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Havering
LONDON BOROUGH

# HEALTH & WELLBEING BOARD
## AGENDA

| 1.00 pm | Wednesday, 18 January 2017 | Committee Room 3B - Town Hall |
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Members: 16, Quorum: 9

**BOARD MEMBERS:**

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| Elected Members: | Cllr Wendy Brice-Thompson (Chairman)<br>Cllr Gillian Ford<br>Cllr Roger Ramsey<br>Cllr Robert Benham |
| Officers of the Council: | Dr Susan Milner, Interim Director of Public Health<br>Andrew Blake-Herbert, Chief Executive<br>Tim Aldridge, Director of Children's Services<br>Barbara Nicholls, Director of Adult Services |
| Havering Clinical Commissioning Group: | Dr Atul Aggarwal, Chair, Havering Clinical Commissioning Group (CCG)<br>Dr Gurdev Saini, Board Member Havering CCG<br>Conor Burke, Accountable Officer,Barking & Dagenham, Havering and Redbridge CCGs<br>Alan Steward, Chief Operating Officer, Havering CCG |
| Other Organisations: | Anne-Marie Dean, Healthwatch Havering<br>Matthew Hopkins, BHRUT<br>Ceri Jacob, NHS England<br>Jacqui Van Rossum, NELFT |

**For information about the meeting please contact:**
**Anthony Clements 01708 433065**
**anthony.clements@onesource.co.uk**

**What is the Health and Wellbeing Board?**

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

**What does the Health and Wellbeing Board do?**

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

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

1. CHAIRMAN'S ANNOUNCEMENTS

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

   Councillor Brice-Thompson

   Start time: 13:00

2. APOLOGIES FOR ABSENCE

   - receive.

3. DISCLOSURE OF INTERESTS

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

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

4. MINUTES (Pages 1 - 10)

To approve as a correct record the notes (attached) of the inquorate meeting of the Board held on 16 November 2016.

Councillor Brice-Thompson

Start time: 13:05

5. DRAFT HEALTH AND WELLBEING STRATEGY

**NOTE: Due to the meeting of 16 November 2016 being inquorate, items 5 - 13 are resubmitted from that meeting in order to take any comments <u>in addition</u> to those shown in the notes of the meeting.**

**Please could members bring with them the agenda papers from the 16 November meeting.**

Cllr Brice-Thompson

13:05

6. LOCAL SAFEGUARDING CHILDREN AND SAFEGUARDING ADULTS BOARD REPORTS

7. SINGLE INSPECTION FRAMEWORK UPDATE (VERBAL)

8. LOOKED AFTER CHILDREN - HEALTH CHECK UPDATE (VERBAL)

9. ADULT SOCIAL CARE LOCAL ACCOUNTS FOR 2015/16

10. REFERRAL TO TREATMENT DELAYS IN BHRUT UPDATE

11. ACO/STP UPDATE (VERBAL)

12. HOUSING DEVELOPMENT

13. BHR CCGs' LOCAL DIGITAL ROADMAP

14. TERMS OF REFERENCE (Pages 11 - 14)

    Report attached.

    Anthony Clements

    Start time: 13:30.

15. COMMUNITY PHARMACY (FOR INFORMATION) (Pages 15 - 18)

    Report attached.

    Oge Chesa/Susan Milner

    13:35

16. REFRESHED HEALTH AND WELLBEING STRATEGY FOR APPROVAL

    Report to follow.

    Susan Milner

    13:50

17. UPDATE ON INTEGRATED CARE PARTNERSHIP (PREVIOUSLY ACO) LOCALITY BOUNDARIES AND STP (Pages 19 - 70)

    Report attached.

    Alan Steward/Barbara Nicholls/Ade Abitoye/Ian Tompkins

    14:10

18. OPEN DIALOGUE - PRESENTATION FROM NELFT (FOR INFORMATION) (Pages 71 - 96)

    Attached.

    Carol White/Russell Razzaque.

14:35

19. UPDATE ON SEXUAL HEALTH SERVICES (FOR INFORMATION) (Pages 97 - 116)

Attached.

Mark Ansell

15:00

20. UPDATE ON REFERRAL TO TREATMENT (VERBAL)

Alan Steward/Matthew Hopkins

15:20

21. LETTER FROM HOME OFFICE: POLICE, CRIME COMMISSIONERS AND HEALTH AND WELLBEING BOARDS (FOR INFORMATION) (Pages 117 - 120)

Attached.

Susan Milner.

22. LETTER FROM DAVID MOWAT MP: (GENERAL PRACTICE FORWARD VIEW: PRIMARY CARE: HEALTH AND WELLBEING (FOR INFORMATION) (Pages 121 - 122)

Attached.

Susan Milner.

23. DATE OF NEXT MEETING

15 March 2016.

**NOTES OF A MEETING OF THE HEALTH & WELLBEING BOARD**
**Committee Room 3A – Town Hall**
**16 November 2016 (1.00 – 3.10pm)**

**Board Members present:**

Councillors Wendy Brice-Thompson (Chairman), Roger Ramsey and Robert Benham
Dr Susan Milner, Interim Director of Public Health, LBH (SM)
Tim Aldridge, Director of Children's Services, LBH (TA)
Anne-Marie Dean, Healthwatch Havering, LBH, (AMD)**Also present:**

Dr Russell Razzaque, Associate Medical Director, NELFT (RR)
Brian Boxall, Independent Chair for SAB and LSCB (BB)
Caroline May, Head of Business Management LBH (CA)
Rob Meaker, Director of Innovation, BHR CCGs (RM)
Simrath Bhandal, Project Manager BHR CCGs (SB)
Louise Mitchell, Chief Operating Officer CCG (LM)
Sarah Tedford, Chief Operating Officer BHRUT (ST)
Carol White, Integrated Care Director NELFT (CW)
Neil Stubbings, Interim Director of Housing Services, LBH (NS)
Elaine Greenway, Acting Public Health Consultant, LBH (EG)
Gloria Okewale, Public Health Support Officer, LBH (GO)
Richard Cursons, Democratic Services Officer, LBH (RC)

1 **WELCOME AND INTRODUCTIONS**

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

2 **APOLOGIES FOR ABSENCE**

Apologies were received from Andrew Blake-Herbert, Chief Executive, Barbara Nicholls, Director of Adult Services LBH, Connor Burke, Accountable Officer BHR CCGS, Alan Steward, Chief Operating Officer Havering CCG, Dr Atul Aggarwal, Chairman Havering CCG, Gurdev Saini, Havering CCG, Ceri Jacob NHS England, Jacqui Van Rossum, NELFT, Councillor Gillian Ford, Phillipa Brent-Isherwood, Head of Business & Performance.

It has been noted that board members should provide details of senior representatives if they are unable to attend the meeting.

3 **DISCLOSURE OF INTERESTS**

There were no disclosures of interest.

4 **MINUTES**

As the meeting was inquorate the minutes could not be agreed or signed by the Chairman, however the points raised previously were noted.

5 **ACTION LOG**

It was noted that the draft refreshed Joint Health and Wellbeing Strategy was circulated to board members as agreed.

The SEND JSNA executive summary was revised and circulated to board members. This included information on exclusions from maintained schools as well as free schools and academies.

Finalised Joint Health and Wellbeing Strategy to be circulated to board members.

SM to identify the organiser of the Havering governing body to ensure future dates doesn't clash with the HWB meeting.

6 **REFRESH OF HAVERING'S JOINT HEALTH AND WELLBEING STRATEGY**

SM advised that the current Joint Health and Wellbeing Strategy (2015–2018) had been signed off by the Havering Health and wellbeing Board in April 2015. It had been reviewed and refreshed in line with recent developments within the local health and social care economy to ensure it remained fit for purpose. The Board agreed the reframed themes and priorities for the strategy in May 2016. These had been reflected in the refreshed strategy document presented to the Board for approval subject to discussion and any subsequent amendments.

The actions required to deliver the themes and priorities within the strategy were contained within a number of other key strategic documents and actions plans. To avoid duplication of effort it had identified, for each priority, the key document(s) which set out the agreed actions to deliver on that priority and who was responsible for ensuring those actions take place. In addition leads had been to identify the key performance indicators to include in the HWB performance dashboard for the strategy. This would provide the Board with

assurance that the actions required to deliver the Joint Health and Wellbeing Strategy were being carried out and were leading to the specified outcomes.

Members were invited to provide feedback by email so that the final document could be brought back to the next meeting.

Members agreed that it would be helpful if the areas that had changed could be highlighted.

BB advised that it would be useful if the Local Safeguarding Children Board (LSCB) could look over the document and email any suggested changes.

AMD asked if going forward the Health & Wellbeing function would remain Havering specific or become tri-borough. RR advised that at present it was planned to keep Health & Wellbeing functions borough specific.

## 7 HAVERING SAFEGUARDING CHILDREN BOARD AND HAVERING SAFEGUARDING ADULT BOARD 2015/16 ANNUAL REPORTS

The report provided the HWB with both the Havering Children and Adult Safeguarding Boards annual reports for 2015-2016.

BB gave a brief update on the highlights of both reports.

Members noted that since the reports had been written there had been a change in the process with a more face to face approach being introduced.

Ofsted had recently inspected the Board and the draft response was awaited.

The police re-structuring was imminent and more details would be known shortly.

The Children's report highlighted the work that had taken place and BB wished to acknowledge the support that was received from all members on the Board at all levels. The Board was of a very good level due to the amount of multi-agency workers working together.

The Multi Agency Sharing Hub (MASH) was now well developed and contact to referral level had increased evidencing improved agency engagement and decision making when determining the level of service required to respond to identified needs. This has also led to a significant increase in the number of contacts being referred to Early Help. There was now evidence of early intervention with children and young people and families requiring support being signposted to the appropriate service.

The Child Protection conferences had seen a problem with the lack of attendance by the police and the pressures it placed on other officers.

Staff stability was key as it impacted on various areas of the service.

Despite many attempts private fostering was still an area that needed improvement.

The Board had also started to work closely with young people from the Children in Care Council (CiCC), the youth parliament and young carers. This interaction was at its early stages but their input to date had been exciting and very insightful for the board and individual agencies.

Members also noted that there was now a high risk register in place.

In relation to the Adult's Board the past year was the first that the HSAB had been operating as statutory body following the introduction of the Care Act 2014. The HSAB has focused on ensuring that it was able to comply with the requirements of the Act.

Adult safeguarding activity had continued to increase over the year especially in respect of the number of contacts and referrals and conference activity. The major increase had been in respect of the application of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLs) assessments.

The safeguarding activity was being undertaken under continued financial constraints and the on-going restructuring of some organisations. This, and the demography of Havering which had the oldest population in London, will continue to pose significant challenges to the local agencies and the HSAB.

Awareness had been raised in the areas of self neglect, modern slavery and domestic violence.

One of the biggest areas of work was around the transition between children's and adults and how users were prepared for the move between the two.

Current risks were:

Mash - Financial constraints may impact on ways in which partners support MASH.

Capacity issue in relation to homecare- Choice for people with care needs depleted and liberty deprived unnecessarily. Impact on residential settings

Capacity issue in relation to DOLS - Volume of referrals was high.

Mental capacity - there was still a need to continuously brief staff in their responsibility to undertake MCA assessments.

RR advised that a first meeting had taken place between local authorities and the police to discuss Havering's involvement in a unified borough command with Barking & Dagenham and Redbridge. There had been a focus on child protection and domestic violence and although there would be the same amount of officers the plan was to de-centralise some of the specialist teams so the borough would have access to more specialist officers. RR also confirmed that the project was a pilot and was reversible if needed. It was also noted that Havering's current Borough Commander Jason Gwillim would oversee the tri-borough pilot.

## 8 SINGLE INSPECTION FRAMEWORK UPDATE

TA gave an update on the recent Ofsted inspection. It was noted that this had involved 12 inspectors over a 4 week period, where they had looked at over 200 cases and met with staff, external partners and parents to gain a complete overview of the service.

The overall rating was "requiring improvement" which was what the service had expected. An action plan was being produced to deal with the areas that needed improvements. It was felt by the inspectors that the vision for the future was good, but improvements needed to be made on the day to day work. Safeguarding was also considered a strength as was CSE/ Missing Service, Early Help and Female Genital Mutilation. Weaknesses included workforce and commissioning of children's services which had been seen as too reactive.

The draft report should be received later this week and then the Council would give its response before the final report is issued in December.

## 9 LOOKED AFTER CHILDREN - HEALTH CHECK UPDATE

TA advised that health of Looked after Children (LAC) had been a risk area that had previously been flagged to the HWB and LSCB and had been an area that Ofsted had looked at recently.

This had become a key priority area during the last six to nine months and there had been some improvement and whilst the report was being compiled colleagues from the CCG and NELFT had been linked with. Works would continue on improving progress. One of the areas of concern had been the initial health assessment which was now at 96% but still needed improvement.

There was a LAC/Heath sub group that would be reviewing progress of measures which took place every six weeks. Improvements had also taken place in the performance of review assessments
Plans were also in place to ensure that all children in care were offered dental and optical checks on an annual basis. The aim is for all children to have those checks or to be offered those checks by March 2017.

There had been an improvement in children in care whose immunisations were up to date.

A strengths and difficulties questionnaire, which was a CAMS tool, was given to service users each year to complete so users could give an indication of where their mental health and emotional wellbeing was. Improved score were being seen and Havering's average was now below the national average.

Plans were in place for developing an in-house team of systemic family therapists who would be providing direct support to the users or carers.

WBT asked about childhood obesity and was advised that that would be tackled by universal and targeted children's services including school nursing.

## 10 ADULT SOCIAL CARE LOCAL ACCOUNTS FOR 2015/16

Local accounts were not mandatory but it was good practise to publish each year by local authorities who had responsibility for adult social care services. These accounts were designed to provide residents and service users with information on their Council's adult social care performance, activity and objectives. The Havering Local Account summarised adult social care and support achievements in 2015-16 and ambitions for the future.

CM highlighted several areas within the report including:

In 2014/15, the Council had supported 7,500 service users with 5,500 over the age of 65. This included over 2,600 people over the age of 85. This had increased to more than 7,770 in 2015/16 – a 2.7% increase from last year – with almost 6,117 of them over the age of 65. This included 3,080 over the age of 85.

The Council faced significant financial challenges due to funding reductions and increasing demand for services. Demand was increasing in terms of numbers of people who needed care and support, and also in terms of complexity.

The Council was actively developing savings plans to address budget shortfalls, in line with overall Council budget plans and considering how it would continue to provide Adult Social Care services. This may mean that it had to provide services in different and innovative ways in order to address the funding reductions that were being seen. 2015/16 savings were £5.2m against a budget of £52m (representing 10% of the service budget).

The Care Act imposed a duty on local authorities to promote individual wellbeing when carrying out any of their care and support functions in respect of a person. This duty was sometimes referred to as the "wellbeing principle" because it was a guiding principle that puts wellbeing at the heart of care and support system.

Much work had taken place to ensure that Havering was compliant with those aspects of the Care Act which came into force on 1 April 2015. This was a large and complex undertaking that had been delivered through a programmed management approach.

The report also detailed the challenges that lay ahead which included:

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

Whilst the need for services was continually increasing and would continue to rise, the financial challenges and the need to be creative in delivering services become more difficult. Havering had a growing population with a profile that was ageing, with need that were more complex. With Havering facing more cuts in funding in the next four years, the challenges in continuing to provide quality services to our residents within available resource would continue to manifest.

## 11 REFERRAL TO TREATMENT DELAYS IN BHRUT UPDATE

The report before Members detailed the progress of the local Hospitals' Trust (BHRUT) and clinical commissioning groups (BHR CCGs) work together to tackle unacceptably long waits for treatment for some patients across the area.

ST and LM briefed jointly on the report which highlighted how the long waits had come about and what measures had been put into place to deal with the issues.

The report detailed how arrangements had been put into place to improve care, the clinical harm programme that had been undertaken, demand management and also showed the drop in the number of patients who had been waiting for more than 52 weeks for treatment.

The demand management had taken into account the ongoing treatment needs and those patients within the backlog and this had lead to commissioning of additional providers offering patients alternative means of treatment.

Members noted that systems were already in place so that the same situation did not arise again and there would be an external check of waiting lists annually which would help act as an early warning system.

BHRUT and Havering CCG had had to submit a system wide action recovery plan to enable them to return to reporting and achieve a standard of 18 week treatment time. The plan had been submitted to NHSE Board which would

make a decision in December as to whether legal directions would remain in place.

Going forward it was planned that by September 2017 all patients would be seen within 18 weeks.

## 12 HOUSING DEVELOPMENT

The report provided the Board with an update on the housing development proposals approved by Council and associated regeneration implications and aspirations.

NS advised that the report attached that went before Cabinet on 12 October contained the latest information regarding the Council's house building programme, funded through the Housing Revenue Account (HRA) to provide affordable housing for local residents.

The Council had an ambition to deliver at least 2000 units of affordable housing through the programme. 1000 of those would replace those already in situ, but 1000 would be new units adding to the stock of the HRA. In combination with the 535 units that had already been approved by the September Cabinet report, this meant that current target for delivery of units was 2500 total with 1500 being new units of affordable housing.

Previously there had been an over-provision of sheltered housing but this was now being overtaken by the need for extra care sheltered accommodation. The proposals previously put forward included estate regeneration, community hubs and not just house building in its simplest form.

AMD enquired as to when the community hubs would be in place. In reply it was hoped that the hubs would be started in the next year.

RR raised a concern regarding extra housing provision and additional healthcare provision going forward. It was felt that discussions should be taking place with the CCG regarding the possible inclusion of healthcare facilities within large developments.

NS advised that discussions were being had with the CCG over the One Public Estate Project where the CCG realised that there were key infrastructure issues that they needed to provide for Barking & Dagenham, Havering and Redbridge.

It was agreed that this should be taken forward to a future meeting.

## 13 BHR CCGs' LOCAL DIGITAL ROADMAP

The report updated the Board on the progress of the Local Digital Roadmap development.

RM advised that following the publication of the Five Year Forward View and Personalised Health and Care 2020, local health and care economies had a requirement to develop and publish their Local Digital Roadmap (LDR). The three-step process began in September 2015 with the organisation of local commissioners, providers and social care partners into LDR footprints. The second step was for NHS providers within LDR footprints to complete a Digital Maturity Self-assessment. Following initial submission of the LDR to NHSE in June 2016, the LDRs had undergone a review and were expected to be submitted for national publication by the end of October 2016**.**

Bids had been submitted for up to £40 million of funding although it was known that the final amounts awarded would be far lower than had been bid for.

In relation to GP clinical systems, meetings with the federations had taken place and an implementation date of April and June 2017 was hoped for. The estimated costs for the implementation of the system in Havering would be approximately £300,000. It was hoped that all GPs would sign up to one system making the implementation easier.

**14 DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT (INFORMATION ONLY, NOT FOR DISCUSSION)**

The Board noted the comments of the report.

**15 FORWARD PLAN**

Copies of the forward plan were distributed, it was noted that items had been raised at this particular plan needed to be added to the plan. Members were reminded that if they wished for items to be added to the plan then they should email SM and GO.

**16 DATE OF NEXT MEETING**

The next meeting of the Board would be on Wednesday 18 January 2017 at 1.00 pm at Havering Town Hall.

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Havering
LONDON BOROUGH

# HEALTH AND WELLBEING BOARD, 18 JANUARY 2017

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|---|---|
| **Subject Heading:** | Health and Wellbeing Board Terms of Reference – Revision re Named Substitutes for Members |
| **London Borough of Havering Officer Lead:** | Susan Milner, Director of Public Health |
| **Report Author and contact details:** | Anthony Clements, Principal Committee Officer, anthony.clements@onesource.co.uk., Tel: 01708 4330655 |
| **Policy context:** | The establishment of named substitutes for Members will allow more effective functioning of the Health and Wellbeing Board |
| **Financial summary:** | There are no financial implications of the decision. |

**The subject matter of this report deals with the following Council Objectives**

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| Havering will be clean and its environment will be cared for | [] |
| People will be safe, in their homes and in the community | X[] |
| Residents will be proud to live in Havering | [] |

**SUMMARY**

Following a recent inquorate meeting of the Board, this report recommends that named substitutes for Board be allowed to attend future meetings of the Board and to have voting rights on issues where a vote is required.

## RECOMMENDATIONS

1. That the Health and Wellbeing Board agree that named substitutes be permitted for members in the event members are unable to attend meetings of the Board. These substitute members to have voting rights on issues where a vote is required.

2. That the following wording is added to the 'Reporting and Governance' section of the Board's Terms of Reference:

    - Named substitutes for Health and Wellbeing Board Members are permitted if advised prior to the start of a meeting. Named substitute members will have voting rights.

## REPORT DETAIL

1. The meeting of the Health and Wellbeing Board that took place on 16 November 2016 had received a number of apologies and had not been quorate. Although productive discussions had still taken place, this had meant that it was not possible for any formal decisions to be made by the Board.

2. In light of this, it was suggested that an addition be made to the Board's Terms of Reference in order to allow the attendance of named substitutes for Board members and for these substitutes to have full voting rights, should a formal vote be required on an issue before the Board.

3. The proposed wording for addition to the Board's Terms of Reference is as shown in recommendation 2 above and it is suggested this will be of considerable assistance should a meeting of the Board be in danger of being inquorate in the future.

## IMPLICATIONS AND RISKS

**Financial implications and risks: None.**

**Legal implications and risks: None.**

**Human Resources implications and risks: None.**

**Equalities implications and risks: None –no impact on equalities issues from allowing of substitute members.**

## BACKGROUND PAPERS

None.

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# HEALTH & WELLBEING BOARD

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| **Subject Heading:** | Pharmacy Integration Fund - Community Pharmacy **(for information)** |
| **Board Lead:** | Susan Milner |
| **Report Author and contact details:** | Oge Chesa<br>Deputy Chief Pharmacist<br>Barking and Dagenham, Havering & Redbridge Clinical Commissioning Groups<br>oge.chesa@nhs.net |

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

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

## SUMMARY

To support the transformation outlined in the Five Year Forward View, and to contribute to the Government's required efficiencies, a new Pharmacy Integration Fund (PhIF) was set up in October 2016. The PhIF is the responsibility of NHS England and is separate to any negotiations related to the Community Pharmacy Contractual Framework (CPCF). It will be used to validate and inform any future reform of the CPCF going forward.

## RECOMMENDATIONS

The board is asked to note the PhIF update.

## REPORT DETAIL

Beginning in December 2016, NHS England will be working to embed pharmacy into the NHS urgent care pathway by expanding the services already provided by community pharmacies in England for those who need urgent repeat prescriptions and treatment for urgent minor ailments and common conditions.
This will be piloted in two work streams to run in parallel from December 2016 to April 2018:

- An urgent medicines supply service –This will involve a direct referral from NHS 111 to community pharmacies. This will speed up access for those needing urgent repeat prescription medicines because they will no longer need a GP out-of-hours appointment, and it will route patients away from A&E who might otherwise attend to request urgent medicines. The aim is to manage more efficiently the approximate 200,000 calls per year to NHS 111 for urgent repeat prescription medicines. The usual NHS prescription charges and exemptions will apply to this service;
- Urgent minor illness care - from December 2016 to April 2018, NHS England will test the technical integration and clinical governance framework for referral to community pharmacy from NHS 111 for people who need immediate help with urgent minor ailments where this is appropriate for community pharmacy. This will develop an evidence-based, clinical and cost effective approach to how community pharmacists and their teams contribute to urgent care in the NHS, in particular making the referral of people with minor ailments from NHS 111 to community pharmacy much more robust. Minor ailments services are already commissioned by clinical commissioning groups (CCGs) across many parts of the country and ultimately NHS England will encourage all CCGs to adopt this joined-up approach by April 2018, building on the experience of the urgent and emergency care vanguard projects to achieve this at scale. It should be noted that NHS England London region commissions Minor ailments schemes for Barking and Dagenham and Havering.

In addition to the urgent care work streams, the PHiF will include a workforce development package for community pharmacy professional teams, deployment of pharmacy teams into care homes, and development of the pharmacist role in integrated urgent care clinical hubs, such as NHS 111.

**Relevant interdependencies**
In delivering the Five Year Forward View there are five Vanguard types (out of the 50 national sites):

a) Multispecialty community providers (MCPs) (14) – moving specialist care out of hospitals into the community. MCP common model and contract framework in place- comments on draft MCP contract documents by 20 January 2017
b) Integrated primary and acute care systems (PACSs) (9) – joining up GP, hospital, community and mental health services. Framework and contract under development.
c) *Enhanced health in care homes (EHCH)* (6) – offering older people better, joined up health, care and rehabilitation services working closely with the NHS, local authorities, the voluntary sector, carers and families to optimise the health of their residents. The EHCH care model is an adjunct to the other new care models that are delivering whole population healthcare. It will become a core element of the MCP and PACS models.
d) Urgent and emergency care (8) – new approaches to improve the coordination of services and reduce pressure on A&E departments
e) Acute care collaborations (13) – linking local hospitals together to improve their clinical and financial viability, reducing variation in care and efficiency.

**Relevance to London Borough of Havering**
The fund is aimed at the integration of pharmacy across primary care with a key project involving pharmacy professionals supporting care home residents. (More details about the care homes project will follow sometime this year). It is envisaged that pharmacy professionals will link into the EHCH model cited above supporting the care home residents in Havering.

## IMPLICATIONS AND RISKS

**Financial implications and risks:**
There are no immediate financial implications and risks.

Public Health England is developing a “value proposition” to inform the local commissioning of community pharmacy services by local authorities as referenced in the December 2015 letter. NICE is expected to publish a guideline in 2018 about the role of community pharmacy in promoting health and wellbeing. This work is separate to the PhIF but will inform the future local commissioning of services for public health services from community pharmacy.

**Legal implications and risks:**

There are none pertaining to this report.

**Human Resources implications and risks:**
There are none pertaining to this report.

**Equalities implications and risks:**
There are none pertaining to this report.

**BACKGROUND PAPERS**

1.

Pharmacy Integration Fund Br

2.

Pharmacy Urgent Care Briefing .pdf

3. NHS England website about the Pharmacy Integration Fund and associated slides

https://www.england.nhs.uk/commissioning/primary-care-comm/pharmacy/integration-fund/

January 2017

Havering
LONDON BOROUGH

# HEALTH & WELLBEING BOARD 18 January 2017

| | |
|---|---|
| **Subject Heading:** | **Update on North East London Sustainability and Transformation Plan** |
| **Board Lead:** | **Conor Burke, Accountable Officer, Barking & Dagenham, Havering and Redbridge CCGs** |
| **Report Author and contact details:** | **Ian Tompkins, Director of Communications & Engagement, NEL STP 07879 335180** ian.tompkins@towerhamletsccg.nhs.uk |

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

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

**SUMMARY**

This report (Appendix 1) provides a further update to the Board on the development of the north east London Sustainability and Transformation Plan (known as the NEL STP). On 21 October we submitted an updated narrative, updated summary and delivery plans to address our local priorities to NHS England.

From 21 October to January, local Healthwatch organisations will be working together to help us gather and understand the views of patients and communities. They will focus on gauging public views on a) promoting prevention and self-care b) improving primary care and c) reforming hospital services.

Further work is continuing to develop the plan in more detail; additional updates will be presented to the Board as they become available. For more information go to http://www.nelstp.org.uk or email: nel.stp@towerhamletsccg.nhs.uk

## RECOMMENDATIONS

The Health and Wellbeing Board is recommended to:

(i) Note the NEL STP
(ii) Provide feedback as set out in Appendix 1

*No formal decisions are required arising from this report.*

## REPORT DETAIL

### 1. Background

1.1 In December 2015 NHS England planning guidance required health and care systems across the country to work together to develop sustainability and transformation plans (STPs).

1.2 For Havering, the work to develop the detail underpinning the STP is being taken forward jointly with Barking & Dagenham and Redbridge through the development of the business case for an Accountable Care Organisation. The issues that any ACO would need to address in order to achieve improved outcomes from health and social care, in the context of a financially sustainable health economy, will be reflected in the contributions from Barking & Dagenham, Havering and Redbridge to the NEL STP.

### 2. Proposal

2.1 See Appendix 1.

### 3. Engagement

3.1 We recognise that the involvement of local people is crucial to the development of the STP. Since we submitted the original draft STP in June 2016 we have been engaging partners, including Healthwatch, local councils, the voluntary, community and social enterprise sector, and patient representatives. The initial feedback we received on the original draft was incorporated into the revised STP for the October 2016 submission.

3.2 Work to obtain further feedback is ongoing. Since October and continuing to February 2017, local Healthwatch organisations are working together to help us gather and understand the views of patients and communities. They will

focus on gauging public views on a) promoting prevention and self-care b) improving primary care and c) reforming hospital services.

## 4. Financial considerations

4.1 The NEL STP will include activities to address current financial challenges across the health and social care economy. The ambition is to ensure that all NHS organisations are able to achieve financial balance by the end of the five year period of the plan.

## 5. Legal considerations

5.1 The NEL STP Board is developing a plan as stipulated by the NHS England guidance.

## 6. Equalities considerations

6.1 An equality screening has been completed to consider the potential equality impacts of the proposals set out in the NEL STP. This is attached as Appendix 2 and includes:

- An overview of all the initiatives included in the NEL STP narrative to determine at which level equality analyses should be undertaken i.e. NEL STP level, Local Area Level, CCG/borough level or London-wide level.
- An initial assessment of the NEL STP overarching 'Framework for better care and wellbeing'.
- Actions to be undertaken during further detailed equality analyses.

The screening recognises that the initiatives included in the STP will be implemented at different times, hence further equality analyses will need to be undertaken over the life of the STP programme.

**Appendices**

Appendix 1: Update on north east London Sustainability and Transformation Plan (NEL STP) January 2017

Appendix 2: North east London Sustainability and Transformation Plan (NEL STP) Equality Analysis December 2016

## BACKGROUND PAPERS

- NHS Five Year Forward View https://www.england.nhs.uk/ourwork/futurenhs/
- Guidance on submission of Sustainability and Transformation Plans https://www.england.nhs.uk/wp-content/uploads/2016/05/stp-submission-guidance-june.pdf

**Appendix 1**

# Update on north east London Sustainability and Transformation Plan January 2017

***Transformation underpinned by system thinking and local action***

## 1. Background

During 2016, health and care organisations (clinical commissioning groups, providers, local authorities and voluntary and community organisations) across north east London (NEL) [1] have worked together to develop a sustainability and transformation plan (STP). It sets out how the NHS Five Year Forward View will be delivered and how local health and care services will transform and become sustainable, built around the needs of local people. The STP builds on our positive experiences of collaboration in NEL but also protects and promotes autonomy for all of the organisations involved. Each organisation faces common challenges including a growing population, a rapid increase in demand for services and scarce resources. We all recognise that we must work together to address these challenges; this will give us the best opportunity to make our health economy sustainable by 2021 and beyond.

The plan describes how north east London (NEL) will:

- meet the health and wellbeing needs of its population
- improve and maintain the consistency and quality of care for our population
- close the financial gap.

A number of different specific local plans are aligned to the STP, enabling its ambitions to be delivered. The STP builds on these existing local transformation programmes and supports their implementation: including Barking and Dagenham, Havering & Redbridge (accountable care system) and City & Hackney devolution pilots; Newham, Tower Hamlets and Waltham Forest: Transforming Services Together programme; and the improvement programmes of our local hospitals, which aim to supports Barts Health NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust out of special measures.

Crucially, the NEL STP is the single application and approval process for transformation funding for 2017/18 onwards.

## 2. Overview of the north east London Sustainability and Transformation Plan

We shared our initial thinking with NHS England in April and submitted a draft NEL STP showing our progress in June. During summer 2016 to facilitate public engagement on the STP, we produced a summary of progress to date and shared the draft STP on our website.

On 21 October we submitted an updated narrative, updated summary and eight delivery plans describing the main priorities of the STP to NHS England (NHS E) and NHS Improvement (NHS I). These are all available on the STP website. http://www.nelstp.org.uk/

[1] North east London includes: Barking and Dagenham, City of London, Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest.

**The NEL STP narrative**

The STP vision and priorities are shown below. A copy of our plan on a page is included in Annex A.

| NEL STP Vision |
| --- |
| 1. To measurably improve health and wellbeing outcomes for the people of NEL and ensure sustainable health and social care services, built around the needs of local people.<br>2. To develop new models of care to achieve better outcomes for all, focused on prevention and out-of-hospital care.<br>3. To work in partnership to commission, contract and deliver services efficiently and safely. |
| **NEL STP Priorities** |
| • The right services in the right place: Matching demand with appropriate capacity in NEL<br>• Encourage self-care, offer care close to home and make sure secondary care is high quality<br>• Secure the future of our health and social care providers. Many face challenging financial circumstances<br>• Improve specialised care by working together<br>• Create a system-wide decision making model that enables placed based care and clearly involves key partner agencies<br>• Using our infrastructure better |

To deliver the STP we are building on existing local programmes such as borough based health and wellbeing strategies and end of life care plans, as well as setting up eight work streams to deliver the priorities. The workstreams are cross-cutting NEL wide programmes, where there are benefits and economies of scale in consolidating a number of system level changes into a single programme. These are:

1. Promote prevention and personal and psychological wellbeing in all we do
2. Promote independence and enable access to care close to home
3. Ensure accessible quality acute services
4. Productivity
5. Infrastructure
6. Specialised commissioning
7. Workforce
8. Digital enablement

Delivery plans have been developed for each of our workstreams; they are live documents which will continue to be updated as the programme develops.

Each work stream has a Senior Responsible Officer (SRO) and Delivery Lead, and task and finish work streams are being established to take forward implementation of the delivery plans. There is local authority involvement and leadership within a number of work streams, for example the Prevention workstream. As we now start to mobilise the work streams we are seeking to strengthen local authority involvement and leadership across them.

## 3. Links with Transforming Services Together and other plans

Plans to implement integrated place-based care were underway before we began working on the STP, with each local health economy pursuing an innovative and ambitious programme to make this a reality. In INEL this includes the City & Hackney devolution pilot, and in Newham, Tower Hamlets and Waltham Forest the Transforming Services Together programme, which are supporting the development of accountable care systems locally.. We will support and enhance these programmes by working together, but they will continue to operate independently with separate programme and governance structures which allow each area the flexibility to best meet local needs. We are actively seeking to collaborate across NEL where it makes sense to do so and have formed a NEL wide group to share learning from the devolution pilots and transformation programmes which underpin the emerging accountable care systems.

## 4. Timetable for implementation

Each of the eight delivery plans sets out the milestones and timeframes for implementation. A critical path for the implementation of the main milestones across the whole STP programme is attached at Annex B.

## 5. Engagement on the Sustainability and Transformation Plan

We recognise that the involvement of local people is crucial to the development of the STP and are committed to involving them and clinicians in any proposed changes. The requirement for the NHS to involve and consult patients on specific service changes is a statutory duty and we will meet that duty and ensure patient and public involvement. At present there are no specific service changes in the INEL area that are worked up and at the stage where public consultation is required.

We started our engagement process when we submitted the draft STP in June, and we have been involving partners, including Healthwatch, local councils, the voluntary, community and social enterprise sector, and patient representatives. The feedback we have received so far was incorporated into the revised STP for the October 2016 submission.

A summary of our engagement activities to date is shown below:

- Published the draft and summary versions of the plan on our website and published regular updates
- Offered to meet all MPs which has resulted in a number of 1:1 meetings. A further briefing for all NEL area MPs is scheduled for 20 February 2017.
- Arranged for elected members from each borough to meet the STP Independent Chair and Executive
- Actively sought involvement of the eight Local Authorities facilitated through the Local Authority representative on the STP Board.
- Local Authorities are represented on the Governance Working Group and have taken part in the workshops developing the plans for transformation (with a Director of Public Health leading the work on prevention).
- Engaged the Local Government Association (LGA) to provide support to individual HWBs to explore self-assessment for readiness for the journey of integration and to a NEL-wide strategic leadership workshop to consolidate outputs from individual HWB workshops.

- Engaged with council and partner stakeholders such as the Inner North East London and Outer North East London Health Scrutiny Committees (HSC); Barking, Havering and Dagenham Democratic and Clinical Oversight Group; the eight Health and Wellbeing Boards; Hackney and Tower Hamlets councillors; and Newham Mayor's advisor for Adults and Health
- Met with local Save our NHS and Keep our NHS Public campaign groups
- Presented at meetings to discuss specific clinical aspects of the STP, for instance the NEL Clinical Senate; the NEL maternity network and maternity commissioners' alliance; mental health strategy meetings; and clinical workshops on the specialist commissioning of cardiac services and children's services. The proposals have also been discussed at a number of Local Medical Committee forums.
- Started to discuss the plans with NHS staff – further engagement is planned.
- Discussed the plans in open board meetings of all our NHS partners and offered opportunities to talk to patients and the public at various annual general meetings and patient group meetings.
- Held wider events on specific topics and developments, e.g. urgent care events involving patients and a wide range of stakeholders such as the London Ambulance Services and community pharmacists.

Our communications and engagement plan (phase 2) sets out how communications with staff, patients, the public, partners and other stakeholders will be managed and delivered. It focuses on the six month period from October 2016 to April 2017. This will be regularly reviewed, refined where necessary and shared with all interested parties, with updates on the outcomes achieved.

The STP programme communications and engagement team is responsible for coordinating work that needs to be done across all CCGs, developing a core narrative and coordinating activity.

Ian Tompkins joined the STP team as Communications Director in November 2016. He has previously worked as a Director of Communications in local authorities (Hackney, Newham, Waltham Forest and Hounslow), the East London NHS Foundation Trust and Newham Clinical Commissioning Group. Ian is currently meeting with local authority and NHS colleagues to develop a collaborative approach to communications and engagement, making use of the many existing and productive networks, including those in public health and the voluntary sector.

A workshop for all NHS and local authority communications and engagement leads, as well as those for policy and strategy and public health, is being held on 26 January 2017.

Local NHS communications teams are responsible for local delivery – understanding local issues and working at a much greater detail to develop local solutions; and engagement on plans that sit under the STP. All are responsible for (and have) links with local authority communications teams and Ian Tompkins will help encourage and support this

In order to ensure we develop the STP using all relevant patient and public views, to ensure efficiency and to reach a wide community of public and patients, we have asked local Healthwatch organisations to review the research and comments they have gathered in recent months and to use existing forums to discuss the STP (see section 6 of the communications and engagement plan).

From 21 October to February 2017, local Healthwatch organisations are working together to help us gather and understand the views of local people. They will make use of any other relevant consultation and engagement groups/networks, such as those of local authorities, where possible.

Our joint aim is to ensure engagement is relevant to local needs and that it builds on previous decisions made and the engagement and consultation work that has already take place across NEL on significant change programmes and developments. Healthwatch organisations will focus on gauging public views on a) promoting prevention and self-care b) improving primary care and c) reforming hospital services; with a local emphasis on:

- the Barking, Havering and Redbridge devolution pilot
- the Hackney devolution pilot
- Transforming Services Together in Newham, Tower Hamlets and Waltham Forest
- The vanguard project in Tower Hamlets

We will continue to exploit the full range of channels and formats for our communications and engagement activities to ensure we are reaching groups that are sometimes missed. We will carry on working with clinicians, local authorities and staff to ensure they too are actively involved in the development of the STP. We will encourage patients and local people to be involved at the design stage and work jointly with local authority engagement colleagues to help ensure a joined up approach; undertaking formal consultation when required.

We are committed to National Voices' six principles for engaging people and communities that set the basis for good, person-centred, community-focused health and care and will embed these across our work. We also believe that staff have a crucial role to play in the success of the STP. We want them to contribute to its development, to understand and support its aims; to feel part of it and be motivated by it.

There will be many opportunities for everyone (including patients, service users, carers and the public) to have their say on the emerging plans, and to continue shaping their development and implementation during the next five years. Any proposals for significant changes that emerge from the plan will be subject to specific engagement and consultation where required.

In addition, we are committed to engaging with all trade unions on the workforce impacts of the STP. There is a member of the London Health Unions Lead Representative on the NEL workforce advisory board, and each NHS provider has its own joint staff side arrangements where STPs are discussed.

## 6. Governance for the NEL Sustainability and Transformation Plan

The launch of the STP process signalled the move towards working in larger geographical areas and the need to develop governance arrangements to support strategy development and change at a system level.

To achieve this, 20 organisations have been working together to develop the NEL STP. However, as we move into the next phase of the programme, focusing on the mobilisation and implementation of our delivery programmes, the governance and leadership arrangements are being updated to ensure they continue to remain effective with appropriate membership. As key players in the development and delivery of the STP, especially in ensuring it meets the needs of the many different communities, local authorities will be suitably represented.

A governance task and finish group (including health organisations, local authorities and Healthwatch) was set up to review and update the governance arrangements to reflect this change in focus. Through this group we have developed a shadow governance structure,

and initial terms of reference for the key governance forums. We will be operating the governance in shadow form until April 2017 to enable us to test and review it.

This governance structure recognises and respects the statutory organisations, while providing the necessary assurance and oversight for system level delivery. In addition to reinforcing some of the existing governance forums (i.e. re-focusing the membership of the NEL STP Board), several new bodies have been added to strengthen the level of assurance and engagement, most notably:

- Community Council – A council of local people, voluntary sector, and other key stakeholders to promote system wide engagement and assurance
- NEL Political Leaders Advisory group - To provide a forum for political engagement and advice to the NEL STP
- Assurance Group – An independent group of audit chairs to provide assurance and scrutiny
- Finance Strategy Group -To provide oversight and assurance of the consolidated NEL financial strategy and plans to ensure financial sustainability of the NEL system.

We have developed a draft Memorandum of Understanding (MoU) for the governance arrangements of the North East London STP between the health and social care partners. The MoU will not be legally binding, but is intended to ensure a common understanding and commitment between the partner organisations on the NEL STP governance arrangements, specifically:

- The scope and objectives of the NEL STP governance arrangements
- The principles and processes that will underpin the NEL STP governance arrangements
- The governance framework / structure that will support the development and implementation of the NEL STP

The draft MoU is being circulated to local authorities, Trust boards and CCG governing bodies in December 2016 -January 2017.

The shadow governance structure is included at Annex C.

## 7. Finance considerations of the NEL STP

The basis for the financial modelling has been the refreshed draft five year CCG Operating Plan and provider Long Term Financial Model templates. These have been prepared by individual NEL commissioners and providers, all of whom followed an agreed set of key assumptions on inflation, demographic and non-demographic growth, augmented with local judgement on other cost pressures and necessary investments in services.

The individual plans have then been fed into an integrated health economy model in order to identify potential inconsistencies and to triangulate individual plans with each other. Activity has been modelled across NEL utilising the TST model. Specialised commissioning and any differences in contract assumptions are included in these projections. The local authority position is modelled separately and a summary is detailed below.

The forecast NEL FY20/21 'do nothing' affordability challenge is c£578m to break even (an additional c£30m to reach 1% surplus target for commissioners). This assumes growth and inflation in line with organisations' plans but that no CIP (Cost Improvement Plans, or Provider efficiencies) or QIPP (Quality, Innovation, Productivity and Prevention schemes, or commissioner savings) would be delivered in any year.

In the 'do minimum' scenario, in which 'business as usual' efficiencies of 2% across all years have been included, the affordability challenge would be c£336m by FY20/21. The Providers in NEL have committed to delivering a further stretch CIP of £84m meaning the estimated gap after achieving internal efficiencies is £251m. Of this, £160m of savings will be delivered through a variety of collaborative transformation schemes, mitigate down from £184m after applying a prudent risk rating. This includes £38m of savings from providers improving their collaboration on back office functions, as well as a total of £111m in a variety of service transformation across the seven boroughs over five years.

A number of factors are driving our rising expenditure. One significant factor is our growing and ageing population in line with GLA projections. We also face a non-demographic demand growth, due to factors such as new technology and increases in disease prevalence; we have assumed that this growth is approximately 1% per year. Pay and price inflation have been assumed in line with NHS I guidance. This results in a steady increase in expenditure over the planning period.

We see significant increases in CCG allocations throughout the planning period. However, Sustainability and Transformation Funding (STF) and some other non-recurrent provider income (such as gains by absorption) primarily affect the initial years and have no impact in the projections of in-year movements from FY18 onwards.

**NEL local authority challenge**
All NEL local authorities and the Corporation of London have provided financial data for the STP modelling, though it is recognised that further detailed work is required to confirm assumptions and what effect local authority funding challenges and proposed services changes will have on health services and vice versa.

For the 'do nothing' scenario, the combined FY17 Local Authority challenge is estimated as £87m reaching £238m by FY21. This figure is based on adult social care, Better Care Fund, children's services and public health at all local authorities.

If Children Services were excluded from the gap analysis, the gap in FY17 would be estimated as £60m reaching £174m by FY21.

A 'do minimum' scenario, where 'business as usual' savings are assumed, will still need to be completed.

**Contracts between providers and commissioners**
Two-year contracts between all NEL providers and commissioners (including NHSE specialised commissioning) for the period 2017-19 were agreed in line with the national timeframe of 23rd December 2016, as well as two year operating plans which reflected these agreements.

STP partners have agreed to use the period January – March to refine the joint delivery plans that support the transformation schemes agreed in the contracts, designed to deliver the efficiencies required to achieve financial balance across the NEL STP footprint.

**8. Equality considerations**
An equality screening has been completed (December 2016) to consider the potential

equality impacts of the proposals set out in the NEL STP. It includes:

- An overview of all the initiatives included in the NEL STP narrative to determine at which level equality analyses should be undertaken i.e. NEL STP level, Local Area Level, CCG/borough level or London-wide level.
- An initial assessment of the NEL STP overarching '**Framework for better care and wellbeing'.**
- Actions to be undertaken during further detailed equality analyses.

The screening recognises that the initiatives included in the STP will be implemented at different times, hence further equality analyses will need to be undertaken over the life of the STP programme.

## 9. Your views on the NEL STP

The STP is a work in progress and this latest draft submission is currently being circulated to health and social care partners. We anticipate feedback from NHSE/I early in 2017, and will continue to evolve the STP following feedback from our local partners, local people and the national bodies. We welcome your comments and input as we further develop the plans.

**Tell us what you think**

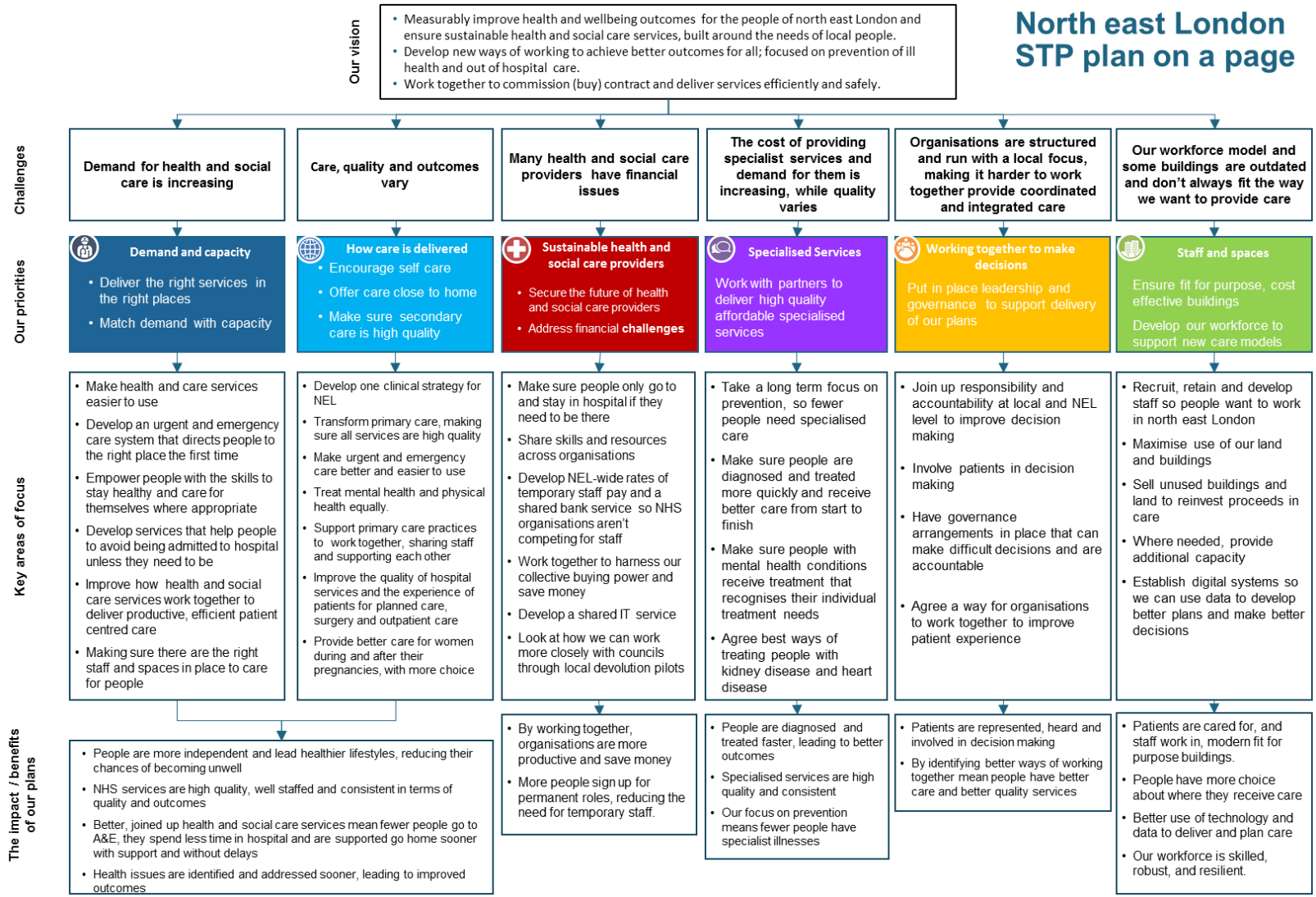
*We'd like to know what you think about our STP. It's still a draft, so the content can and will change. We'd like to hear from as many people as possible about what you think so we can refine our ideas and further develop our STP, based on your comments, before it is finalised later in the year.*

- **What do you think about what we've chosen to focus on?**
- **Do you think we have the right priorities?**
- **Is there anything missing that you think we should include?**

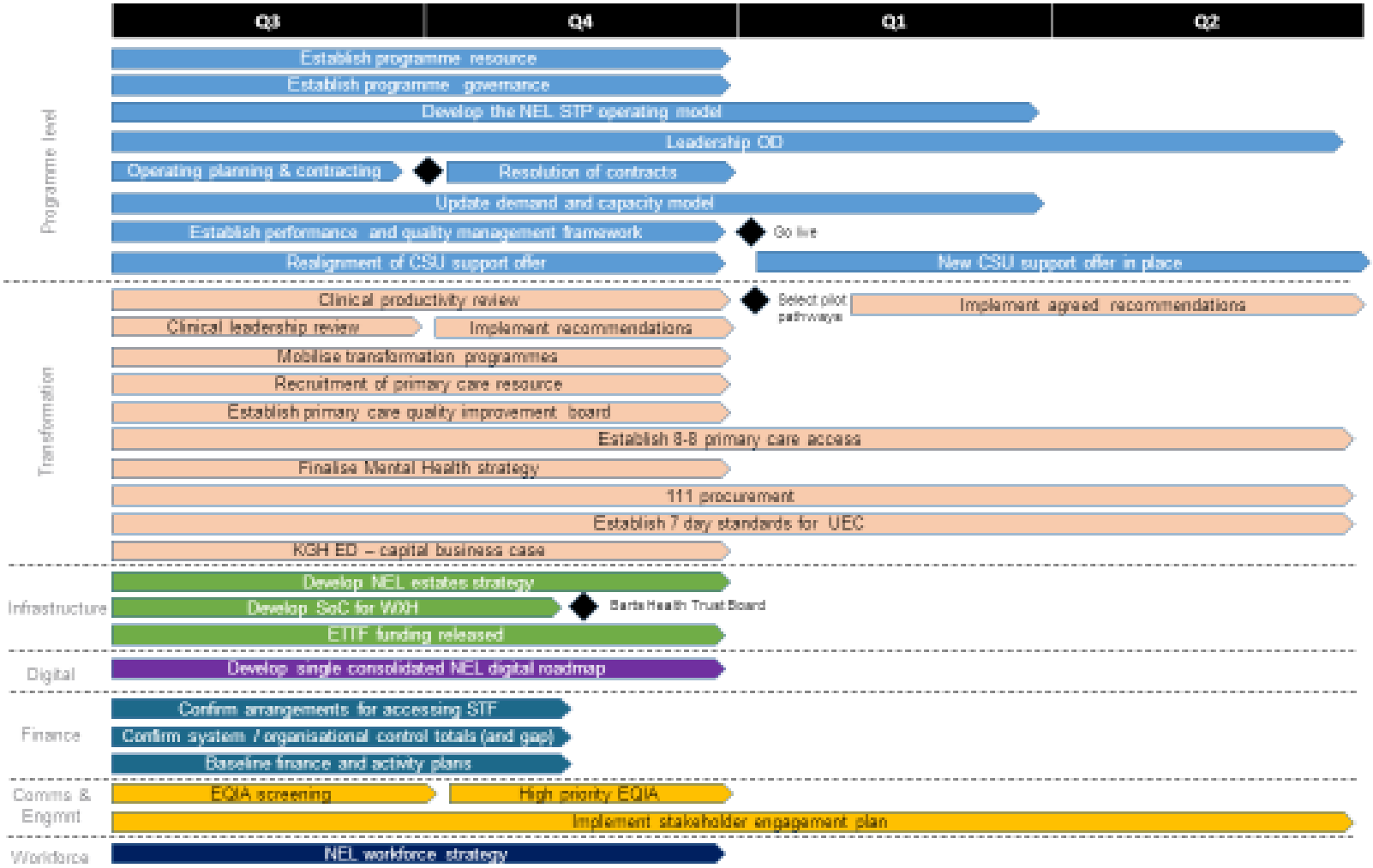
Please send us an email and tell us what you think: nel.stp@towerhamletsccg.nhs.uk

For more information about the NEL STP visit http://www.nelstp.org.uk/

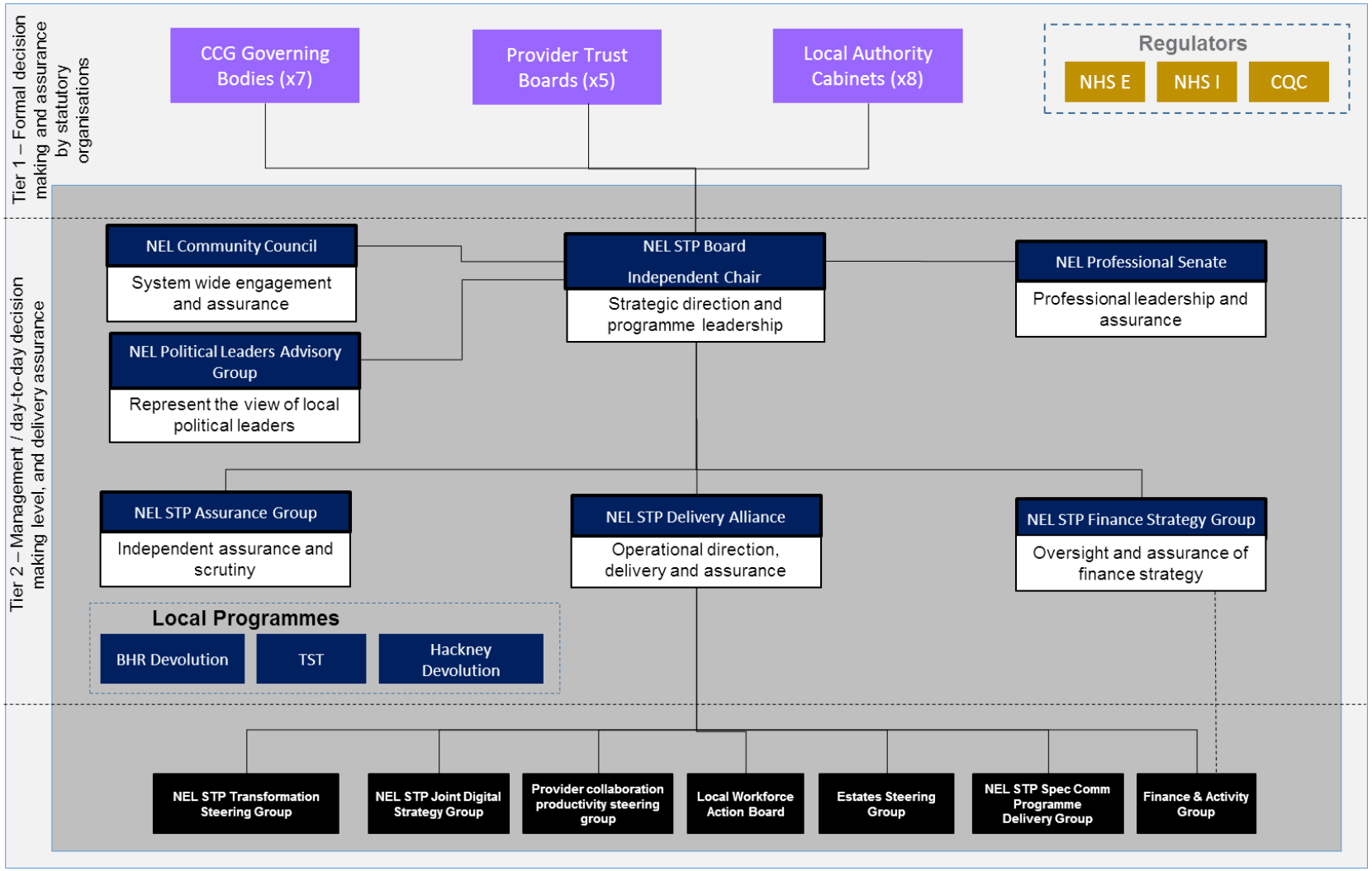
## Annex A: NEL STP Plan on a page



**Annex B** **NEL STP Year 1 Critical Path**



## Annex C NEL STP Shadow governance structure



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APPENDIX 2

# North east London Sustainability and Transformation Plan

## EQUALITY ANALYSIS

(Equality Impact Assessment screening)

## Contents



## Section 1: Introduction

**Name of policy/function being assessed**

North east London Sustainability and Transformation Plan (NEL STP)

**The policy/function being assessed is a:**

| | |
|---|---|
| Strategy/Plan | ☑ |
| Written Policy | ☐ |
| Service | ☐ |
| Guideline/Framework | ☑ |
| Procedure | ☐ |
| Project | ☐ |
| Agreement/Contract | ☐ |
| Consultation | ☐ |
| HR Restructure | ☐ |
| Other, please state: | ☐ |

**Is this a new or existing policy/function?**

New **X** Existing **X**

**Senior Responsible Officer for the policy/function**

Jane Milligan, Chief Officer, Tower Hamlets CCG and Executive Lead for north east London Sustainability and Transformation Plan (NEL STP)

## Lead person responsible for conducting the equality analysis

This initial screening of the STP has been conducted by the STP Programme Office, led by Nichola Gardner STP Programme Director.

## A brief description of policy/function

This Equality Screening considers the potential equality impacts of the proposals set out in the north east London Sustainability and Transformation Plan (NEL STP) draft submitted to NHS England on 21 October 2016.

The STP is the new national planning framework for NHS services, which is intended to support the delivery of a transformed health service, which is set out in the Five Year Forward View (5YFV). During 2016, 20 organisations across NEL (which covers seven CCGs and eight local authority areas[1]) have worked together to develop the NEL STP. A detailed public health profile for north east London was carried out in March 2016 to identify the local health and wellbeing challenges to be addressed by the STP.

The NEL STP has adopted the following joint vision and priorities.

| NEL STP vision |
| --- |
| 1. To measurably improve health and wellbeing outcomes for the people of NEL and ensure sustainable health and social care services, built around the needs of local people.<br>2. To develop new models of care to achieve better outcomes for all, focused on prevention and out-of-hospital care.<br>3. To work in partnership to commission, contract and deliver services efficiently and safely. |
| **NEL STP priorities** |
| • The right services in the right place: Matching demand with appropriate capacity in NEL<br>• Encourage self-care, offer care close to home and make sure secondary care is high quality<br>• Secure the future of our health and social care providers. Many face challenging financial circumstances<br>• Improve specialised care by working together<br>• Create a system-wide decision making model that enables placed based care and clearly involves key partner agencies<br>• Using our infrastructure better |

To implement this we have developed a common framework (see below) that will be consistently adopted across the system through our new model of care programmes. This framework is built around our commitment to person-centred, place-based care for the population of NEL.

[1] Barking and Dagenham, City of London, Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest.


Promote prevention and personal and psychological wellbeing in all we do
• Workplace
• Housing
• Self-service care
• Leisure
• Education
• Employment
ACCESSIBLE QUALITY ACUTE SERVICES
CARE CLOSE TO HOME
PREVENTION
COMMUNITIES, FRIENDS AND FAMILY
PEOPLE-CENTRED SYSTEM
• Self-care
• Peer-led services
• Voluntary sector services
• Home-based support
• Mental health services
• Children's services
• Social care services
• Opticians/dentists/pharmacies
• GPs
• Integrated multi-disciplinary teams
• Support from volunteers
• Maternity
• Acute physical and mental care
• Emergency care
• Specialised services
NHS
Promote independence and enable access to care closer to home
Ensure accessible, high quality acute services for people who need it

To deliver the STP we are building on existing local programmes such as borough based health and wellbeing strategies and end of life care plans, as well as setting up eight workstreams to deliver the priorities. The workstreams are cross-cutting NEL wide programmes, where there are benefits and economies of scale in consolidating a number of system level changes into a single programme. These are:

1. Promote prevention and personal and psychological wellbeing in all we do
2. Promote independence and enable access to care close to home
3. Ensure accessible quality acute services
4. Productivity
5. Infrastructure
6. Specialised commissioning
7. Workforce
8. Digital enablement

Delivery plans have been developed for each of our workstreams; they are live documents which will continue to be updated as the programme develops.

A communications and engagement plan has been produced (see below), and joint memorandum of understanding has been agreed by the multi-organisational Governance Working Group to underpin this work.

The NEL STP builds on the existing local transformation programmes (shown below) and supports their implementation; it also supports our local hospitals out of special measures.

| Local transformation programmes |
|---|
| Barking and Dagenham, Havering and Redbridge (BHR): devolution pilot (accountable care system) |
| City and Hackney: Hackney devolution |
| Newham, Tower Hamlets and Waltham Forest: Transforming Services Together programme (TST) |
| Barts Health NHS Trust |
| Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) |

A copy of our plan on a page is included in Appendix 1.

## Information/Evidence

The following key messages are taken from the detailed public health profile for north east London carried out in March 2016; they have informed the development of the NEL STP.

**Overall**

- There is a significant projected increase in population in the next five years to 2021, with projections of 6.1% (120,000), from 1.95 million to 2.07 million. This varies from 3% Redbridge and Waltham Forest to 13.2% Tower Hamlets.
- Over 15 years, to 2031, the increase is expected to by around 345,000 or 18%, to 2.3 million people.

- There are significant health inequalities across NEL and within boroughs, in terms of life expectancy and years of life lived with poor health.

**Age**

- NEL has higher rates of obesity among children starting primary school than the averages for England and London. All areas have cited this as a priority requiring system wide change across the NHS as well as local government.
- This is not reflected in the statistics for excess weight in adults: only Barking and Dagenham has significantly higher rates than England, and half of all NEL boroughs have significantly lower rates. NEL has generally higher rates of physically inactive adults, and slightly lower than average proportions of the population eating 5-a-day.
- Right Care analysis identified that for NEL rates of admission for people age 65+ with dementia are poor. With a rising older population continuing work towards early diagnosis of dementia and social management will remain a priority.

**Disability (including long term limiting illness and mental illness)**

- For males, Barking and Dagenham, and Hackney have significantly higher premature mortality rates from cancer than England and London. Tower Hamlets and Havering also have higher rates that narrowly fail the 5% significance test. Only Redbridge has significantly lower rates than England and London.
- For females, Tower Hamlets' rate for premature mortality from cancer is significantly higher than England's and London's. With the exception or Redbridge, all the other boroughs' rates are not significantly different from England's. Barking and Dagenham's rates is significantly higher than the London average. Only Redbridge has rates significantly lower than England and London.
- Breast cancer screening rates vary: Havering's rate is significantly higher than England's; Redbridge's rate is significantly below England's but above the London average; while rates in Waltham Forest, Barking and Dagenham, Newham, Tower Hamlets, and Hackney are significantly below the London average.
- There is an increased risk of mortality among people with diabetes in NEL and an increasing 'at risk' population. The percentage of people with Type 1 and Type 2 diabetes who receive NICE-recommended care processes is poor.
- Cancer survival rates at year one are poorer than the England average and screening uptake rates below England average.
- There is a shortage of high quality relevant data for people with mental illness and learning disabilities.
- Acute mental health indicators identify good average performance however concerns identified with levels of new psychosis presentation.
- Suicide rates are lower than the England average. NEL has higher than average rates of mental health clients living independently.
- The percentage of adults with learning disabilities living independently varies across NEL.

**Gender reassignment**

Data on gender re-assignment is not available at a NEL level, but a Home Office funded study for the Gender Identity Research and Education Society, estimated there were 300,000 – 500,000 transgender people in the UK[2].The study quotes a 2007 report which estimates that 20 people per

[2] Gender Identity Research and Education Society, The Number of Gender-Variant People in the UK, 2011

100,000 of the UK population (potentially 400 people in NEL) had sought medical care for gender variance – around 10,000 people, of whom 8,000, had undergone transition.

**Pregnancy and Maternity**

- The teenage pregnancy rate in Barking and Dagenham is very much higher than the England and London rates. Redbridge's rate is significantly lower than England's and London's. Rates in the other boroughs are not significantly different from each other or from London and England.
- Smoking in pregnancy rates vary across NEL. Hackney and Newham have significantly higher rates the London and England. Barking and Dagenham's rate is between those of London and England. Havering's rate is not significantly different from England's. Data for the other boroughs was not published because of data quality issues.
- Hackney and Newham have significantly higher rates of breast feeding than the London and England. Barking and Dagenham's rate is between those of London and England. Havering's rate is not significantly different from England's. Data for the other boroughs was not published because of data quality issues.
- NEL boroughs have notably low rates of childhood immunisation. City and Hackney's rate is similar to England's. Havering's and Barking and Dagenham's rates are significantly below that of England but above the London average. Waltham Forest and Redbridge's rates are significantly lower than that of London.

**Race and Religion**

- North east London is ethnically very diverse. The GLA estimates the under half the population (951,000, 49%) are ethnically White, while 51% are from Black and Minority ethnic (BME) groups (which includes all mixed ethnicities).
- Some BME groups will grow differentially faster, South Asians by 10.5%, but Black groups slightly less than the total, about 5.1%. These groups have higher risks of major, potentially preventable, health conditions.
- Estimates suggest differentially high growth in ethnic groups at increased risk of some priority health conditions. Black groups and South Asian groups have higher risk of diabetes. North east London faces a stiff challenge in diabetes prevention, as the biggest components of its expected population growth are in ethnic groups at higher risk.
- South Asian groups have 50% higher risk of ischemic heart disease than White groups, while Black groups have lower risks of heart disease than the general population. Black groups have double the risk of stroke than the general population, and South Asian groups have rates 50% higher than the general population.

**Sex**

- For males there is a 3.3 year difference between the longest life expectancy (Redbridge) and the shortest (Barking and Dagenham). Male life expectancy in Redbridge is significantly higher than for London and England, while in Havering it is significantly higher than England overall but not significantly different from London. In Waltham Forest male life expectancy is significantly below that of London but not significantly different from England. Male life expectancy in Newham, Hackney, Tower Hamlets, and Barking and Dagenham is significantly lower than both London and England.
- For females there is a 2.5 year difference between the longest life expectancy (Redbridge) and the shortest (Barking and Dagenham). Female life expectancy in Redbridge is significantly higher than for London and England, while in Havering and Waltham Forest

female life expectancy is significantly higher than for England overall but not significantly different from London. Female life expectancy in Hackney and Newham is significantly below that of London but not significantly different from England. In Tower Hamlets, and Barking and Dagenham female life expectancy is significantly lower than both London and England.

**Sexual orientation**

- We do not have NEL level data for people identifying as lesbian, gay or bisexual. However based on estimates for London[3] 2.6% of the population identify themselves as lesbian, gay or bisexual, 0.3% describe themselves as 'other', a further 6.9% 'don't know' or 'refuse to say' and 2% did not respond to this question. Nearly 90% of Londoners describe themselves as straight or heterosexual.
- Syphilis is an important public health issue amongst men who have sex with men among whom incidence has increased over the past decade. The highest rate is in the City of London, but absolute numbers are small. Tower Hamlets and Hackney have significantly higher rates than the London average. Waltham Forest and Newham have rates significantly lower than the London average, but higher than the England average. Redbridge, Havering and Barking and Dagenham have rates non-significantly lower rates than the England average.

**Socio-economic groups**

- NEL has generally very high levels of deprivation compared with the rest of England. According to the Index of Multiple Deprivation 2015 (IMD 2015) average scores, Tower Hamlets is the ninth most highly deprived upper tier local authority in England, Hackney the tenth, Barking and Dagenham the eleventh. Five of the eight NEL STP boroughs are in the most deprived quintile. Redbridge, Havering and the City of London are in the less deprived 50% of local authorities.
- Overall, NEL has unemployment rates about 35% higher than the national average. The highest rate is in Barking and Dagenham.

Additional evidence about the NEL key overall care and quality challenges is shown in the draft NEL STP.

[3] ONS Integrated Household Survey, January – December 2014

## Consultation, engagement and contribution

Since March 2016 we have been engaging partners, including Healthwatch, local councils, the voluntary, community and social enterprise sector, and patient representatives including meeting with local Save our NHS, 38 Degrees and Keep our NHS Public campaign groups[4]. In addition we have published regular updates, as well as an updated narrative, updated summary and eight delivery plans describing the main priorities of the STP. These are available on our website, www.nelstp.org.uk A summary of communications and engagement activity from June to November 2016 can be found in Appendix 2.

In order to ensure we develop the STP using all relevant patient and public views, to ensure efficiency and to reach a wide community of public and patients, we have asked local Healthwatch organisations to review the research and comments they have gathered in recent months and to use existing forums to discuss the STP. From October 2016 to February 2017, the local Healthwatch organisations across the STP area will be working together to help us gather and understand the views of patients and communities. Our joint aim is to ensure engagement is relevant to local needs. Healthwatch organisations will focus on gauging public views on a) promoting prevention and self-care b) improving primary care and c) reforming hospital services; with a local emphasis on:

- The Barking and Dagenham, Havering and Redbridge devolution pilot
- The Hackney devolution pilot
- Transforming Services Together in Newham, Tower Hamlets and Waltham Forest
- The vanguard project in Tower Hamlets

A communications and engagement plan http://www.nelstp.org.uk/downloads/Publications/Delivery-plans/NEL-STP-Delivery-plan-9-Comms-and-Engagement-Oct-submission.pdf has been produced which sets out the arrangements for communication with patients, the public, voluntary and statutory sector partners, staff and other stakeholders between October 2016-April 2017. The plan details the suggested evidence that local Healthwatch organisations will interrogate and the meetings where the STP is likely to be a focus of the discussions. The feedback we have received has as far as possible been addressed and incorporated into the revised STP in October 2016.

A further communications and engagement plan will be developed for any subsequent phases, or in light of any significant changes. We will need to review existing local arrangements on patient participation to ensure they are fit for future purpose, e.g. increasing self-care; using expert patients, self-help groups etc. Once the detailed options being considered within each workstream have been scoped, there is a need for further engagement work with patients and local communities with protected characteristics.

## Consultation outcomes

We recognise that some changes proposed in the STP may require formal public consultation, and are committed to the government's principles for consultation (2016). We will look at how to tailor consultation to the needs and preferences of particular groups, such as older people, younger people or people with disabilities that may not respond to traditional consultation methods.

[4] A list of engagement activities between June and November is included in Appendix 2.

## Section 2: Test of Relevance and Initial Screening Assessment

### Scope of the equality screening

The proposals in the STP programme relate to the need to pay 'due regard' to the Public Sector Equality Duty (s.149, Equality Act 2010) to: ***'advance equality of opportunity between those who share a "protected characteristic" and those who do not share that protected characteristic'***. The STP proposals need to be analysed to how they will be advancing this equality aim including the need to:

- *Remove or minimise disadvantages experienced by people due to their protected characteristic*
- *Take steps to meet the needs of people from protected groups where these are different from the needs of other people including steps to take account of disabled people's disabilities*
- *Encourage people from protected groups to participate in public life or in other activities where their participation in disproportionately low*

The draft STP states that:

*'We are committed to ensuring that everyone has equal access to high-quality services and care, regardless of gender, race, disability, age, sexual orientation, religion or belief. We will work closely with patients, staff, partners and voluntary organisations to help reduce inequalities and eliminate any discrimination within NHS services and working environments. As part of the development of the final STP we will carry out engagement with people who have protected characteristics as set out in the Equality Act 2010. We will conduct equality impact assessment (EIA) screenings to identify where work needs to take place and where resources need to be targeted to ensure all groups gain maximum benefit from any changes proposed as part of the STP.'*

### Approach to the NEL STP equality screening

An initial equality screening conversation between NEL CSU and the NEL STP Team to discuss the intended equality impacts of the proposals, agreed that:

- An overview of all the initiatives included in the NEL STP narrative was needed to determine at which level equality analyses should be undertaken i.e. NEL STP level, Local Area Level, CCG/borough level or London-wide level.

- As this is an umbrella plan and many of the initiatives are being developed and delivered at a local area or borough level, this equality screening will focus on those initiatives, which will be delivered at NEL STP level.

- In recognition that the initiatives will be implemented at different times, further equality analyses will need to be undertaken over the life of the STP programme.

The STP team is leading on the overview equality screening of the STP programme and providing the oversight for the NEL-wide initiatives. Each NEL wide initiative will have an identified lead who will:

- Work to the principles in the NEL STP Communications and Engagement Plan to ensure that direct engagement with the communities most affected by the proposals
- Be responsible for ensuring that the equality screening is carried out
- Consider any HR implications for staff arising from the STP proposals
- Ensure that any identified actions resulting from the equality analysis are implemented

Equality screenings of borough and local level initiatives are being led by the relevant local programme leads.

This document includes:

- An equality screening of the projects included in the STP (see Appendix 3).
- An governance assessment of all the initiatives included in the NEL STP that seeks to determine at which level equality screening should be undertaken i.e. NEL STP level, Local Area Level, CCG/borough level or London-wide level and their progress to date (see Appendix 4) and the potential timescales.

Between November 2016 and March 2017 equality screenings for the NEL-wide initiatives below will be completed:

*(Please note these are works in progress so the dates are subject to change.)*

## Section 3: Conclusion

**Comments or recommendations**

The scale and scope of the STP programme means that there is the potential for many equalities impacts, relevant to all groups sharing protected characteristics, and/or people living in deprivation. Some of these will relate to small numbers of patients/people with multiple, complex needs and communities. Where relevant, the STP programme will need to ensure that these are considered in a proportionate and timely manner to inform service design.

It is likely that the most significant impacts, and the highest equalities risks, will relate to those living in the more deprived areas of NEL. It is particularly important that the STP programme ensures a high level of involvement by representatives of these communities in planning and decision-making. The STP programme will need to consider how to engage with:

- people who are not in touch with patient representatives and community groups or organisations but who will nevertheless be impacted by potential changes to services arising from the programme
- discrete groups and communities within each NEL borough most affected by the proposals

The equality screening in Appendix 3 and the governance chart in Appendix 4 will be used to identify where more work needs to take place and where resources need to be targeted to ensure all protected groups gain maximum benefit from the improvements.

## Actions

| Actions | Lead(s) | Timescale |
|---|---|---|
| 1. Equality analysis leads to be identified for each NEL-wide initiative | STP Executive Lead | End of Nov |
| 2. Carry out equality analyses for each NEL-wide initiative including:<br>• working with Directors of Public Health to undertake further population needs analysis when required<br>• taking account of equality analyses already undertaken on local transformation programmes<br>• recognising that some initiatives will require separate HR analyses | Equality leads for each initiative | Dec 2016 onwards |
| 3. Consider how to incorporate equalities monitoring into service specifications to improve knowledge about those using services e.g. requiring providers to develop collection and recording of patient and client personal data as part of patient care plans and records | SROs for each workstream | Dec 2016 onwards |
| 4. Ensure that key dependencies across each workstream are addressed e.g. are children and young people's issues addressed within acute care and specialist commissioning | STP Programme Director | Dec 2016 onwards |
| 5. Jointly with NEL boroughs, map each borough's engagement structures and work with the relevant groups to carry out direct engagement with the communities most affected by the proposals | STP Director of Comms | Dec 2016 onwards |
| 6. Undertake detailed planning across all workstreams on the training requirements for various staff groups to support them in meeting the needs of patients, residents and staff in groups with protected characteristics | SROs for each workstream | Dec 2016 onwards |

## Final outcomes

This equality screening has concluded that the overarching framework proposed by the NEL STP programme will have a positive effect on the residents of north east London. The overview screening shows that some STP initiatives will continue as planned whilst others will need further analysis to ensure that the proposals better advance equality.

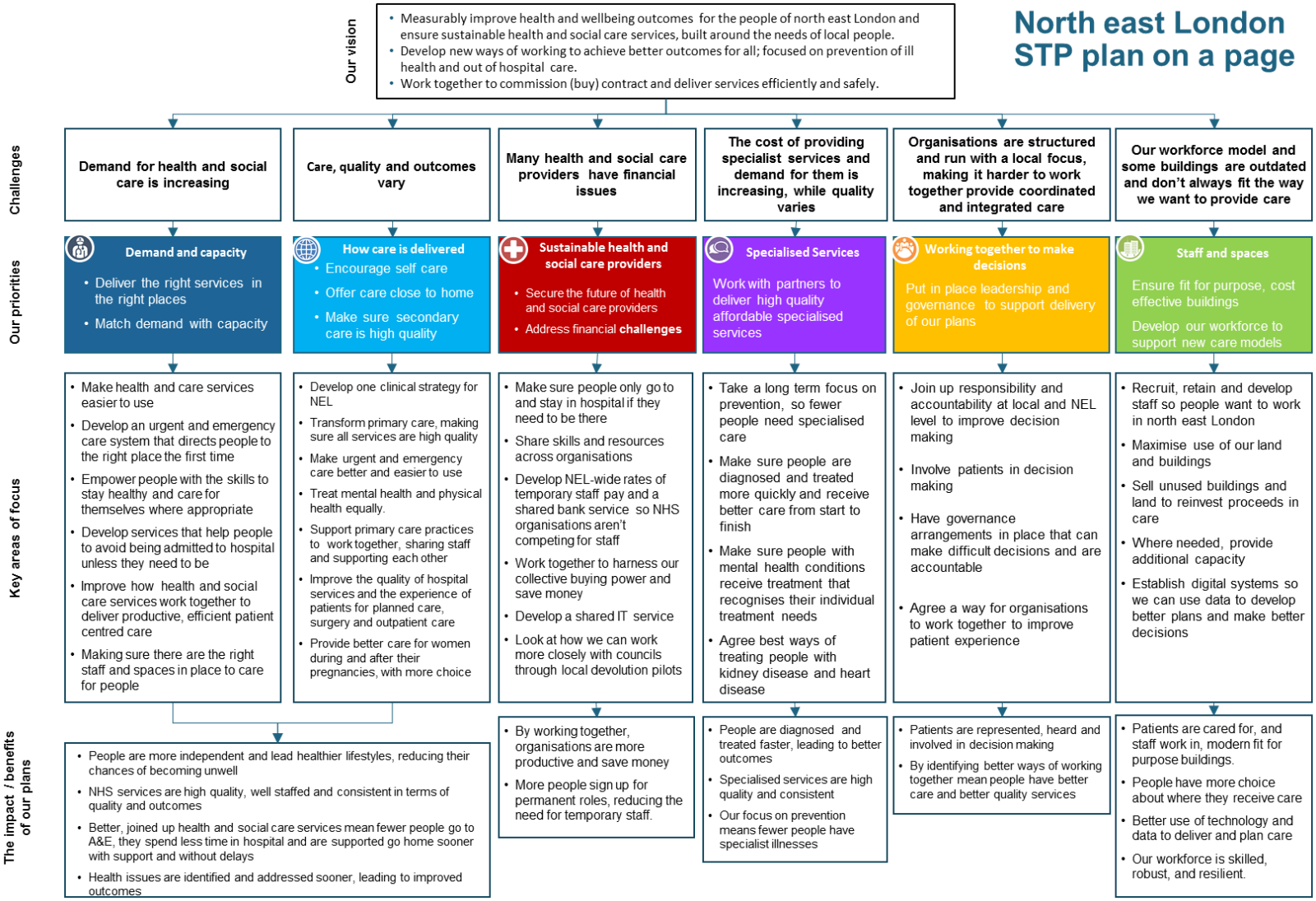
a) Continue with the policy as it is X
b) Continue with the policy with adjustment or further analysis X
c) Stop/remove the policy

## Signature of the Senior Responsible Officer

## Date and date of next review

Date: 20 December 2016
Date of next review: During the life of the STP programme (2016-2021) detailed equality analyses will be completed for NEL-wide STP initiatives. Indicative dates for each are shown in Appendix 4.

# Appendix 1: NEL STP Plan on a page



## Appendix 2: NEL STP Engagement activities June – November 2016

- Published the draft and summary versions of the plan on our website and published regular updates
- Offered to meet all MPs which has resulted in a number of 1:1 meetings
- Arranged for elected members from each borough to meet the STP Executive
- Actively sought involvement of the eight Local Authorities facilitated through the Local Authority representative on the STP Board.
- Local Authorities are represented on the Governance Working Group and have taken part in the workshops developing the plans for transformation (with a Director of Public Health leading the work on prevention).
- Engaged the Local Government Association (LGA) to provide support to individual HWBs to explore self-assessment for readiness for the journey of integration and to a NEL-wide strategic leadership workshop to consolidate outputs from individual HWB workshops.
- Engaged with council and partner stakeholders such as the Inner North East London and Outer North East London Health Scrutiny Committees (HSC); Barking, Havering and Dagenham Democratic and Clinical Oversight Group; the eight Health and Wellbeing Boards; Hackney and Tower Hamlets councillors; and Newham Mayor's advisor for Adults and Health
- Met with local Save our NHS and Keep our NHS Public campaign groups
- Presented at meetings to discuss specific clinical aspects of the STP, for instance the NEL Clinical Senate; the NEL maternity network and maternity commissioners' alliance; mental health strategy meetings; and clinical workshops on the specialist commissioning of cardiac services and children's services. The proposals have also been discussed at a number of Local Medical Committee forums.
- Discussed the plans with staff.
- Discussed the plans in open board meetings of all our NHS partners and offered opportunities to talk to patients and the public at various annual general meetings and patient group meetings.
- Held wider events on specific topics and developments, e.g. urgent care events involving patients and a wide range of stakeholder such as the London Ambulance Services and community pharmacists.

## Appendix 3: Equality screening for the NEL STP

**Screening for overarching NEL-wide framework**
Our framework for better care and wellbeing is built around our commitment to person-centred, place-based care for the population of NEL.

This screening focuses on the three outward facing delivery plans covering prevention, promoting independence and care close to home, and quality acute services.

The remaining delivery plans: 4 – provider productivity; 5 – estates infrastructure; 6 – specialised commissioning; 7 – workforce and 8 – digital enablement will also affect protected groups, but through the first three delivery plans.

**Delivery Plan 1:** Promote prevention and personal and psychological wellbeing in all we do

A proactive approach to disease prevention within all that we do, addressing unhealthy behaviours that may lead to serious conditions further down the line and thus reducing the burden on the healthcare system. We will take action to motivate people to take ownership of their own health and encourage healthy environments to enhance the quality of life for our population. Initiatives aim to reduce smoking and diabetes and to improve workplace healthiness.



| Protected groups | Impact (high, medium, low, none) | Nature of potential impact (positive/negative/ unknown) | Evidence of impact (describe how the policy will impact on each protected group) | Recommendations/mitigating actions (actions to be taken to tackle inequality and advance equality of opportunity) |
|---|---|---|---|---|
| Age | High | Overall positive | • Promoting prevention and improving wellbeing will help people of all ages.<br>• Older people in general experience greater health problems than the rest of the population and are more likely to develop long-term conditions which can be alleviated by changes in lifestyle.<br>• Children will benefit from initiatives to reduce excessive weight.<br>• Some initiatives are likely to be of less benefit to older people (e.g. online prevention schemes) | • Target prevention programmes at those most in need including older people including to address diabetes, heart disease and respiratory difficulties.<br>• Workplace initiatives are less likely to improve the health of older people and children so it is important to ensure other schemes do focus on these age groups. However NHS workplace initiatives aim to reduce staff turnover, stress etc – thereby improving the quality of care overall.<br>• Services provided on new media (e.g. online smoking cessation) should be additional to existing services in order to preserve choice until it is clear that traditional services are no longer needed. |

| Protected groups | Impact (high, medium, low, none) | Nature of potential impact (positive/negative/ unknown) | Evidence of impact (describe how the policy will impact on each protected group) | Recommendations/mitigating actions (actions to be taken to tackle inequality and advance equality of opportunity) |
|---|---|---|---|---|
| Disability | Medium | Overall positive | • Promoting prevention and improving wellbeing will help people of all disabilities.<br>• Workplace initiatives are less likely to improve the health of disabled people (who are more likely to be out of work).<br>• Online services are likely to be beneficial to some people with physical/mobility difficulties<br>• Cross-device services e.g. on apps could enable services to be better presented to people with learning disabilities<br>• Targeting illnesses such as diabetes and smoking will reduce future disability. | • Workplace initiatives are less likely to improve the health of disabled people so it is important to ensure other schemes do focus on this group. However NHS workplace initiatives aim to reduce staff turnover, stress etc – thereby improving the quality of care overall.<br>• When developing services, we need to seek to consider how to take advantage of cross-device (computers/mobiles) opportunities to reach the widest audience. |
| Gender reassignment | Medium | Overall positive/to be checked | • Likely to be affected the same as the general population. | • Need to check this assessment is correct. |
| Marriage and civil partnership | Medium | Overall positive/to be checked | • Likely to be affected the same as the general population.<br>• Those in a marriage or partnership may have more support than single people (to travel, for encouragement etc). | • Need to check this assessment is correct. |
| Pregnancy and maternity | Medium | Overall positive/to be checked | • Likely to be affected the same as the rest of the population. | • Need to check this assessment is correct. |
| Race | High | Positive | • Promoting prevention and improving wellbeing will help people of all races.<br>• Some ethnic groups tend to have poorer general health outcomes than others and higher rates of illness (e.g. diabetes) so these proposals will have the potential to have greater positive effect.<br>• For those who do not speak fluent English, who are accustomed to accessing services they need in a familiar location and way, they may experience some difficulties. | • Ensure prevention programmes are relevant and particularly targeted to local black and ethnic group communities.<br>• Need to build on existing good practice working with local community groups and interpreters where necessary and seek to recruit a workforce that reflects the community. |
| Religion or | Medium | Overall | • Likely to be affected the same as the rest of the | • Need to check this assessment is correct. |

| Protected groups | Impact (high, medium, low, none) | Nature of potential impact (positive/negative/ unknown) | Evidence of impact (describe how the policy will impact on each protected group) | Recommendations/mitigating actions (actions to be taken to tackle inequality and advance equality of opportunity) |
|---|---|---|---|---|
| belief | | positive/to be checked | population | |
| Sex | Medium | Overall positive/to be checked | • Initiatives that prevent suicide and encourage better self-care/seeking early advice etc are more likely to benefit men. | • Need to check this assessment is correct. |
| Sexual orientation | Medium | Overall positive/to be checked | • Initiatives that prevent suicides will have a greater positive effect on the lesbian, gay, bisexual and trans (LGBT) community. | • Need to check this assessment is correct. |
| Socio-economic groups and other vulnerable groups | High | Positive if the group is targeted | • People in lower socio-economic groups, homeless people and people unregistered with a GP are more likely to be benefit from prevention activities, however it is likely that they will not be able to afford to live healthily as easily as those with higher incomes and they may not be included in activities unless efforts are made to particularly target them in initiatives.<br>• Workplace initiatives are less likely to benefit those in lower socio-economic groups (although they should benefit from improved care). | • Ensure prevention programmes are relevant and targeted to people in lower socio-economic groups, homeless people and those not registered with a GP. |

**Delivery Plan 2:** Promote independence and enable access to care close to home

Locally designed, integrated models of care in place across north east London, that wrap around the individual, supporting them to manage their own care and to access services that are delivered close to home.

| Protected groups | Impact (high, medium, low, none) | Nature of potential impact (positive/negative/ unknown) | Evidence of impact (describe how the policy will impact on each protected group) | Recommendations/mitigating actions (actions to be taken to tackle inequality and advance equality of opportunity) |
|---|---|---|---|---|
| Age | Medium | Positive | • Older people tend to need to rely more on public transport. Enabling older people to receive more care locally (from hospital to the community or repatriated from out of area to a local hospital) will make access to health services easier for them and their carers.<br>• Younger people are more likely to be able to take advantage of online/mobile/digital opportunities for care and advice.<br>• Reducing the proportion of hospital beds to the population may mean that some people (mainly elderly) may be discharged into the community without appropriate family support or social/health care. | • Develop transport solutions in partnership with e.g. TfL, to ensure there is adequate transport to enable people to easily receive care close to home.<br>• When developing services, we need to seek to consider how to take advantage of cross-device (computers/mobiles) opportunities to reach the widest audience.<br>• Ensure social and health care is developed alongside hospital bed changes.<br>• Ensure programmes are relevant and targeted at this group. |
| Disability | Medium | Positive | • Disabled people tend to need to rely more on public transport. Enabling disabled people to receive more care locally (from hospital to the community or repatriated from out of area to a local hospital) will make access to health services easier for them and their carers.<br>• Improving services for people with a learning disability will reduce the equality gap for this group of people. Reducing the number of learning disability beds (in order to care for people in the community) should improve care and should repatriate some people from outside the area, but has a risk attached if services in the community are not well developed. | • Develop transport solutions in partnership with e.g. TfL, to ensure there is adequate transport to enable people to easily receive care close to home.<br>• Ensure community services are developed in advance or in conjunction with any proposed reduction in learning disability beds.<br>• Ensure programmes are relevant and targeted at this group. |
| Gender reassignment | Medium | Positive/to be checked | • Likely to be affected the same as the rest of the population | • Need to check this assessment is correct. |
| Marriage and civil partnership | Medium | Positive/to be checked | • Likely to be affected the same as the rest of the population | • Need to check this assessment is correct. |

| Protected groups | Impact (high, medium, low, none) | Nature of potential impact (positive/negative/ unknown) | Evidence of impact (describe how the policy will impact on each protected group) | Recommendations/mitigating actions (actions to be taken to tackle inequality and advance equality of opportunity) |
|---|---|---|---|---|
| Pregnancy and maternity | Medium | Positive/to be checked | • Likely to be affected the same as the rest of the population | • Need to check this assessment is correct. |
| Race | High | Positive | • Due to the increased incidence of mental health problems in some ethnic groups, improving mental health services will have a particularly beneficial effect on this group.<br>• Black and minority ethnic groups tend to need to rely more on public transport. Enabling these groups to receive more care locally (from hospital to the community or repatriated from out of area to a local hospital) will make access to health services easier for them and their carers.<br>• For those who do not speak fluent English, who are accustomed to accessing services they need in a familiar location and way, they may experience some difficulties. | • Develop transport solutions in partnership with e.g. TfL, to ensure there is adequate transport to enable people to easily receive care close to home.<br>• Ensure programmes are relevant and targeted at this group.<br>• Need to build on existing good practice working with local community groups and interpreters where necessary and seek to recruit a workforce that reflects the community. |
| Religion or belief | Medium | Positive | • Some religions have restrictions on travel (e.g. travel on the Sabbath; women not travelling unaccompanied). Enabling these groups to receive more care in their local community will make access easier. | • Develop transport solutions in partnership with e.g. TfL, to ensure there is adequate transport to enable people to easily receive care close to home.<br>• Ensure programmes are relevant and targeted at this group. |
| Sex | Medium | Positive | • Women tend to need to rely more on public transport[5]. Enabling these groups to receive more care in their local community will make access to health services easier for them and their carers.<br>• Due to the increased incidence of mental health problems in men, improving mental health services will have a particularly beneficial effect on this group. | • Develop transport solutions in partnership with e.g. TfL, to ensure there is adequate transport to enable people to easily receive care close to home.<br>• Ensure programmes are relevant and targeted at this group. |
| Sexual orientation | Medium | Positive | • Due to the increased incidence of mental health problems in some LGBT groups, improving mental | • Ensure programmes are relevant and targeted at this group |

[5] http://content.tfl.gov.uk/women.pdf (2012); https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/457752/nts2014-01.pdf (2015)

| Protected groups | Impact (high, medium, low, none) | Nature of potential impact (positive/negative/ unknown) | Evidence of impact (describe how the policy will impact on each protected group) | Recommendations/mitigating actions (actions to be taken to tackle inequality and advance equality of opportunity) |
|---|---|---|---|---|
| | | | health services will have a particularly beneficial effect on this group. | |
| Socio-economic and other vulnerable groups | Medium | Positive if the group is targeted | • Lower socio-economic groups tend to need to rely more on public transport. Enabling these groups to receive more care locally (from hospital to the community or repatriated from out of area to a local hospital) will make access to health services easier for them and their carers. | • Acute attendance does not rely on registration so there will be a failsafe.<br>• Ensure programmes are relevant and targeted at this group.<br>• Develop transport solutions in partnership with e.g. TfL, to ensure there is adequate transport to enable people to easily receive care close to home. |

**Delivery Plan 3:** Ensure accessible quality acute services

When people fall seriously ill or need emergency care, local hospitals provide strong, safe, high-quality and sustainable services

| Protected groups | Impact (high, medium, low, none) | Nature of potential impact (positive/negative/ unknown) | Evidence of impact (describe how the policy will impact on each protected group) | Recommendations/mitigating actions (actions to be taken to tackle inequality and advance equality of opportunity) |
|---|---|---|---|---|
| Age | Medium | Positive if mitigations are put in place | • As high users of acute services, older and younger people will benefit from higher quality local acute services, improved referral times, and reduced avoidable admissions.<br>• Moving surgical services (e.g. surgical hubs) could affect transport arrangements for this group although repatriating surgery from outside of area could benefit patients.<br>• There is a risk that some people will be discharged from hospital without the necessary support at home.<br>• Cancer survivorship is a key strand of the cancer strategy and will impact more on older people. | • Develop transport solutions in partnership with e.g. TfL<br>• Ensure pre and post-operative requirements are met at the hospital or community service closest to home.<br>• Ensure strong links between health and social care services. |
| Disability | Medium | Positive if mitigations are put in place | • As higher users of acute services, disabled people will benefit from higher quality local acute services, improved referral times, reduced avoidable admissions.<br>• Moving surgical services (e.g. surgical hubs) could affect transport arrangements for this group although repatriating surgery from outside of area could benefit patients.<br>• There is a risk that some people will be discharged from hospital without the necessary support at home. | • Develop transport solutions in partnership with e.g. TfL<br>• Ensure pre and post-operative requirements are met at the hospital or community service closest to home.<br>• Ensure strong links between health and social care services. |
| Gender reassignment | Low | Positive/neutral | • Likely to be affected the same as the rest of the population | • Need to check this assessment is correct |
| Marriage and civil partnership | Low | Positive/neutral | • Likely to be affected the same as the rest of the population | |
| Pregnancy and maternity | High | Positive | • Developing continuity of care with one midwife will bring benefits to the vast majority of women, but there may be times when a relationship does not flourish at a time when women are vulnerable and needing support. | • Need to put in place ways in which mothers can raise any concerns regarding their midwife in a sensitive way.<br>• Identify whether midwifery-led care satisfactorily meets the needs of mothers |

| | | | | |
|---|---|---|---|---|
| | | | • Some mothers may not have the home conditions to be able to give birth at home.<br>• A specific target of the STP is to reduce inequalities by improving outcomes, continuity of care and women's experience for all. The focus on outcomes includes a review for vulnerable women and measures to address concerns. | wanting a more natural birth. |
| Race | Low | Positive/neutral | • For those who do not speak fluent English, who are accustomed to accessing services they need in a familiar location and way, they may experience some difficulties. | • Need to build on existing good practice working with local community groups and interpreters where necessary and seek to recruit a workforce that reflects the community. |
| Religion or belief | Low | Positive/neutral | • Likely to be affected the same as the rest of the population | |
| Sex | Low | Positive/neutral | • Likely to be affected the same as the rest of the population | |
| Sexual orientation | Low | Positive/neutral | • Likely to be affected the same as the rest of the population | |
| Socio-economic groups | Low | Positive | • Screening programmes, early diagnosis of diseases etc will be more problematic for homeless people, people not registered with a GP etc. | • Acute attendance does not rely on registration so there will be a failsafe. Therefore encourage local uptake of national screening programmes through hospitals. |

## Appendix 4: Governance assessment

This document sets out the various proposals in the NEL STP and considers whether equality screenings / impact assessments have already been conducted, or where and when they might be best carried out.

In general we have categorised the levels as:

- Borough – one CCG
- Local area level – two or more boroughs and CCGs working together
- North East London (NEL) level – assessment most appropriately carried out across all seven CCGs.
- London-wide level

*(Please note these are works in progress so the proposals and dates are subject to change.)*

| Overarching | Level | Comment | Timescale |
|---|---|---|---|
| Our framework for better care and wellbeing | NEL level | Plan in development | 2016/2017 |
| Developing Accountable Care Systems (ACS) in NEL | Local Area level | Barking and Dagenham, Havering, and Redbridge (BHR) ACS | To be assessed as part of pilot |
| | | Waltham Forest, Newham and Tower Hamlets (WEL – Waltham Forest and East London) and the Transforming Services Together (TST) programme - Screenings carried out for each element of work, except Mile End and Whipps Cross hospitals and shared care records, which will be undertaken once details are more fully developed. | http://www.transformingservices.org.uk/equality-impact-assessment-screening.htm |
| | | City and Hackney (C&H) | To be assessed as part of pilot |

| Delivery Plan | Workstream/priority | Level | Comment | Timescale |
|---|---|---|---|---|
| **1. Promote prevention and personal and psychological wellbeing in all we do** | Environment, leisure and physical environment | Borough | Included in borough level:<br>• Health and wellbeing strategies<br>• Local Plans (covering planning requirements)<br>• Regeneration plans<br>• Housing strategies<br>• Children and young people's plans | Ongoing in each borough |
| | Employment | Borough | | |
| | Early years, schools and healthy families | Borough | | |
| | Housing and planning | Borough | | |
| | Healthy living and smoking cessation | Borough | Included in borough health and wellbeing strategies | Ongoing in each borough |
| | Diabetes | Borough/Local Area level | Established programme in WEL and City and Hackney. | Equality analyses will take place in BHR as and when the programme starts. |
| **2. Promote independence and enable access to care close to home** | Integrated health and social care | Borough | To be determined locally. May be included in Better Care Fund (BCF) planning. | Ongoing work in each borough/local area |
| | Integrated children's and young people's care | Borough | Ongoing work subject to existing local arrangements between CCGs and Local Authorities | Ongoing work in each borough/local area |
| | Community based end of life care | Borough | Ongoing work subject to existing local arrangements between CCGs and Local Authorities. A high level screening was produced to support the TST Strategic Investment Case. | Ongoing work in each borough/local area |
| | Enhanced primary care | Borough or local area level | The local delivery plans for implementing the Strategic Commissioning Framework will need to be assessed locally. A high level screening was produced to support the TST Strategic Investment Case. | Ongoing work in each borough/local area |
| | Transforming sexual health services | London / local area level | This is being conducted at a London level and also through local programmes in C&H, BD, Havering, and across the Barts footprint (WF, Newham, TH and Redbridge). | To be agreed |

| Delivery Plan | Workstream/priority | Level | Comment | Timescale |
|---|---|---|---|---|
| | Reducing unnecessary diagnostics | Local area level | Elements of planned care transformation are co-ordinated across WEL through TST<br><br>A high level screening was produced to support the TST Strategic Investment Case for Surgical Hubs, Outpatient Pathways and Diagnostics. | http://www.transformingservices.org.uk/equality-impact-assessment-screening.htm |
| | Pathway redesign and best-in-class clinical productivity, especially in outpatient care | Local area level | | |
| | High quality integrated mental health care and support | NEL and borough | Plans in development | Will require EA during 2017-18. |
| | Integrated urgent and emergency care (including London Ambulance Service) | NEL and borough | Overview screening to be conducted through the NEL Urgent and Emergency Care (UEC) network but local areas will also need to conduct EAs as local plans come online. | Ongoing |
| | Ambulatory (outpatient) Care | NEL and borough | Plans still in development. A high level screening was produced to support the TST Strategic Investment Case. | Likely to require EA during 2017-18. |
| | Local programmes for learning disabilities | Local area level (Inner North East London (INEL) and BHR) | Each Transforming Care Partnership to conduct an EA when plans are finalised. | To be agreed. |
| **3. Ensure accessible quality acute services** | Maternity | NEL or local area level (BHR, C&H and WEL) | Maternity transformation is currently coordinated across the NEL footprint. A high level screening was produced for WEL - TST maternity and newborn care workstream. | Timescales for meeting the national Better Births outcomes means that an EA is needed for 2017-19. |
| | Improving the treatment of cancer in community and secondary settings | NEL / and/or jointly with NCL for the Vanguard | Cancer transformation is currently coordinated across the NEL footprint.<br>There was an equality impact assessment for the London Specialist Cancer Services Reconfiguration in 2013. A high level screening was produced for WEL - TST surgery workstream which is also relevant. We will also adhere to national guidance, in which equalities have | Timescales for meeting the national mandatory outcomes means that an EA is needed for 2017-19. |

| Delivery Plan | Workstream/priority | Level | Comment | Timescale |
|---|---|---|---|---|
| | | | been considered. | |
| | Planned care strategy including surgery | Local area level currently/ (by Acute Provider across NEL when plans are scoped) | Elements of planned care transformation are co-ordinated across WEL through Transforming Services Together. A high level screening was produced to support the TST Strategic Investment Case for: Surgical Hubs, Outpatient Pathways and Diagnostics. | Discussions underway about wider collaboration across providers, including initially Referral to Treatment, thus no current wider EA requirement. |
| | Medicines optimisation/ management | NEL | Workstreams agreed; opportunities still being scoped. | EA to be carried out during 2017/18 |
| | Safely transitioning patients from King George Hospital's emergency department | NEL and local area level | This is being managed at local level with the STP taking a co-ordinating role and before any implementation there will be further work on safety and equality impact. | An EA was carried out in 2010-11 as part of Health for NEL and will be updated during 2017-18. |
| **4. Productivity** | Bank and Agency and back office (HR) | NEL | Any potential changes to back office HR service arrangements would need to be discussed with staff and would include assessment of equality impacts. This would need to be factored into any options appraisal. | Service modelling likely to be carried out in 2016-17. |
| | | | Changes to bank and agency processes will need to take into consideration what impact this might have on provision of services to patients. | Bank and agency processes are being reviewed in 2016-17 |
| | Back office (finance) | Provider Trust | Any potential changes to back office finance service arrangements would need to be discussed with staff and would include assessment of equality impacts. This would need to be factored into any options appraisal. | Options appraisal is likely to be in 2016-17. |
| | Pathology | Provider Trust | Any potential changes to pathology service arrangements may need to go through a staff and stakeholder engagement process. This would need to be factored into any options appraisal. | Options appraisal is likely to be in 2016-17. |

| Delivery Plan | Workstream/priority | Level | Comment | Timescale |
|---|---|---|---|---|
| | Procurement | NEL / Provider Trust | Any potential changes to procurement service arrangements will need to assess the impact of any changes on staff and patients. | Initial options may be developed in 2016-17 |
| | | | Changes to products / services e.g. medical consumables (i.e. moving to a NEL wide consumables list) will need to be agreed through engagement with clinical staff and potentially patient groups to ensure that there is no negative impact on specific patient groups. | Review of medical consumables will begin in 2016-17 but will most likely be an ongoing process. |
| | IT (back office) | NEL / (borough and Trust) | Any potential changes to IT service arrangements will need to go through a staff engagement process. This would need to be factored into any options appraisal. | Initial options appraisal is likely to be in 2016-17. |
| **5. Infrastructure** | NEL Estates strategy | NEL, Local Area and borough | Ongoing work subject to further development of governance arrangements, respecting the principles of subsidiarity agreed within the STP, and taking account of the governance arrangements for providers, commissioners and local authorities.<br><br>The *local* implementation plans for Strategic Estates Plan (SEP) will be assessed/ managed at CCG level | May require an EA during 2017-18. |
| | Utilisation and productivity | NEL, Local Area and borough | Being conducted at NEL level and in local programmes at TST, BHR and borough level<br><br>Discussions need to explore wider collaboration across commissioners, providers and property owners on reviewing the utilisation through joint working at NEL level | May require an EA during 2017-19. |
| | Disposals | NEL, Local Area and borough | This is being conducted at a NEL level and also at TST, BHR and borough level.<br><br>Further discussion will be held on reducing the amount of unoccupied land in NEL. | May require an EA during 2017-19. |
| | Additional capacity | NEL, Local Area and borough | Demand modelling being conducted at a NEL level and by local programmes in TST. | May require an EA during 2017-18. |

| Delivery Plan | Workstream/priority | Level | Comment | Timescale |
|---|---|---|---|---|
| | | | Use demand and capacity modelling to develop estimates for future infrastructure requirements including acute and maternity capacity to accommodate population increase. | |
| | Assurance | NEL | External assurance for investment and savings assumptions to be determined at NEL level. | May require an EA during 2017-19. |
| **6. Specialised commissioning** | Renal dialysis | London, NEL, provider and/or borough | Pilot models in place in Tower Hamlets, and City and Hackney. Newham and Waltham Forest due to roll out by end of 2016. STP objective is to roll out similar model across BHR CCGs during 2017-2019. | Plans and business case approval to be completed in 2017. EA due in 2017/18 |
| | Cardiology (AF and HF) | London, NEL / provider | Plans being developed for how to adapt the pathway | EA due in 2017/18. |
| | Additional pathway transformation | London, NEL, provider and/or borough | Other pathway transformation opportunities not yet developed. Pathways to include cancer, mental health, neuro rehab, neonates and specialist paeds. | EA for various pathway developments due in 2017-2019. |
| **7. Workforce** | Staff recruitment and retention | NEL Level | This programme comprises a number of different work streams and is in the early stages of scoping with the focus on looking at evidence. Equality analysis should be done at the stage of proposals being developed | Unknown at this stage. |
| | Workforce for new models of care | NEL Level | Equality analysis would be best undertaken by the individual programme with one of the aspects being workforce. | To be led by each transformation programme |
| **8. Digital enablement** | Shared records | NEL and local area level | There are three digital roadmaps covering NEL which are being currently being combined and will be submitted to NHS E in March 2017. The equality screening of the plans for digital enablement is being undertaken as part of this process. | The combined document will be published in 2017 following agreement by NHS E. |
| | Co-ordinated care and care planning | | | |
| | Patient enablement | | | |
| | Advanced system-wide analytics | | | |
| | Digital infrastructure | | | |

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Havering
LONDON BOROUGH

# HEALTH & WELLBEING BOARD

| | |
|---|---|
| **Subject Heading:** | Update on Integrated Care Partnership (previously ACO), locality boundaries and STP |
| **Board Lead:** | Conor Burke / Barbara Nicholls |
| **Report Author and contact details:** | Keith Cheesman, Interim Head of Integration<br>01708 433 742<br>keith.cheesman@havering.gov.uk |

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

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

**SUMMARY**

Following the submission of the Strategic Outline Case in September 2016, work is underway to deliver an Integrated Care Partnership and also to develop 'fast track' localities teams that will design and test a new way to deliver better care and improve the health and wellbeing of our population. It is recognised that the transformation will be very challenging and can only be delivered through strong democratic and clinical leadership to champion and support the changes.

This paper sets out a brief update on progress and particularly the intended configuration of the three localities for Havering.

Also, this paper provides an update on the North East London Sustainability Transformation Plan (NEL STP) and in particular will describe the progress made to date on the governance structure for the Plan.

## RECOMMENDATIONS

Health & Wellbeing Board is asked to note the detail of this report and to agree the defined locality areas.

## REPORT DETAIL

Our health and wellbeing system is facing significant challenges. The existing model of commissioning and providing prevention and care is struggling to meet the current levels of demand as a result of pressure from population growth, rising levels of long term conditions, variable levels of deprivation, and a constrained financial situation. The status quo is therefore simply not an option.

The locality delivery model is a more intelligent way of delivering health and social care, built around a defined population rather than around institutions, with a focus on delivering better outcomes. The model was developed with primary care leaders and partner organisations through a programme of workshops in early in 2016.

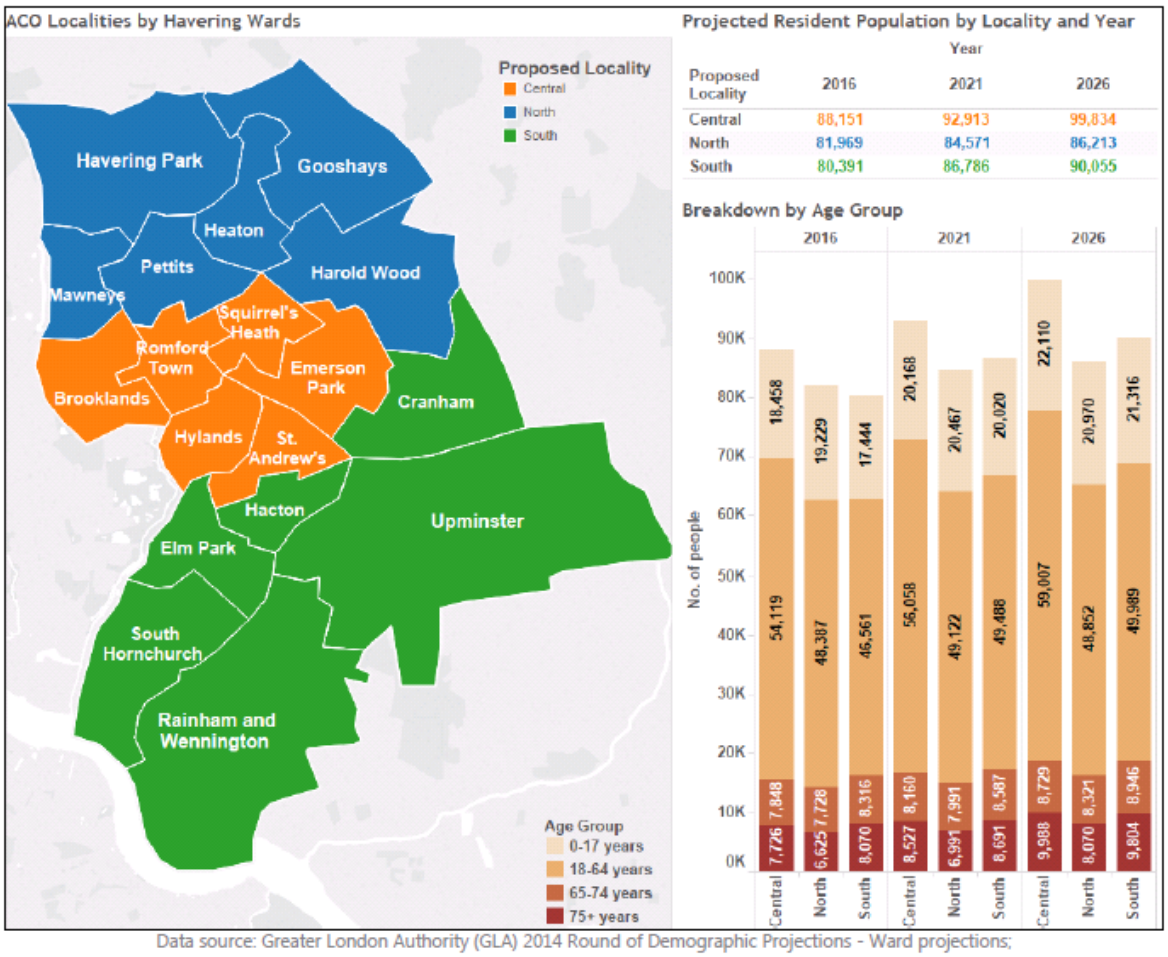
As a result of the Devolution opportunities and development of a Strategic Outline Case (SOC) for Barking Havering and Redbridge we have a much clearer picture of what we can do together to address our challenges.

Research suggests that the best way to meet the needs of our people is through development of a new locality delivery model, which integrates health and wellbeing services for our population, based on place-based care - this builds on local experiences with Health 1000, and international experience with examples such as the Alzira model in Spain. We want to develop local teams empowered to deliver better outcomes for our local population.

Identification of the issues, needs and opportunities was informed by:

- **Public and staff engagement** – involving 8,000 people over the past twelve months who work in health and care, or live, in Barking and Dagenham, Havering and Redbridge.
- **Voluntary sector engagement** - dialogue and workshops, with voluntary sector organisations across Barking and Dagenham, Havering and Redbridge, as well as north east London and national.

The localities model responds to the outputs of this programme of engagement, where health and care staff highlighted the impact that artificial barriers between services can have on the delivery of high quality care, and a number of the population reported feeling confused about the services available to them, which ones were the right ones to access, and how and when they should access them. Detailed work to develop the model is being conducted through the Havering Localities Development Group through a series of workshops and development sessions. The map below shows the Havering localities as currently defined. These have taken into account current population as well as future population growth, and a breakdown of age by locality is also included for information:




Data source: Greater London Authority (GLA) 2014 Round of Demographic Projections - Ward projections; SHLAA-based; short term migration assumption; Capped Household Size model (for projected population data)

**Figure 1:** Proposed Havering Localities, by ward and estimated resident population of all ages, children (aged 0-17 years), adults (aged 18-64 years) and older adults in two bands (aged 65-74 years and 75+ years) and for 2016, in five years (2021) and in ten years (2026)

Initial consideration of the option to create an Accountable Care Organisation concluded that the structural realignment required for a new and separate organisation would add relatively little over and above what could be achieved by closer integration of services, closer commissioning arrangements and the localities model. Therefore, thinking moved towards an Accountable Care System,

where much of the spirit of that original intent is retained but without the additional organisation form. Recognising that the BHR Health and Care system has been working together through the Integrated Care Coalition for some years, the term "Integrated Care Partnership" has been adopted for the group of senior politicians, clinical leaders and senior management of the partner organisations that started meeting as the "Democratic and Clinical Overview Group" at the beginning of 2016 and which steered the development of the SOC.

A sub-group has been formed to consider how joint commissioning arrangements between the CCGs and Local Authorities across the three boroughs can be developed.

**North East London Sustainability Transformation Plan (NEL STP)**
Partners from across North East London are working together to deliver a common plan to drive genuine and sustainable change, putting the patient and their experience at the heart of quality improvement and achieving improved health outcomes in the longer term by developing the STP for north east London. This involves organisations including: 7 CCGs, 8 Local Authorities and 5 NHS Provider organisations. Also involved are GP provider groups, colleagues from NHS England, NHS Improvement, Health Education England and UCL Partners.

The STP is a plan for working together across north east London where it makes sense to do so. A number of local plans are aligned to the STP that help achieve those ambitions including the BHR accountable care plans mentioned above. All 44 STPs nationally have now been published, and you can read the NEL STP, delivery plans for the priority workstreams and a summary on our website

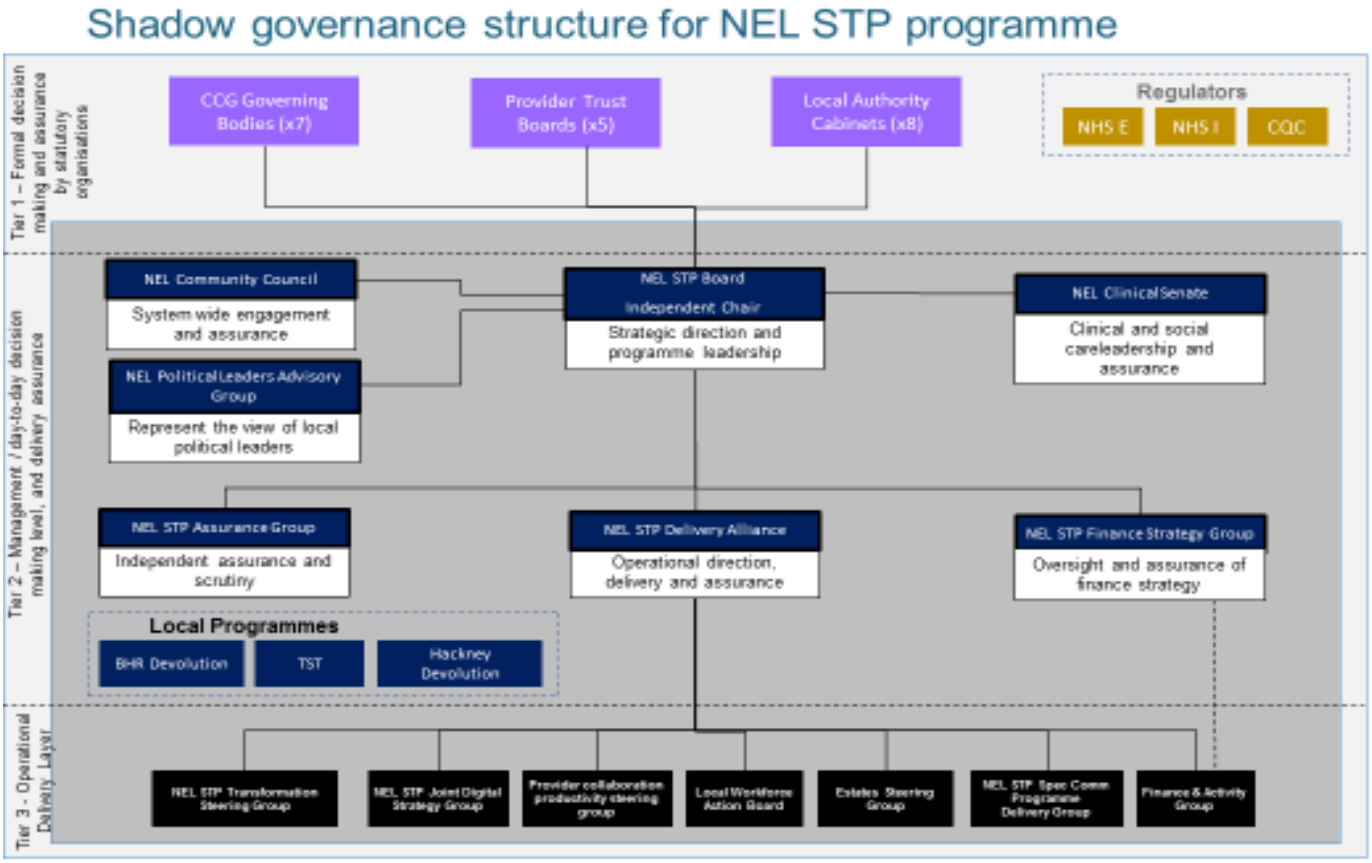
The top three stated ambitions are:
**1. Promoting prevention and self-care** – to reduce the burden on health care services, we want to encourage more people to look after themselves and their health so that they stay well.
**2. Improving primary care** – to meet the rising demand placed on our primary care services, we will transform primary care by working together and using multi-disciplinary teams comprised of community, social care and healthcare professionals.
**3. Reforming hospital services** – most of our hospital care does not currently meet the required standards. We will change this by reforming hospital care through redesigning patient pathways and working together more closely.

The launch of the STP process signalled the move towards working in larger geographical areas and the need to develop governance arrangements to support strategy development and change at a system level. To achieve this, the governance and leadership arrangements are being updated to ensure they continue to remain effective with appropriate membership.

A governance task and finish group (including health organisations, local authorities and Healthwatch) has been set up to review and update the governance arrangements to reflect this change in focus. Through this group a shadow

governance structure has been developed, with initial terms of reference for the key governance forums. This governance structure recognises and respects the statutory organisations, while providing the necessary assurance and oversight for system level delivery. In addition to reinforcing some of the existing governance forums (i.e. re-focusing the membership of the NEL STP Board), several new bodies have been added to strengthen the level of assurance and engagement, most notably:

- Community Council – A council of residents, voluntary sector, councillors and other key stakeholders to promote system wide engagement and assurance
- Assurance Group – An independent group of audit chairs to provide assurance and scrutiny
- Finance Strategy Group -To provide oversight and assurance of the consolidated NEL financial strategy and plans to ensure financial sustainability of the NEL system.




Focus is now on the 2017-19 operational planning and contracting round. These contracts will reflect two-year activity, workforce and performance assumptions that are agreed and affordable and we're working towards the target deadline of having all 2017-19 contracts signed by 23 December 2016.

NEL workstreams are being supported to take forward the transformation of clinical and support services to start to implement the good ideas and solutions in their

delivery plans.

A Memorandum of Understanding has also been developed for the shadow governance arrangements and this is currently with boards of local authorities, NHS Trusts and CCGs for review and sign off. Once this happens the governance arrangements will be tested for a period of six months.

In scope for this MoU are:

- Governance arrangements for the development of the North East London STP
- Governance arrangements for the implementation of the STP schemes defined in the North East London STP
- Alignment with the wider health system plans and governance, including devolution programmes and regional boards
- Development and operation of the governance arrangements for the NEL STP Financial Strategy to achieve the system control total (once agreed)

Out of scope are:

- Local organisational governance arrangements for CCG Governing Bodies, Provider Trust Boards and Local Authorities
- Internal organisational decision making processes
- Local governance arrangements for the delivery of local (non-NEL wide) programmes including the BHR Accountable Care System

The NEL STP system level governance arrangements that support the development and implementation of the NEL STP will require collaboration and active engagement from all system partners to ensure the interests of all organisations are appropriately represented.

A key aspect of this process is the agreement of a common set of principles that will guide the development of the new governance arrangements. The proposed set of principles for the NEL STP system governance, which have been developed collaboratively by the Governance Working Group and endorsed by the STP Board, are outlined as follows:

- **Participation**: Representation and ownership from health and social care organisations, local people and lay members to clearly demonstrate collaborative and representative decision making
- **Collaboration**: All parties will work collaboratively to deliver the overall NEL STP strategy, in the best interests of the wider system and local people
- **Engagement**: Local people will be engaged and involved in the NEL STP governance to ensure their views and feedback are considered in the decision making processes. This engagement should operate at 2 levels; individual level and organisational level (i.e. via patient representative forums and other local community groups)

- **Accountability**: Define clear accountabilities, delegation procedures, voting arrangements and streamlined governance structures to support continuous progress and timely decision making. Delegation of work to the groups with the relevant expertise and authority to deliver it
- **Autonomy**: Recognise the autonomy of the health and social care partners of the NEL STP. Operate in a manner that is compliant with legal duties and responsibilities of each constituent organisation and the NHS as a whole (e.g. legal responsibility for consultation on service changes). Ensure alignment with the local organisations' governance and decision making processes recognising statutory and democratic procedures
- **Subsidiarity**: Ensure subsidiarity so that decisions are taken at the most local level possible, and decisions are only taken at a system level where there is a clear rationale and benefit for doing so
- **Professional Leadership**: Demonstrate strong professional leadership and involvement from clinicians and social care to ensure that decisions have a robust case for change and senior level support
- **Accessibility**: Ensure complete transparency in all decision making to support the development of mutual trust and openness between organisations. Provide the necessary assurance to system partners on key decisions. Collaborative working and information sharing between working groups to ensure consistency.
- **Good Governance**: Recognise that good system level governance will require robust planning and horizon scanning to ensure that proposals are presented to the statutory organisations in a timely way, that align with their local governance and decision making processes. However, where necessary local organisations will try to be flexible to support the system level governance

It is proposed that this Memorandum of Understanding will be superseded by a formal partnership agreement between these organisations, no later than April 2017 when the shadow NEL STP governance arrangements are formalised.

**BACKGROUND PAPERS**

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Havering
LONDON BOROUGH

# HEALTH & WELLBEING BOARD

| | |
|---|---|
| **Subject Heading:** | Open Dialogue |
| **Board Lead:** | Jacqui van Rossum, Executive Director - Integrated Care (London) and Corporate Communications |
| **Report Author and contact details:** | Dr Russell Razzaque , Consultant Psychiatrist, Associate Medical Director |

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

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

**SUMMARY**

Open Dialogue is a model of mental health care pioneered in Finland that has since been taken up in a number of countries around the world, including much of the rest of Scandinavia, Germany and some US states. It involves a holistic, person-centred, social network approach to care, where all staff receive training in family therapy and related psychological skills, and treatment is focused around whole system/network meetings. It is a quite different approach to much of UK service provision, yet it is being discussed with interest by several Trusts around the country. Part of the reason is the striking data from nonrandomised trials so far eg. 72% of those with first episode psychosis treated via an Open Dialogue approach returned to work or study within 2 yrs, despite significantly lower rates of medication and hospitalisation compared to TAU.

Key to the model are the regular network meetings which are the primary forum where decisions are made in a collaborative manner, and staff are specifically trained to utilise these meetings in a way that facilitates improved agency and long term recovery from day one. A further core element of the model (as utilised in a number of services, like New York) involves the inclusion of peer workers within each locality. Peers are seen as experts in their own right, as well as important partners in the process who can work to enhance the social networks around patients, where this is necessary, by cultivating a supportive peer community around them.

By making patients, their families, social networks and fellow peers fundamental to the provision of care - with empowerment & co-production at the heart of the process - service users will feel more comprehensively supported with a significantly better experience of their care. In addition, it may lead to a longer term reduction in chronicity, dependence on services and, therefore, costs.

## REPORT DETAIL

Six NHS Trusts in the UK - North East London (NELFT), North Essex, Nottinghamshire and Kent & Medway, Somerset and Avon & Wiltshire - are setting up pilot Peer-supported Open Dialogue services over the next couple of years. Training for the first wave of teams – 55 staff in total - started in October 2014, and finished in October 2015. A second wave of training for a further 75 staff started in January 2016 and this is due to finish in October of that year. A further wave of training will also take place in 2017, when further Trusts may join, and the course will be offered on an ongoing basis thereafter. It is expected that the pilot teams will be launched in a staggered way in 2017, and it is hoped that outcomes from them will be compared to treatment as usual, as part of a national multi-centre cluster randomised controlled trial, for which a £2.3million grant application has been submitted to the NIHR. The Chief Investigator for the trial is Prof Steve Pilling, and the aim is to deepen the evidence base over time, and thus enable more wide scale take up across NHS services, should the outcome improvement and cost reductions remain consistent. Other members of the research panel include Prof Sonia Johnson, Prof Tom Craig and Prof Sabine Landau.

The training for staff consists of 4 residential one week modules - spread over a year - with some online work in between, making it accessible to Trusts across the country. 12 trainers have been brought in from 5 different countries to provide the training and this includes the international founders of Open Dialogue; Prof Jaakko Seikkula from Jyvaskyla University, Finland & Dr Mary Olsen from the University of Massachusets Medical School. The diploma awarded will be accredited as a Foundation level qualification by the *Association of Family Therapists*.

Each Trust in the project is committed to operationalising the model – with full continuity of care across the care pathway – over time, in the selected areas allocated in the study. An increasing number of other Trusts are now also sending staff on the training and exploring ways of joining the evaluation.

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NELFT NHS
NHS Foundation Trust

# OPEN DIALOGUE in the UK

**Dr Russell Razzaque**

**Consultant Psychiatrist**

***Associate Medical Director***

**North East London NHS Foundation Trust**

NELFT NHS
NHS Foundation Trust

# Family/Network is Key To Better Care & Outcomes

- "*Having friends (& a social network) is associated with more favourable clinical outcomes and a higher quality of life in mental disorders*" (Giacco et al., 2012)
- *"A systematic review of Randomised Controlled Trial (RCT) evidence suggests that family therapy could reduce the probability of hospitalisation by around 20%, and the probability of relapse by around 45%"* (Pharoah 2010)
- *"The estimated mean economic savings to the NHS from family therapy are quite large: £4,202 per individual with schizophrenia over a three-year period"*

NELFT NHS
NHS Foundation Trust

# Family/Network is Key

- **WHO International Pilot Study of Schizophrenia (IPSS), 1967;** ***patients in countries outside Europe and the United States have a lower relapse rate than those seen in developed countries***

- **Ten Country Study (Jablensky et al., 1992). [Data on outcome after 2 years were obtained for 78% (n=1078) of the original sample]** ***The long term outcome for patients diagnosed with broad schizophrenia was more favourable in developing countries than in developed countries***

- **WHO International Study of Schizophrenia (ISoS), 2000 [based on numerous cohorts including the original IPSS and Ten Country Study cohorts]** ***replicated the developed versus developing differential through long term follow up (>13 years follow-up)***





NELFT NHS
NHS Foundation Trust

# Family Work/Therapy & NICE



- **Recommended across the board in a range of guidelines;**
  - Depression
  - Bipolar
  - Schizophrenia (strongly recommended)

- **But how many receive it? (?<10%)**

# *But This Is Lacking In Our Services…*
# 2014 National CQC MH SU Survey*

| Poor network involvement … | |
|---|---|
| "A family member or someone close to me was involved as much as I would like" | 55% |
| … leads to poor collaboration/agreement | |
| "Mental health services understand what is important in my life" | 42% |
| "Mental health services help me with what is important" | 41% |

- *16,400 SU respondents from 51 MH Trusts

NELFT NHS
NHS Foundation Trust

# Open Dialogue…
## *A Relational & Network Based Approach*

- All MDT staff receive rigorous training in family therapy and related social network engagement skills
- This is therefore knitted into the very fabric of care – not an additional intervention offered on the side
- Every crisis is an opportunity to rebuild fragmented social networks (friends & family, even neighbours), by instilling a sense of group agency
- The patient's family, friends and social network are seen as "competent or potentially competent partners in the recovery process [from day one]" (Seikkula & Arnkil 2006)
- There is an emphasis on building deep & authentic therapeutic relationships from the start





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# Outcomes

**2 Year follow up (Open Dialogue Vs Treatment As Usual):**

| | OpD | TAU |
|---|---|---|
| Mild/no symptoms | 82% | 50% |
| NO Relapse | **74% returned to work or study** | **(7% in the UK)** |
| DLA | 23% | 57% |
| Neuroleptic usage | 35% | 100% |
| Hospitalisation | < 19 days | ++ |



**In a subsequent 5 year follow up, 86% had returned to work or full time study**

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# Global Take Up

- **First Wave:**

**Finland, Norway, Lithuania and Sweden**



- **Recent Years:**

**Germany, Poland, New York ($150m invested in Manhatten by 2016), Massachusetts, Vermont, Georgia (U.S.)**

**…training evolving and improving, becoming more accessible and focused.**

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# Open Dialogue…
# *A Different Approach*

## Core principles…

- **The provision of immediate help** – first meeting arranged within 24 hours of contact made.

- **A social network perspective** – patients, their families, carers & other members of the social network are always invited to the meetings

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# Open Dialogue…
# *A Different Approach*



- **Psychological continuity:** The same team is responsible for treatment – engaging with the same social network – for the entirety of the treatment process

- With this as the backbone of treatment, hospitalisation is resorted far less often

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# Open Dialogue…
# *A Different Approach*

- **Dialogism**; promoting dialogue is primary and, indeed, the focus of treatment. "the dialogical conversation is seen as a forum where families and patients have the opportunity to increase their sense of agency in their own lives."

- This represents a fundamental culture change in the way we talk *to and about* patients. All staff are trained in a range of psychological skills, with elements of social network, systemic and family therapy at its core

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# Open Dialogue…
# *A Different Approach*



- **Social network meetings occur regularly – daily if necessary – for the first 2 weeks**

- **A sense of safety is cultivated through the meetings – both their frequency and their nature**

- **Tolerance of uncertainty: "An active attitude among the therapists to live together with the network, aiming at a joint process… so as to avoid premature conclusions or decisions"**

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# Open Dialogue…
# *A Different Approach*

- **Flexibility & Mobility**: "Using the therapeutic methods that best suit the case"

- Rapid response where physical safety threatened, otherwise, leaving models at the door (biological, CBT etc.) and using whatever works/arises in the moment through a dialogical process

- Minimum 3 meetings before new medication prescribed.

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# Open Dialogue…
# *Making a Mindful Connection*



- **Being In The Present Moment:** ***"Therapists… main focus is on how to respond to clients' utterances from one moment to the next"*** **(not using a "pre-planned map")**

- ***"Team members are acutely aware of their own emotions resonating with experiences of emotion in the room."***

- ***Mindfulness*** ***is a major aspect of training (studies show how it improves therapeutic relationships)***

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# Peer-supported Open Dialogue (POD)

- **Their experience is itself recognised as a form of expertise for the team**

- **They affect the culture of the team – keeping the hierarchy flattened and the combatting "them and us" mentality**

- **They help cultivate local peer communities – of value especially where social networks are limited or lacking**

# UK Multi-centre POD RCT

**Training**

- A % of one team (EIP or CRT) for 1 year from 6 Trusts
- North East London, Nottinghamshire, North Essex, Kent, Avon & Wiltshire, Somerset
- Strong support from medical and service directors in each area
- Training organized by N.E. London NHS Foundation Trust
- Delivered by 12 trainers from 5 different countries – inc. Mary, Jaakko, Mia, Kari
- Diploma to be accredited by AFT
- First wave of 50 students completed in 2015
- Second wave training starts in Jan 2016 (70 more with 10% peer workers)

# UK Multi-centre POD RCT

**Trial**

- Led by Prof Steve Pilling with robust panel from Kings, UCL & Middlesex Uni.
- Program grant submitted to NIHR for £2.4 million
- If successful, launch teams throughout 2017 and evaluate from end of 2017
- Recruit for 1 year and follow up for 2 years
- Compare to TAU re relapse + hospitalization, agency, social network size & depth, medication use, recovery/functional outcomes and wider service use

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# Initial Feedback/Response

- **SU feedback:**
  - “I feel very safe in these meetings”
  - “I have never been able to share like this, with anyone in all the years I have had mental healthcare”,
  - “I wouldn’t have been in services for 20 years if I had this”
  - “I wish I had this before – it would have changed my life.”
  - “I never want any other kind of care again”
  - “how can I help promote this so that everyone is treated this way?”,
- **Staff Moral:**
  - “This is the most important training I’ve had in my career”
  - “I want to work in this way full time now”





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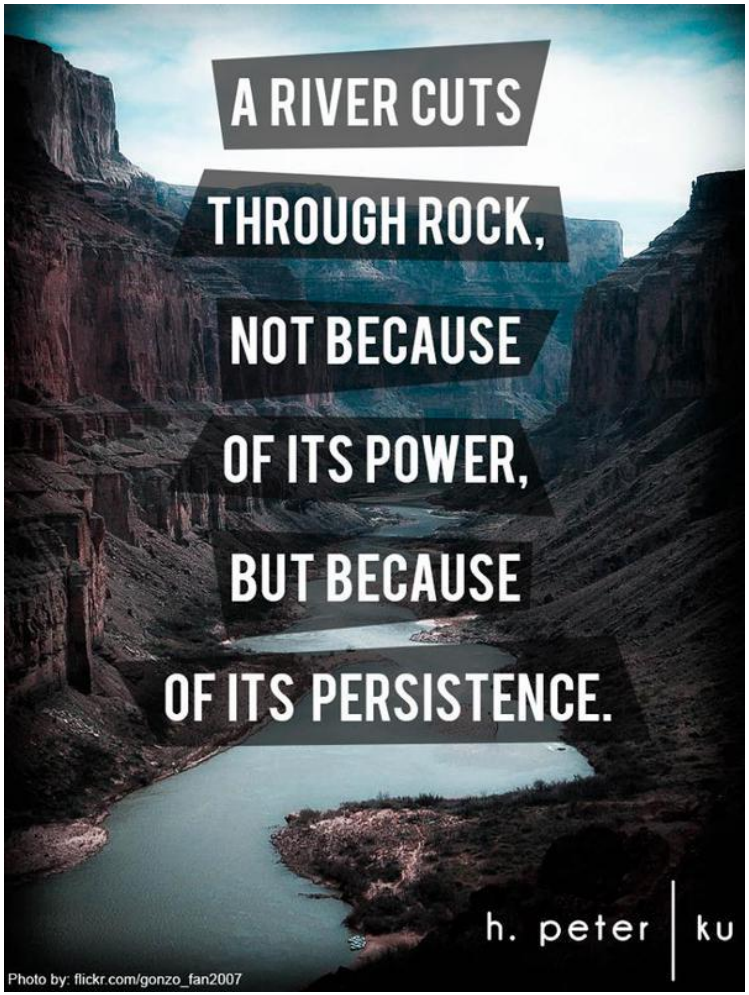
# April 2016 National Conference

# Challenges Ahead

- **Developing operational policies**
  - Creating a separate recovery POD team
  - With own culture & non-hierarchical way of working
  - Regular supervision to maintain practice and self work
  - Maintaining continuity of care across HTT and Recovery Team

- **i.e. can we be true to OD principles, and also deliver on a large scale?**

- **Can we also measure everything that happens/makes a difference?**


A RIVER CUTS
THROUGH ROCK,
NOT BECAUSE
OF ITS POWER,
BUT BECAUSE
OF ITS PERSISTENCE.
h. peter | ku
Photo by: flickr.com/gonzo_fan2007

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# THANK YOU

*Russell.Razzaque@nelft.nhs.uk*

***For regular updates on the POD project, please go to:***

**www.podbulletin.com**

Havering
LONDON BOROUGH

# HEALTH & WELLBEING BOARD

| | |
|---|---|
| **Subject Heading:** | Update on Sexual Health services |
| **Board Lead:** | Sue Milner, Director of Public Health |
| **Report Author and contact details:** | Mark Ansell, Consultant in Public Health, Mark.ansell@havering.gov.uk ; 01708 431818 |

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

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

## SUMMARY

The paper provides the Health and Wellbeing Board with an annual update regarding: -

- The sexual health of people in Havering – in most respects, it remains similar to if not slightly better than the national and London average, with the notable exception of abortion rates which remain high. The diagnosed prevalence of HIV in Havering remains below the national average but has for the first time increased above the threshold used to identify 'high prevalence' areas.
- Local specialist sexual health services – the redesign discussed at Health & Wellbeing Board last year has just gone live; further changes are in-train e.g. an e-service allowing residents to request home self-sampling tests; ahead of an open procurement exercise with LB Barking and Dagenham and LB Redbridge to award a new contract for integrated sexual health services by September 2018.

- Relevant, complementary services commissioned by other agencies are discussed and opportunities to improve sexual health services through greater collaboration are highlighted.

## RECOMMENDATIONS

The Health and Wellbeing Board is asked to: -

- Note the contents of this report.
- Support attempts to improve collaboration between sexual health commissioners and providers, possibly as part of the BHR Integrated Care Partnership.
- Receive further updates about sexual health, at least annually.

## REPORT DETAIL

See Attached paper.

## IMPLICATIONS AND RISKS

**Financial implications and risks:**

None arising directly from this paper.

The cost of sexual health services results in a very significant charge against the Council's Public Health Allocation. The proposals outlined in the paper serve to mitigate the risk that costs increase still further in the future.

**Legal implications and risks:**

None arising directly from this paper.

The paper sets out how the Council will continue to meet the legal requirement established in the Health and Social Care Act 2012 to ensure residents have open access to sexual health services.

The planned procurement will ensure compliance with relevant legislation and the Council's own constitution.

**Human Resources implications and risks:**

None arising directly from this paper.

Services will need to change to ensure they continue to meet the changing needs of local residents and offer best value. Any HR implications/ risks will fall on the service provider in the first instance.

**Equalities implications and risks:**

None arising directly from this paper.

Use of sexual health services varies between groups with protected characteristics. Any specific proposals impacting on sexual health services would be subject to an Equality Impact Assessment before any decision is made.

**BACKGROUND PAPERS**

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## Update on sexual health and sexual health services: January 2017

Mark Ansell, Consultant in public health, London Borough of Havering

## 1. Executive Summary

The paper provides the Health and Wellbeing Board with an annual update regarding: -

- The sexual health of people in Havering – in most respects, it remains similar to if not slightly better than the national and London average, with the notable exception of abortion rates which remain high. The diagnosed prevalence of HIV in Havering remains below the national average but has for the first time increased above the threshold used to identify 'high prevalence' areas. A review of current HIV testing practice and affordable approaches to increasing HIV testing is recommended.
- Local specialist sexual health services – the redesign discussed at Health & Wellbeing Board last year has just gone live; further changes are in-train e.g. an e-service allowing residents to request home self-sampling tests, ahead of an open procurement exercise with LB Barking and Dagenham and LB Redbridge to award a new contract for integrated sexual health services by September 2018.
- Relevant, complementary services commissioned by other agencies are discussed and opportunities to improve sexual health services through greater collaboration are highlighted.

## 2. The sexual health of Havering residents

Indicators of the sexual health of Havering residents did not change markedly over the last 12 months and remain largely similar to if not better than the national average.

### 2.1 Sexually transmitted infections

Overall, 1655 new STIs were diagnosed in residents of Havering in 2015 (895 in males and 754 in females).

Rates of all STI infections were more or less unchanged from the previous year and below the national average.

Rates of gonorrhoea, together with syphilis, seen as markers of risky sexual behaviour, increased but rates of both infections remain below the national average.

The chlamydia detection rate in 15-24 year olds in Havering (1353 per 100,000) was well below the PHE recommendation (at least 2,300). The lower detection rate in Havering was due to a lower rate of testing (19.2% of 15-24 year olds were tested vs a national average of 22.5%) and a lower positivity rate (7.0% vs 8.4%).

All sections of the community are at risk of STIs but young people (aged 15-24 years), men who have sex with men (MSM), black and mixed ethnic groups and disadvantaged communities have higher rates of infection.

**Table 1: Rates per 100,000 population of new STIs in LBH, LBBD and LBR and England: 2014-2015**

| | Diagnoses Rate: 2015 | | | | Rank within England: 2015** | | | % change 2014 to 2015 | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | LBH | LBBD | LBR | England | LBH | LBBD | LBR | LBH | LBBD | LBR |
| New STIs (excl. those with chlamydia aged 15-24) ^ | 789 | 1106.2 | 809.6 | 815 | 77 | 29 | 69 | 1.1 | 2.7 | 2.9 |
| Chlamydia | 248.8 | 389.3 | 235.8 | 361 | - | - | - | 0.3 | -2.8 | -7.2 |
| Gonorrhoea ¥ | 59.8 | 104.9 | 87.7 | 70.7 | 64 | 26 | 35 | 25.6 | 36.8 | 16.8 |
| Syphilis | 2 | 4 | 7.2 | 9.3 | 251 | 152 | 69 | -59.2 | 0 | 5.9 |
| Genital Warts‡ | 135.8 | 122 | 106.8 | 118.9 | 64 | | 167 | 0.6 | 97 | -1.6 |
| Genital Herpes ± | 72.4 | 77.2 | 52.2 | 57.6 | 54 | 43 | 142 | 3.6 | -3.7 | -0.6 |

Rates are calculated using 2014 ONS population estimates

* % change not provided where rate per 100,000 population in 2014 was 0.0

** Out of 326 local authorities, 1st rank has the highest rates.

^ Population is restricted to those aged 15-64 years

¥ Any increase in gonorrhoea diagnoses may be due to the increased use of highly sensitive Nucleic Acid Amplification Tests (NAATs) and additional screening of extra-genital sites in MSM

‡ Any decrease in genital warts diagnoses may be due to a moderately protective effect of HPV-16/18 vaccination

± Any increase in genital herpes diagnoses may be due to the use of more sensitive NAATs

Data Source: The GUM Clinic Activity Dataset v2 (GUMCAD) and chlamydia test and diagnosis data are sourced from the Chlamydia Testing Activity Dataset (CTAD)

## 2.2 HIV

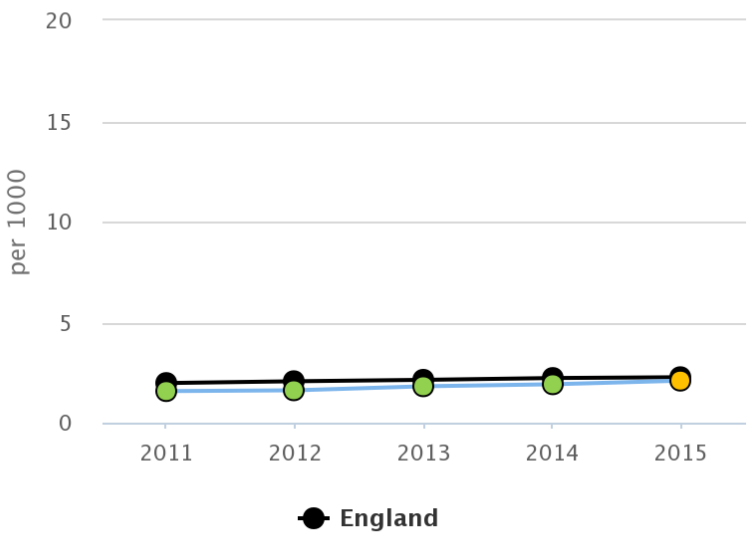
Anyone can acquire HIV but MSM and black African men and women are particularly at risk.

There were 15 new HIV diagnoses in Havering in 2015.

More than a third of diagnoses were made at a late stage of infection, similar to the average for England.

The diagnosed prevalence of HIV in Havering remains below the national average, however it increased above 2.0 per 1,000 population aged 15-59 years for the first time in 2015, the threshold used to identify 'high prevalence' areas.

**Figure 1:** HIV diagnosed prevalence rate / 1,000 aged 15–59 – Havering



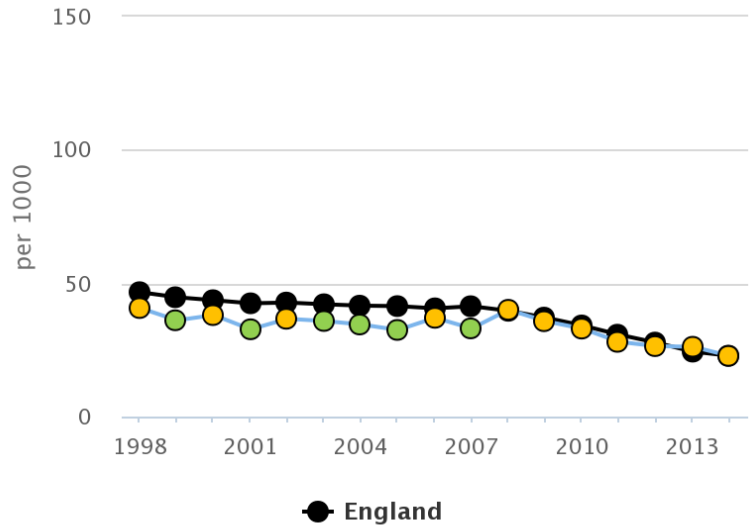

PHE and NICE recommend a more proactive approach to HIV testing in high prevalence areas (see section 4).

## 2.3 Teenage conception rates

Rates of teenage conception in Havering have declined each year for the last 7 years, in line with national trends.

In 2014, the under 18 conception rate per 1,000 females aged 15 to 17 years in Havering was 22.8, similar to the rate for England (also 22.8).

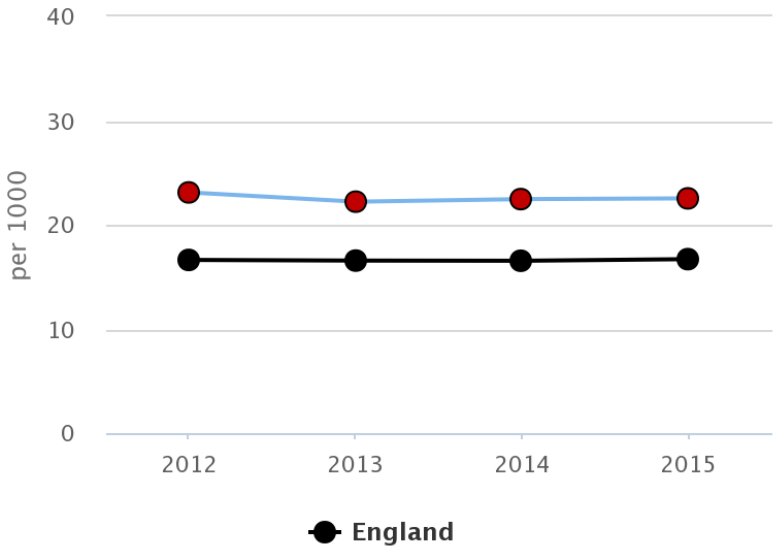
**Figure 2:** Under 18s conception rate / 1,000 (PHOF indicator 2.04) – Havering




## 2.4 Abortion rates

The total abortion rate per 1,000 female population aged 15-44 years in Havering (22.5) remains significantly higher than the rate for England (16.7).

**Figure 3:** Total abortion rate / 1000 – Havering




Of those women under 25 years who had an abortion in 2015, 32.1% had had a previous abortion; compared to the England average of 26.5%.

## 3. Sexual health services

### 3.1 Integrated sexual health services

The Health and Social Care Act 2012 requires Local Authorities to ensure that residents have open access services for contraception and the diagnosis, treatment and partner notification of sexually transmitted diseases.

Councils will usually commission and hold a contract with their local provider but residents can attend any service they wish and the provider will cross charge the Council they live in wherever that might be.

The local provider of integrated (GUM and contraception) sexual health services is BHRUHT, providing services from sites in Havering, Redbridge and Barking and Dagenham.

The contract for this service novated to the Council in 2013, when responsibility for public health at local level was transferred from the NHS to local government. Subsequently, the three boroughs sought to award a new contract, but a prolonged joint procurement exercise in 2014/15 failed to identify a provider able to meet the service specification at an affordable cost.

Furthermore, BHRUHT refused an extension to the existing contract having concluded following participation in the procurement that the income earned did not cover the costs of delivering the service. As a result, the contract lapsed and all activity has been non-contracted since April 2016 pending the agreement of a service redesign to reduce the provider's costs.

That redesign, presented to the Health and Wellbeing Board in March 2016 and summarised overleaf, was developed by BHRUHT and officers from all 3 Councils. Implementation requires residents to travel further as services will be provided from fewer sites. The great majority of residents and service users who responded to a public consultation objected to the redesign for this reason. Nonetheless, the redesign was agreed by all 3 Councils as greater investment in sexual health would necessitate dis-investment elsewhere and minimal impact on outcomes was expected, in part because general practitioners provide a very local alternative source of contraception care and a new 'e- service' will reduce the need for asymptomatic patients to attend GUM services at all.

The redesign went live on 3rd January 2017. The overall capacity of the service after redesign will be greater than expected demand and includes more out-of-working hours provision and booked appointments. Provider and commissioners will closely monitor the redesigned service and will further amend the revised clinic timetable if necessary.

Given that the redesign has been agreed, commissioners expect to be able to agree an interim contract for sexual health services with BHRUHT pending a new procurement exercise.

**Table 2: Redesign of integrated sexual health services provided by BHRUHT**

| Borough | GUM Services | | Family planning services | |
|---|---|---|---|---|
| | Old location | New location | Old location | New Location[1] |
| LBH | Queens Hospital | _ | • Queens Hospital<br>• Harold Hill HC.<br>• S. Hornchurch HC<br>• Myplace[2]<br>• St Kilda's CC[2] | Romford[3] |
| LBBD | Barking Hospital | Barking Hospital | • Barking Hospital<br>• Oxlow Lane HC<br>• Vicarage Fields HC | Barking Hospital[4] |
| LBR | _ | _ | • Hainault HC<br>• Loxford HC | • Hainault HC<br>• Loxford HC[5] |

[1] Family planning clinics will also offer asymptomatic STI testing
[2] Young people's clinics only, not including the fitting of LARC devices
[3] The intention is to identify a suitable community location within Romford; until then the service will be located at Queens Hospital
[4] The LBBD family planning service will be located at Barking Hospital which will also act as the sexual health services hub for patients with complex contraceptive needs across the three boroughs.
[5] Neither site can accommodate the number of clinics required. Clinics will be provided at both, but as whole days, until a suitable, centrally located site is identified in Redbridge.

All 3 boroughs are now committed to jointly undertake a further open procurement exercise to award a new contract for integrated sexual health services by October 2018 at the latest. This exercise is required to comply with relevant procurement law and the Councils' respective constitutions. Despite the history of failed procurement, a successful outcome is expected this time given the major change in local requirements and improvements in commissioning practice fostered by the London Sexual Health Transformation Programme (section 3.3). Nonetheless delaying the procurement somewhat is desirable as it will allow: -

- Senior clinicians and managers at BHRUHT to ensure that the redesigned service works effectively before having to focus on a competitive procurement exercise.
- For the impact of the London wide e-service (section 3.2) to become clearer.
- For the 3 boroughs to agree a common service specification and funding mechanism and take the procurement through their respective decision making processes (section 3.3).
- For procurement exercises in neighbouring areas to progress (section 3.3) so there is greater clarity about the pattern of services in adjoining areas and allow potential providers to focus on one procurement at a time rather than have to compete on multiple fronts.
- More time to explore the opportunities that might be afforded by an Accountable Care System and/or other forms of collaboration with other commissioners / providers (section 3.4).

## 3.2 Self-sampling at home for STIs using e-services

LB Havering is one of 22 London Boroughs[1] collaboratively commissioning a web-based 'e-service' which will serve as a single 'front door' to sexual health services across the capital; triaging patients to local services that best meets their needs, including the opportunity to request a home self-sampling[2] test.

The procurement is proceeding with the aim of having a basic service (i.e. that will allow appropriate residents from participating boroughs to order a self-sampling kit) in place and mobilised by May 2017. Further developments (e.g. the opportunity for test +ve patients to subsequently book an appointment online at their local provider) will come on stream thereafter.

The opportunity for appropriate people to request a self-sampling kit is expected to increase the total number of tests undertaken thereby increasing the number of cases detected and reducing delays in diagnosis. Nonetheless, commissioners are expected to save money as the cost of a self-sampling kit will be very much lower than the current cost of an attendance at GUM services. It's thought that up to 50% of people who currently attend GUM service are asymptomatic and might be suitable for self-sampling. The proportion that actually does so is much more difficult to predict. A behaviour change specialist has been commissioned to advise boroughs on how 'channel shift' can be maximised.

Providers of local integrated sexual health services will be required to collaborate with and support the provider of e-services, including distributing self-sampling kits to suitable patients who continue to attend physical services and encouraging them to use the self-sampling option in the future. This will reduce activity at GUM services and hence their income necessitating further redesign and the adoption of more cost effective service models if services are to remain financially viable from the provider's perspective.

## 3.3 London Sexual Health Transformation Programme

The procurement of the 'e-service' is one part of a thorough rethink of sexual health services across London as a whole being coordinated via the London Sexual Health Transformation Programme (LSHTP) with the aim of putting in place an effective, consistent, affordable and hence sustainable model of services across the capital.

This has resulted in two key products to assist with the redesign of GUM and contraception services at sub-regional level.

To ensure that services in adjacent areas are compatible with each other and the new e-service, as well as relevant best practice guidance, the LSHTP has developed a new service specification which all boroughs are strongly encouraged to employ in any future procurement.

The LSHTP has also improved the integrated sexual health tariff (ISHT) initially developed by former London PCTs. This would replace the simple first and follow-up tariff structure

[1] LB Redbridge is also participating; LB Barking and Dagenham has the opportunity to do so at a later date.
[2] The term self-sampling is used for services where the user takes a sample at home which is returned to a laboratory for testing. The term home testing refers to systems where the user is given a point of care test and interprets the results themselves. Laboratory based systems are generally more accurate.

currently in use with a more complex system that ensures that payment better reflects the cost of the specific care provided during each individual contact. The ISHT seems fairer in principle and should encourage providers to seek more cost effective models of care. The LSHTP have shared some preliminary modelling regarding the impact of adopting the ISHT on commissioner costs. A period of prospective shadowing the ISHT would give greater certainty regarding the impact of adoption. A future procurement would be the obvious means of introducing the ISHT should commissioners chose to do so.

A number of sub-regional procurements are already underway or are planned for the near future. Of most immediate relevance to Havering is the joint procurement planned by LB Tower Hamlets, LB Newham and LB Waltham Forest. They have recently undertaken a public consultation[3] on proposals that would see the level 3 services currently provided from Newham General and Whipps Cross Hospital relocated to a single new site in Stratford. If approved and implemented, a level 3 service in Stratford would be as close as or closer than Barking Hospital in terms of travel time by public transport for half of Havering residents. Hence the local provider of services for Havering will need to consider other aspects of user experience if it is to remain the preeminent provider of sexual health services to Havering residents.

It makes sense to delay our procurement so we can learn from experience elsewhere; better understand the distribution of sexual health services in adjoining areas and maximise provider interest.

## 3.4 Collaboration to improve sexual health services

The Health and Social Care Act resulted in responsibility for sexual health commissioning being split between a number of different agencies. With regard to contraceptive care: -

- Councils commission specialist contraception and GUM services for the testing and treatment of STIs.
- NHSE (and CCGs depending on the degree of co-commissioning in place) commission GPs to provide contraception care as an additional GMS service. This covers all forms of contraception except IUD/IUS and implants. It's estimated that GPs provide more than ¾ of all contraception, mostly in the form of the contraceptive pill.
- Councils can also commission GPs with the necessary knowledge and skills (and other primary care professionals) to provide services on top of their basic GMS responsibilities e.g. insertion and removal of IUD/IUS and implants.
- CCGs commission abortion services. Unwanted pregnancy may result from inadequate contraception provision and abortion is itself an opportunity to offer effective contraception.

Commissioning collectively, for the whole pathway, would ensure women get consistent and mutually complementary care.

3 http://www.towerhamlets.gov.uk/lgnl/council_and_democracy/consultations/past_consultations/Changes_to_sexual_health_services.aspx

However currently, these various interlinked and interdependent services are commissioned and provided by different agencies, sometimes with different and potentially conflicting financial incentives, with little collaboration or coordination.

Greater coordination between commissioners can only help.

A more integrated approach to commissioning the whole of the contraception pathway would represent the ultimate in 'joined up' commissioning and would help move a much greater proportion of contraceptive care into the community where it belongs.

Such an approach (often via ACOs) is commonly associated with the care of frail elders and older people and chronic illness, however the 7 characteristics identified by PWC as being common to most successful ACOs[4] readily map to sexual health:-

1. *Proactive management of population groups to inform early intervention and prevention*
2. *Multiple organisations are involved in delivering health and care services*
3. *Ability to manage and co-ordinate the care of individuals along the full length of clinical and social care pathways*
4. *A focus on integration and collaboration resulting in more multi-disciplinary working*
5. *Treating and supporting patients in different, more appropriate, settings as a result of improved co-ordination and flexibility within the contracts*
6. *Increased involvement and engagement of patients and service users in the design, delivery and improvement of services*
7. *Integrated IT solutions to support collaboration and sharing of information*

Hopefully the fundamentals of the approach to any BHR Integrated Care Partnership (ICP) will be agreed soon, allowing time for relevant stakeholders to consider if and how contraceptive care could be delivered more effectively via this means, so that any implications can be factored into the forthcoming procurement of specialist integrated sexual health services which will need to begin by October '17.

Other forms of collaboration short of the ICP might also add value and to this end meetings are planned between Council sexual health leads and BHR CCG to discuss opportunities: -

- to improve delivery of contraception under the existing GMS arrangements e.g. through the provision of clinical education for GPs and practice nurses and the development and dissemination of relevant performance information
- to identify alternative premises in Romford to enable the re-provision of all sexual health services off the Queens Hospital site.

[4] http://www.pwc.co.uk/industries/government-public-sector/healthcare/insights/shifting-to-accountable-care-characteristics-and-capabilities.html

### 3.5 Summary of next steps regarding commissioning of integrated sexual health services

Ahead of the open procurement expected to commence in October'17, we will: -

- Offer an interim contract to BHRUHT
- Refresh our sexual health needs assessment as required.
- Model the likely impact of the 'e-service', the change in physical location of level three services and introduction of the ISHT on patient flows and costs.
- Explore an ICP and/or alternative means of increasing collaboration with CCGs to :-
    - To identify an alternative site for level 2 services in Romford
    - Develop a programme of work to improve the GP contraception offer.
- Agree a common service specification and payment mechanism for integrated sexual health services for residents in the 3 boroughs.

## 4. HIV prevention, testing and treatment

As with contraception, commissioning responsibilities regarding HIV are split between multiple agencies

- Councils commission HIV prevention and population testing e.g. in primary care; other sexual health services and social care support for people living with HIV.
- CCGs commission HIV testing in CCG commissioned services and care for any other physical and mental health conditions people living with HIV might have
- NHSE commissions HIV treatment services, including the cost of antiretroviral treatments; and antenatal screening

### 4.1 HIV prevention and testing

Increasing the proportion of people living with HIV who are diagnosed as such is an essential element of efforts to end the HIV epidemic as set out the UNAIDS 90:90:90 vision for 2020 which calls for at least :

- 90% of people living with HIV to be diagnosed
- 90% of those diagnosed to receive treatment
- 90% of those treated to be virally suppressed

The UK continues to fail with regard to the first of these aspirations in that only 87% of people thought to have HIV are diagnosed.

To reduce undiagnosed HIV, NICE and PHE recommend action to normalize HIV testing, with tests being provided in a wide range of settings and circumstances. PHE recommends that the following messages should be widely and consistently communicated:

- HIV is no longer a fatal infection but a chronic manageable disease
- treatment is available that allows the vast majority of people with HIV infection to be considered non-infectious
- regular HIV testing should be seen as a routine healthy behaviour and it has never been easier to have an HIV test

Activity to this end is ongoing at national, regional and local level.

**HIV Prevention England** (HPE) is the national HIV prevention programme for England; funded by Public Health England and managed by the Terrence Higgins Trust. It delivers a nationally co-ordinated programme of HIV prevention work with UK-based black African people and with gay men/men who have sex with men (MSM). Key elements include: -

- The 'It Starts with Me' annual summer campaign (May to August) which aims to engage people with a call to action related to condom use, risk reduction and HIV testing.
- National HIV Testing Week (November) raises awareness of the importance of HIV testing as well as motivating clinical and voluntary sector providers to increase opportunities to test – be it in clinical settings, in primary care, through community-based rapid testing or via postal testing. The ultimate goal is to increase regular HIV testing in the most affected groups.

**The London HIV Prevention Programme (LHPP)** is a collaboration involving all 33 London local authorities, which enables the commissioning and delivery of a range of city-wide HIV prevention interventions[5].

The overarching aims of the LHPP are to reduce new HIV infections and increase earlier diagnosis of HIV by:

- Increasing the uptake of HIV testing
- Promoting condom use
- Advocating for safer sexual behaviours.

These aims are delivered by the LHPP through three key elements:

- "Do It London" – multimedia communications on HIV for all Londoners, with specific campaigns targeted at key at-risk groups of MSM and black African communities; an estimated 50K Londoners were contacted in Q2 2016/17.
- condom procurement, promotion & distribution; more than 200k each quarter
- targeted outreach to MSM via face to face and digital channels; 44000 men received an intervention in the first two quarters of 2016/17; one late night club session in Romford was visited in Q2.[6]

Locally **Positive East** is commissioned by the Council to:-

- foster a safer sex culture
- reduce late diagnosis by encouraging HIV testing
- improve the wellbeing of individuals and communities affected by HIV

Activity is focused on MSM and black African communities; is culturally and linguistically sensitive and delivered in partnership with NHS agencies.

[5] The London HIV Prevention Programme (LHPP): A Report to Leaders' Committee, London Councils, December 2016 http://www.londoncouncils.gov.uk/download/file/fid/19660.

[6] London HIV Prevention Programme HIV testing, Condom Distribution and Outreach Services Report: Quarter 2 (1 Jul– 30 Sep, Financial Year 2016 –2017) GMI & FREEDOMS SHOP PARTNERSHIP

Key elements of the service include: -

- Outreach providing information & advice to people at risk of HIV exposure both face to face in a range of appropriate community-based and commercial venues and via media including social media.
- 1:1 support to encourage and assist individuals to
    - get tested
    - practice safe sex
    - access and maintain engagement with treatment services
    - address the welfare, employment, housing and immigration issues that otherwise might hinder engagement with treatment services
- Training for health and social care professionals, community groups etc about the specific needs of high risk groups

Both LB Barking and Dagenham and Redbridge separately commission services using the same service specification and the 3 boroughs have had an exploratory meeting about commissioning more collaboratively in the future.

In addition to action to normalize testing; PHE and NICE recommend action to increase the offer of testing in clinical services with a particularly proactive approach in areas described as having 'high' and 'very high' prevalence (see table 2).

Locally, HIV testing is:-

- offered on a universal 'opt-out' basis as part of the National Antenatal Infections Screening Programme with very high rates of participation (>99.8% for London in 2014/15).
- routinely offered in local GUM services. BHRUHT regularly reports the % of new patients tested against a minimum target of 85% which is consistently exceeded.
- offered by drug treatment services

Information about HIV testing when patients attend hospital or their GP with risk factors or diagnoses that suggest they are at increased risk of HIV is not available at the time of writing this report.

HIV testing is not routinely offered to all patients attending A&E or admitted to hospital where blood tests are being undertaken for another reason as NICE recommends in areas with 'high' prevalence. Neither is it routinely offered when patients register with a new GP.

In 2014/15, the Council commissioned three practices in areas serving communities with a relatively high proportion of black African residents to pilot the offer of HIV testing as part of new patient checks using POCT. The pilot was terminated when it became clear that very few patients agreed to testing. LB Redbridge is currently evaluating a similar service. Preliminary data suggest that uptake has also been low. LB Barking and Dagenham has just launched a similar service for its residents but it is too soon to draw any conclusions about uptake.

**Table 2: NICE recommendations about HIV testing in different settings and prevalence**

| Setting | Offer and recommend an HIV test to everyone who has not previously been diagnosed with HIV and who | All areas | High prevalence areas | Very high prevalence areas |
|---|---|---|---|---|
| Public health commissioned health care services | 1. Attends for testing or treatment at specialist sexual health services | X | X | X |
| | 2. Attends their first appointment at a drug dependency programme | X | X | X |
| Secondary and emergency health care services | 3. Attends termination of pregnancy services | X | X | X |
| | 4. Attends services providing treatment for hepatitis B and C, lymphoma and TB | X | X | X |
| | 5. Is admitted to hospital, including emergency departments, and:<br>•has symptoms that may indicate HIV or HIV is part of the differential diagnosis<br>•is known to be from a country or group with a high rate of HIV infection<br>•if male, discloses that they have sex with men, or is known to have sex with men, and has not had an HIV test in the previous year<br>•is a trans woman who has sex with men and has not had an HIV test in the previous year<br>•reports sexual contact with someone from a country with a high rate of HIV<br>•discloses high-risk sexual practices, for example the practice known as 'chemsex'<br>•is diagnosed with, or requests testing for, a STI<br>•reports a history of injecting drug use<br>•discloses that they are the sexual partner of someone known to be HIV positive, or of someone at high risk of HIV | X | X | X |
| | 6. Is admitted to hospital, including emergency departments, and who undergoes blood tests for any other reason. | | X | X |
| | 7. Is admitted to hospital, including emergency departments. | | | X |
| General practice | 8. Consults their GP regarding any of indications for testing listed in section 5 | X | X | X |
| | 9. Registers with a new GP | | X | X |
| | 10. Undergoes blood tests for another reason and has not had an HIV test in the previous year | | X | X |
| | 11 Attends for any consultation, whether bloods are being taken for another reason or not, based on clinical judgement. | | | X |

The decision to terminate the pilot of testing in general practice was in part made because Councils had the opportunity to opt-in to a national HIV self-sampling service being procured by PHE. LB Havering is one of 85 participating local authorities, including LB Barking and Dagenham and LB Redbridge. To be eligible, individuals must be aged 16 years and over, resident in a participating areas and self- identify as being in an at-risk group. The service became operational in November 2015. In the first year of operation, 220 tests were requested by Havering residents of which 110 were returned for testing – similar to the return rate seen nationally. Requests peak in November around HIV testing week. In 2015 and 2016, PHE has paid for HIV tests requested during this peak period i.e. 100 of all tests requested by Havering residents in year one. Nationally, 2/3rds of service users reported never testing or testing over a year ago[7] suggesting the service is expanding the reach of testing.

## 4.2 HIV treatment

Treatment has transformed HIV from a fatal infection into a chronic, manageable condition and people living with HIV in the UK can now expect to live into old age if diagnosed promptly. Moreover effective HIV treatment results in an 'undetectable' viral load which is protective from passing on the virus to others.

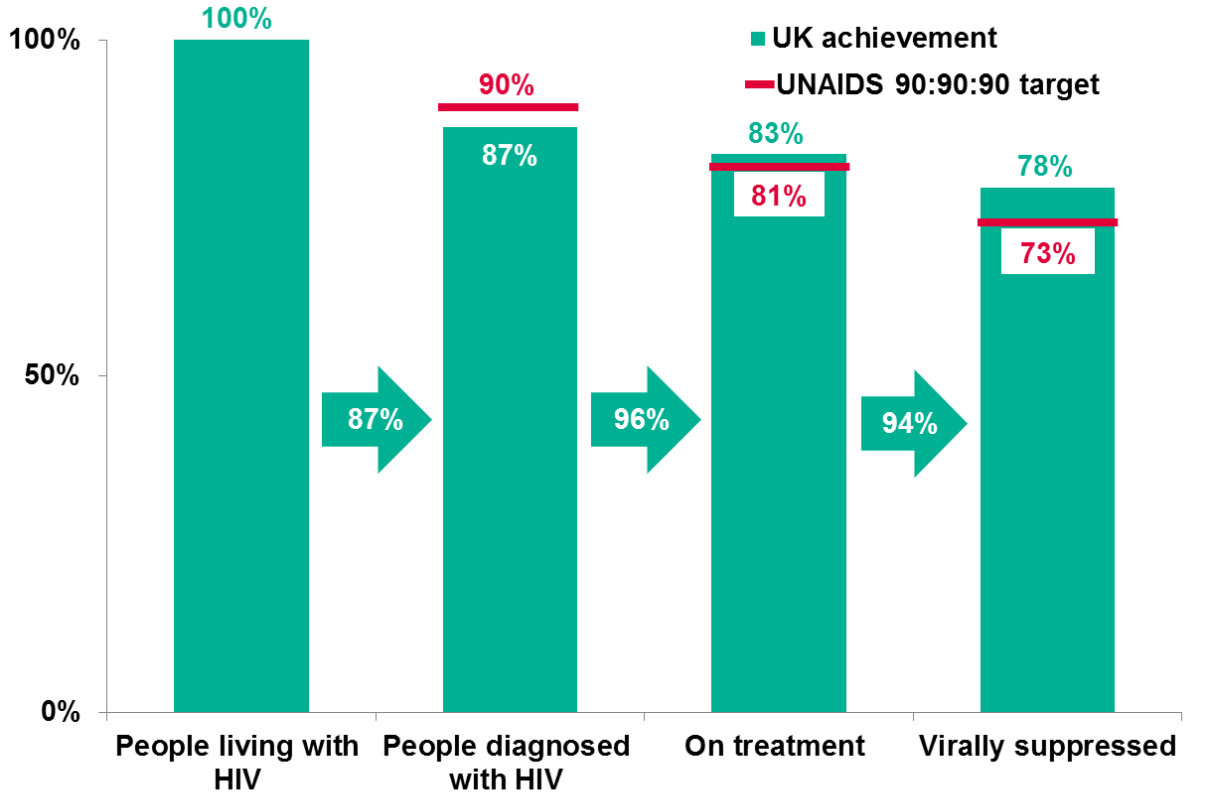
HIV treatment is commissioned by NHSE. Data about access to and delivery of care is collected and analysed by PHE. Results at trust level (local treatment services are provided by BHRUHT from the Barking Hospital site) are only available to service providers and commissioners. National data are publically available[8]. These demonstrate that the quality of treatment in the UK is excellent. Nearly all (97%) of the people diagnosed with HIV in 2015 were linked to specialist HIV care within three months of diagnosis and the vast majority (94%) of people accessing HIV care were receiving anti-retro therapy (ART) and as a result have undetectable virus in their blood and body fluids and are very unlikely to pass on their infection to others. Since the vast majority of people diagnosed with HIV are effectively treated, most new HIV infections are passed on from persons unaware of their infection. Hence condoms continue to be an important way to prevent HIV, other STIs and unintended pregnancy and are recommended, with new and casual partners in particular.

Given the effectiveness of treatment services, an increase in the % of cases diagnosed would see the UK meet the UNAIDS target in full.

[7] National HIV Self-Sampling service 4th Quarter report. Guerra L etc al. PHE November 2016

[8] Kirwan PD, Chau C, Brown AE, Gill ON, Delpech VC and contributors. HIV in the UK - 2016 report. December 2016. Public Health England, London. https://www.gov.uk/government/publications/hiv-in-the-united-kingdom

**UK HIV continuum of care: progress against UNAIDS target**




Source: PHE 2016.

### 4.3 Next steps regarding HIV

Review local testing practice to identify affordable means of increasing testing, particularly amongst high risk populations.

Participate in the review of HIV treatment services in London currently being undertaken by NHS England.

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TO:
Chairs of Health and Wellbeing Boards
Chief Constables
Police and Crime Commissioners

15 November 2016

Dear All

**Police and Crime Commissioners and Health and Wellbeing Boards**

We are writing to highlight and support some of the important benefits that can be realised through closer collaboration between policing and health partners.

The interface between crime and public health is well-documented – in the Department of Health's public health outcomes framework, for example, which contains a number of indicators that recognise the links, including: entry to the youth justice system, people in prison with a mental illness, domestic abuse, violent crime, re-offending, drug treatment outcomes and perception of community safety.

In many areas of the country, police and health and care partners, in both the NHS and Local Government, are working collaboratively to deliver better outcomes for individuals, including the most vulnerable and local communities and there is potential for further joint working. For example, local authorities, the NHS and the police are required members of Safeguarding Adult Boards which help ensure a collaborative, inter-agency approach to the responses and prevention of abuse or neglect.

In addition, many health and wellbeing boards already include amongst their membership either their Police and Crime Commissioner (PCC) or representatives from their local police force or criminal justice agencies. This has enabled boards to take a broader strategic view of their area beyond health and social care, and through Joint Strategic Needs Assessments (JSNAs) provides boards with the opportunity to better understand the nature of public needs and demands on local services – which can in turn influence local commissioning strategies.

There are already a number of areas where greater collaboration has had positive outcomes including:

- Every area in England is now working to implement their local Mental Health Crisis Care Concordat action plans, involving NHS services, police forces and local authorities, and many of these local partnerships are using their Boards to ratify their plans and support progress. Local action plans and other helpful information on the Concordat can be found here: http://www.crisiscareconcordat.org.uk/

- In addition, around 30 police forces now have some form of street triage in operation. These models, often jointly commissioned by the PCC and Clinical Commissioning Groups, ensure mental health nurses staff support and advise police officers in their responses to people in mental health crisis. In some forces mental health workers and police officers provide joint responses in the community; in others mental health professionals work in emergency call centres in order to provide real time advice and support to frontline officers. The evaluation of nine initial pilot sites evidenced that the schemes contributed towards large reductions in the use of police custody as a place of safety for those vulnerable people detained under section 136 of the Mental Health Act.

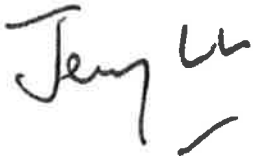
- Around 25 police forces operate a drug intervention initiative which involves policing and health partners working together to identify, assess and refer users into appropriate treatment pathways. Investment in treatment is proven to reduce reoffending, with every £1 spent saving £2.50 for the Criminal Justice System, and with access to treatment reducing the impact of wider health harms including the spread of blood borne viruses and drug related mortality.

- A recent Home Office and Public Health England initiative in Middlesbrough brought together senior partners in policing, health and probation to consider the impact of heroin misusing offenders in their area and the wider implications this was having on individuals and the community. This has galvanised further collaborative working, including the development of a joint strategy to address their local needs and consider opportunities for developing a multi-agency commissioning approach for treatment services.

- The first phase of the local alcohol action areas programme, which ran until March 2015, saw police and health partners work closely together to reduce a range of alcohol-related harms. For example, Gravesham began a one-year pilot of a Make Every Adult Matter approach to street drinkers. An operational group is led by the area's alcohol and drug treatment provider with members including the police, third sector organisations, primary care providers, Jobcentre Plus and the Prison Service. Early indications are that the project is working well and that links between partner agencies are much improved and that better coordinated services for individuals with multiple needs are emerging. Invitations to apply to take part in the second phase of the programme were sent to PCCs, chief constables and all local authorities in England and Wales last month. The programme will begin in January and will again encourage active partnerships between local agencies to reduce alcohol harms.

Given the benefits outlined above, and the pressures on health and care services and police forces, we would like to ask Health and Wellbeing Boards and PCCs to consider how they can better work together by ensuring appropriate representation from both sectors on Health and Wellbeing Boards.

**The Rt Hon Amber Rudd MP**



**The Rt Hon Jeremy Hunt MP**

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Department of Health

*From David Mowat MP*
*Parliamentary Under Secretary of State for Community Health and Care*

*Richmond House*
*79 Whitehall*
*London*
*SW1A 2NS*

Dear Health and Wellbeing Board Chairs,

I am writing to you in your capacity as a Health and Wellbeing Board (HWB) Chair to highlight the General Practice Forward View, recognising the important relationship that primary care has with the delivery of local health and wellbeing strategies. This document is part of the future vision for the NHS being developed as part of NHS England's overarching Five Year Forward View.

The role of general practice is central to our health and care system, but we know that pressure on GPs and other general practice staff is increasing. The Government and NHS England have recognised the need for additional support and, on 21st April 2016, NHS England published the GP Forward View. This is a package of support to help get general practice back on its feet, improve patient care and access, and invest in new ways of providing primary care. It sets out that we are investing an extra £2.4 billion a year for general practice services by 2020/21, which represents a 14% increase in real terms. The overall investment includes a £500 million five year Sustainability and Transformation package to support GP practices, which contains measures to help boost the workforce, drive efficiencies in workload and modernise primary care infrastructure and technology.

However, as HWBs will be very well aware, general practice cannot work effectively in isolation, and the GP Forward View looks at general practice's role in relation to the wider system – both how improved integration can provide additional support to general practice and the contribution that general practice staff make on wider social issues. It also highlights the important role that primary care can play in supporting integration across local health and care systems.

We acknowledge that many HWBs are already promoting strong and effective relationships between general practice services and other health, social care, public health and wider local services; and that they recognise the centrality of primary care in integrating their local health and care systems and the need to ensure access to all relevant support services. These links are going to be even more important in the future, and so I am writing to ask all HWBs to review the GP Forward View document and consider what more Boards could do to build effective relationships between primary care and wider local services.

There are many examples of effective collaboration with primary care at a local level, including:

- *Just What the Dr Ordered* (published by the Local Government Association in April 2016) contains case studies on social prescribing from: East Riding of Yorkshire;

Blackburn with Darwen; Knowsley, Halton and St Helen's; Luton; Rotherham; Cotswold; Doncaster; Tower Hamlets; and Forest of Dean: http://www.local.gov.uk/documents/10180/7632544/L16-108+Just+what+the+doctor+ordered+-+social+prescribing+-+a+guide+to+local+authorities/f68612fc-0f86-4d25-aa23-56f4af33671d.

- Northumberland's network of community hubs with strong voluntary, community and faith sector engagement and support planners working with GPs.

- Social prescribing in Gloucestershire: http://www.gloucestershire.gov.uk/extra/CHttpHandler.ashx?id=63219&p=0.

- Wiltshire's community hubs where primary care services are co-located with other services in buildings such as libraries: http://www.wiltshire.gov.uk/hwb-2015-annual-report.pdf.

HWBs will additionally already be engaged in the Sustainability and Transformation Plan (STP) process. As set out in the NHS Shared Planning Guidance, published in December 2015, the success of STPs will depend on having an open, engaging, and iterative process that involves clinicians, patients, carers, citizens, clinicians, local community partners including the independent and voluntary sectors, and local government through, for example, health and wellbeing boards, building on existing plans such as Health and Wellbeing Strategies and Joint Strategic Needs Assessments.

The arm's length bodies responsible for the NHS Five Year Forward View – NHS England, NHS Improvement, the Care Quality Commission, Public Health England, Health Education England and the National Institute for Health and Care Excellence – have asked for local engagement plans as part of the Sustainability and Transformation Plan process, building where appropriate on existing engagement through health and wellbeing boards and other local arrangements, including GP services.

In summary, given the potential benefits outlined above, I am asking HWBs to consider how, through their work and specifically through Joint Health and Wellbeing Strategies, they can encourage action to develop and strengthen relationships with general practice services in local areas, in order to generate benefits for the whole system and better outcomes for patients.

Yours faithfully,

**DAVID MOWAT**