of Havering and B&D Local Medical Committee.

Within this capacity, Dr Baldwin has championed the integrated community diabetes service in Havering and is currently working to implement artificial intelligence to improve health care through the Atrial Fibrillation AF case finding project. Dr Baldwin was the co-author of a BMJ article on the Quality Improvement approach to improve diabetes care (BMJGP 2000 Jan edition).



Dr Baldwin was awarded with fellowship of RCGP in 2021, and in 2022, won the General Practice Award for Clinical Improvement as part of the UCLP proactive care team.

As the Chair for the National Diabetes Prevention Program for North East London Dr Baldwin is passionate about early identification and intervention in long term conditions, specifically in Diabetes/CVD /stroke/AF /CKD prevention agendas in line with National and local ambitions to improve Quality of care, reduce health and digital inequality across Havering and North East London. Dr Baldwin has spoken nationally about the importance of technology in identifying conditions such as kidney disease (Urine ACR project, BBC Morning Live, 24 Jan 2023).

More recently, Dr Baldwin attended an audience with King Charles as the South East Asian representative for North East London to discuss important issues such as the state of the NHS, and the plight of political detainees in Burma.

Alongside her passion for improving care for local people, Dr Baldwin is dedicated to improving care in her native Burma, and founded ‘Mission Burma Charity UK’ to drive forward this work.

# Dr Atul Aggarwal

Dr Aggarwal qualified in 1988 and spent his early years in Wales training in orthopaedics and in accident and emergency services.

In 1992 Dr Aggarwal became a general practitioner in Havering, and is a longstanding Partner at Maylands HealthCare.

Dr Aggarwal has held senior roles within the borough and across Barking and Dagenham, Havering and Redbridge, working closely with our local hospital trust, local authority and community providers.



Dr Aggarwal is also an associate medical director at BHRUT with a strong focus on bringing a primary care perspective to services that are delivered from our acute trust and improving links with primary care.

Dr Aggarwal passionate about his role as the clinical lead for the innovative St Georges wellbeing hub development. His comprehensive experience and knowledge of the local population, alongside his keen interest in building community resilience, imbedding prevention and improving integration of services, will enable him to lead development of a truly integrated model of care and support for not only local people and carers, but wider Havering residents.

# Dr Jyoti Sood

Dr Jyoti Sood has worked as a General Practitioner in Barking and Dagenham, Havering and Redbridge for over 17 years. Dr Sood has gained vast clinical experience during this time, and works as a GP with special interest in both diabetes and dermatology.

Dr Sood has held system clinical leadership positions for a number of years, and has and driven transformative improvement in Long term conditions, Diabetes, Learning Disability and Autism in this capacity.

She has a significant interest in education, and believes this to be the golden thread running across everything we do in health and social care settings. She has developed education programmes for various workstreams  to support the workforce to gain skills and ultimately improve the delivery of care to local people.

Dr Sood has  a real passion for reducing inequalities and has worked with national teams to develop reasonably adjusted pathways across a variety of workstreams. She is keen to continue working on the inequalities faced by our citizens, particularly those with a Learning Disability and/or autism .

Dr Sood is keen to develop an integrated collaborative offer for patients with LD and Autism, embedding service change and transformation that is driven by the experiences of local people, with their voice heard at every level.

# Dr Mary Burtenshaw

Dr Mary Burtenshaw qualified from Barts and the London in 2003, initially pursuing a career in anaesthesia before undertaking training in General Practice, qualifying in 2015. Since April 2019 Dr Burtenshaw has been a partner at Hornchurch Healthcare, a rapidly growing practice, rated 'good by CQC. Dr Burtenshaw has embedded a culture of continuous improvement within the practice, and has worked to raise the profile of patient participation.

Dr Burtenshaw is particularly interested in women's health, frailty, and addressing health inequalities and, as a previous Clinical Director with Havering Clinical Commissioning Group, has made significant improvements in these areas for local people. Through this Clinical Director role, Dr Burtenshaw's portfolio primarily included urgent and emergency care, with a particular focus on prehospital pathway improvement, among a number of innovative partnership initiatives to improve access to urgent and emergency care for local people, and support them to remain well at home. Dr Burtenshaw was chair of the Barking and Dagenham, Havering and Redbridge Urgent and Emergency Care Transformation Board and will continues to drive forward these improvements through the new BHR Places Urgent Care forum.

As a member of the South Havering Primary Care Network Executive Committee Dr Burtenshaw continues to drive and shape improvements to primary care, and is also able to make inroads to addressing inequalities as the Health Inequalities Lead for the South Primary Care Network.

# Dr Richard Burack

Richard is the senior / executive partner at a large training practice in Havering and has been at the same practice since completing his vocational training over 3 decades ago.  Aside from his practice commitments, he has held various medical roles including Youth team Dr for a professional football Team; GP tutor in Academic Department of General Practice at QMW University of London; Out of hours / urgent care clinical director; an FHSA/PCT and CCG clinical lead; Honorary Consultant at Great Ormond Street for children working in the late effects clinic for child survivors of cancer and strategic clinical lead for CYP services across the BHR footprint. He has particular interest in adolescent health and wellbeing, having conducted local research and published papers focussing on CYP access to primary care services  and remains a long-standing member of the RCGP Adolescent Working Group.



In 2012, he became the Named GP for children's safeguarding for both Havering and Barking & Dagenham and is the current co-chair of NHSE London Named GP Network and an active member of the National Network of Named GPs (NNNGP). Currently, he is also the practice clinical lead and representative for the Havering Marshalls Primary Care Network (MPCN) and has recognised leadership roles and responsibilities for MPCN and their involvement in the COVID vaccination programme; children and safeguarding agenda; extended access provision and local estates (Raphael's House) development.

Married for 31 years, 4 months and 5 days (but who's counting) with 3 growing, older children (aged 27, 25 and 20) and a fourth younger child (now aged 2.5, this time of the four legged variety – a first for the family and likely to be the biggest parenting challenge yet.)

# Dr Uzma Haque

Dr Uzma Haque is a qualified General Practitioner based in Barking and Dagenham where she has worked for nearly 20 years.

Dr Haque has led system transformation across Barking, Dagenham, Havering and Redbridge as a Clinical Director for Older People and Frailty for a number of years. She is now the clinical and care pathway lead for older Adults and Frailty in each of the three BHR Boroughs. She has an interest in education and health inequalities, and continues to work across primary care.

Dr Haque has significant local clinical leadership experience across a wide range of areas such as Inclusion health, Population health management and building learning environments. She has been a past BDH Local Medical Committee Chair and recently stepped down as urgent care lead for BHR. She is looking forward to new ways of working, improving lives with our residents for our residents.

## Vicki Kong

Vicki Kong is a pharmacist who graduated from University College London in 1998 and completed her training with Leicestershire Hospitals and AstraZeneca. She has worked in different aspects in the NHS: hospital, intermediate care, community pharmacy and primary care. Her journey started in hospital as a clinical pharmacist rotating in various clinical areas whilst completing a postgraduate diploma in Clinical Pharmacy with the University of Wales. She later managed the Medicines Information Service in BHRUT, training other pharmacy colleagues and working in collaboration with clinicians to develop guidelines and treatment pathways.



Since 2008, Vicki has worked in the Medicines Optimisation team, specialising in digital. During the COVID vaccination programme, she supported Havering vaccination sites and various initiatives to encourage uptake for the local population. In 2022, she joined the Digital First Team, North East London as a Clinical Lead for Community Pharmacy. She has developed strong partnership working to enable rollout of pharmacy digital projects across the region. She is currently undertaking the Masters in Digital Health Leadership with Imperial College (due to complete summer 2023) focussing on risk stratification in bowel cancer screening. She is passionate in using digital and data to support clinicians and partner organisations to improve the health of the local population and reduce inequalities.

Vicki is an avid chess player.

# Rhiannon Haag

Rhiannon Haag qualified as a Speech & Language Therapist in 2008 and has worked across various roles in the field of adult acquired disorders, including acute and community settings. Since 2011, Rhiannon has worked as a specialist therapist in head and neck cancer and voice disorders for NELFT. She has developed additional special interests in the development of services within the community setting and acts as an advisor for the Royal College of Speech & Language Therapists regarding endoscopic evaluations of swallowing and SLT services for people with head and neck cancers.

In recent years, Rhiannon has developed a keen interest in Quality Improvement and is a Q community member. She works as a mentor for NELFT staff undertaking QI projects and has presented her own projects at national and international conferences. As clinical lead SLT, she champions the use of QI methodology across her team, which has led to successful collaborations with various clinical teams and voluntary organisations. After establishing the UK's first comprehensive domiciliary service for people following laryngectomy, she is currently working with the NELFT QI team to lead a co-production project to consider how the care pathway can be further improved, particularly through increased collaboration with community based professionals.

Before qualifying, Rhiannon studied modern languages and worked in education settings in the UK and abroad. She continues to maintain strong international links and still enjoys learning new languages whenever the chance arises. She is married with one daughter.

## Shelley Hart

Shelley is the founder and CEO of Havering Volunteer Centre in Romford, an award winning centre of excellence.  During her working career she has worked in private, public, health and voluntary public sector roles.

Shelley has been working in the voluntary sector since 2001 when she joined Havering Victim Support in Hornchurch. She was promoted to the Borough Manager for Barking and Dagenham and subsequently promoted to cover Havering as the Borough Manager for both boroughs. She remained in these roles until 2013.

Shelley was previously a Practice Manager for a large Romford Medical Practice where she learned about GP operations and working with health partners.  Following her greatest passion, Shelley re-joined the voluntary Sector back in 2015.



Shelley has gained vast experience and leadership skills around many complex issues and community crisis support. She was instrumental in the support for victims and families involved in the London 7/7 bombings, support with the Grenfell disaster and Croydon Fires, and more recently with the Afghan and Ukrainian humanitarian appeals and the support following fires in Wennington.  Shelley was ready to mobilise Havering Volunteer Centre during the pandemic and subsequent lock downs, ensuring the most vulnerable in Havering to ensure they had access to medication, food and other key support. Shelley set up the Check in Chat Care befriending calls for those isolated and alone, which still continue to this day.

Shelley is also involved in the climate challenge and helping make the community greener and safer. Shelley is Chair of the Safer Neighbourhood Board, Chair off the Havering Volunteer Managers Forum, a Steering Group Member of Havering Compact, is the Havering lead and integral to the Voluntary and Community Sector Emergency Partnership and London Emergency Committee, member of the NEL ICS Alliance and is part of the wider voluntary sector network across London.

# Mike Armstrong

Mike Is Managing Director of Havering Care Homes which provide nursing care to the elderly in the Borough.  Previously he was Chief Executive of a charity running a residential home and was Deputy Leader of Havering Council.

Whilst a Councillor he held several portfolio's including housing, regeneration, the environment, transformation and strategic planning.

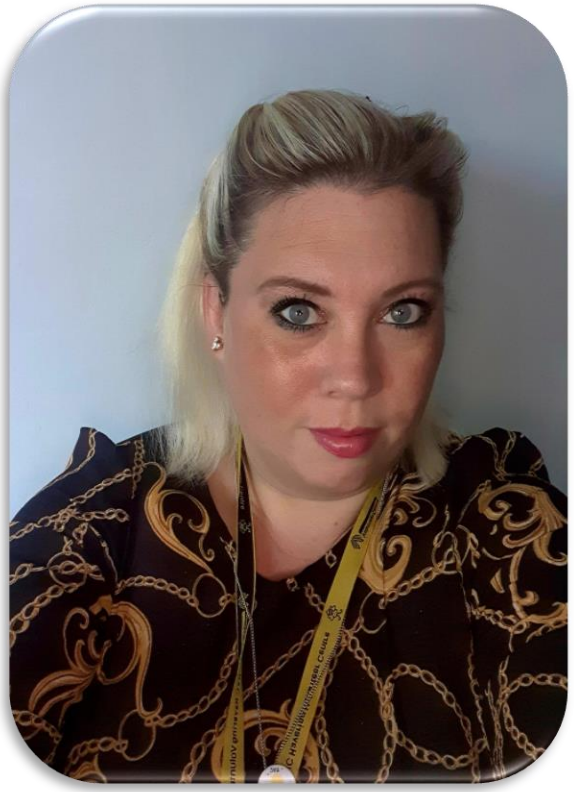
Mike is currently the Care Provider Lead for the London Oversight group behalf of the Care Association Alliance.  He works with the NHS in London as the Care Provider Lead for the Healthy London Partnership.  This has given him the opportunity to be involved in several pilots across the system including trusted assessor and shared care records, which he believes is fundamental to a system that shows equality of esteem to the workforce, whilst building meaningful partnership that delivers a more seamless service for those who need it.



As Chairman of the Havering Care Association and Co-Chair of Care Providers Voice he has developed a network of care providers across NEL, who the organisations seek to support with recruitment, workforce development and to ensure providers are part of the solution and given the opportunity to share some of the great work that goes on in the sector.

Mike is keen to see service development and transformation projects have the residents experience at the heart of its design.

# Rebecca Mazrreku



Rebecca Mazrreku is the Centre Operations Manager at Havering Volunteer Centre (HVC). She has first-hand experience in the establishment of upscaling a new charity and developing the strategic operational functionalities of a busy Volunteer Centre. She has developed innovative ways of formalising partnerships across all sectors to bridge divides in responding to service need in Havering.

In partnership with the CEO, Rebecca steered Havering Volunteer Centre's staff and volunteer base through the pandemic to deliver emergency support to thousands of residents, ensuring each person's individual needs were met. This involved redesigning and restructuring HVC's operating framework to deliver crisis intervention.



In 2020, Rebecca played a pivotal role when the Covid-19 Vaccination Programme was rolled out across two locations in Havering. The partnership working between the NHS and Voluntary Sector was further cemented with the support provided by the engagement of volunteers. This process required a new way of working for both sectors and sourcing a way to blend clinical needs with community needs. Rebecca spearheaded the delivery of structured volunteer engagement to successfully ensure that patients had the best vaccination experience possible.

Rebecca continues to work in partnership with multi-agency partners across sectors, continuously building and developing working relationships whilst ensuring that the community has a voice and is represented.

Priding herself on delivering excellent customer service, Rebecca believes that the route to a good experience begins with the first stages of customer experience. Making people feel valued and listened to right from the beginning is the foundation to a good working relationship. It's this ethos that enables her to forge strong working partnerships which achieves results for the end user.

Rebecca has been a Havering resident all her life; she is passionate about the borough and passionate that residents have access to the very best services available.

# John Timbs

John is owner and Managing Director of Lodge Group Care Uk Ltd, a Havering based provider of homecare services and children & adults learning disability services in residential and supported living settings.

He is also a Director of; Havering Care Association, and their lead for homecare and learning disability/mental health services, and Care Providers voice, a free network that engages with over 400 providers across North East London and commissioning teams and other partners.
John sits on the North East London Care Provider group, Skills for Care London CEO Group and various work streams locally, regionally and nationally.



John is a Community Board member of Care City, a health innovation hub for healthy ageing and well-being across East London.

John is also Director of Housing and Care at Abbeyfield South Downs Ltd, a charity providing supported living housing to older people across East Sussex and is very proud of their newly opened £13m development of 48 units of bespoke care enabled sheltered accommodation.

John is passionate about ensuring social care plays a full and active part in a truly integrated system delivering best outcomes to residents and patients.

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