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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD
AGENDA

1.00 pm	Wednesday, 29 January 2020	Committee Room 3B - Town Hall

Members: 16, Quorum: 6

BOARD MEMBERS:

Elected Members:	Cllr Robert Benham Cllr Jason Frost (Chairman) Cllr Damian White Cllr Nisha Patel
Officers of the Council:	Andrew Blake-Herbert, Chief Executive Barbara Nicholls, Director of Adult Services Mark Ansell, Interim Director of Public Health
Havering Clinical Commissioning Group:	Dr Atul Aggarwal, Chair, Havering Clinical Commissioning Group (CCG) Ceri Jacob, BHR CCG
Other Organisations:	Anne-Marie Dean, Healthwatch Havering Jacqui Van Rossum, NELFT Fiona Peskett, BHRUT

For information about the meeting please contact:
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luke.phimister@onesource.co.uk

What is the Health and Wellbeing Board?

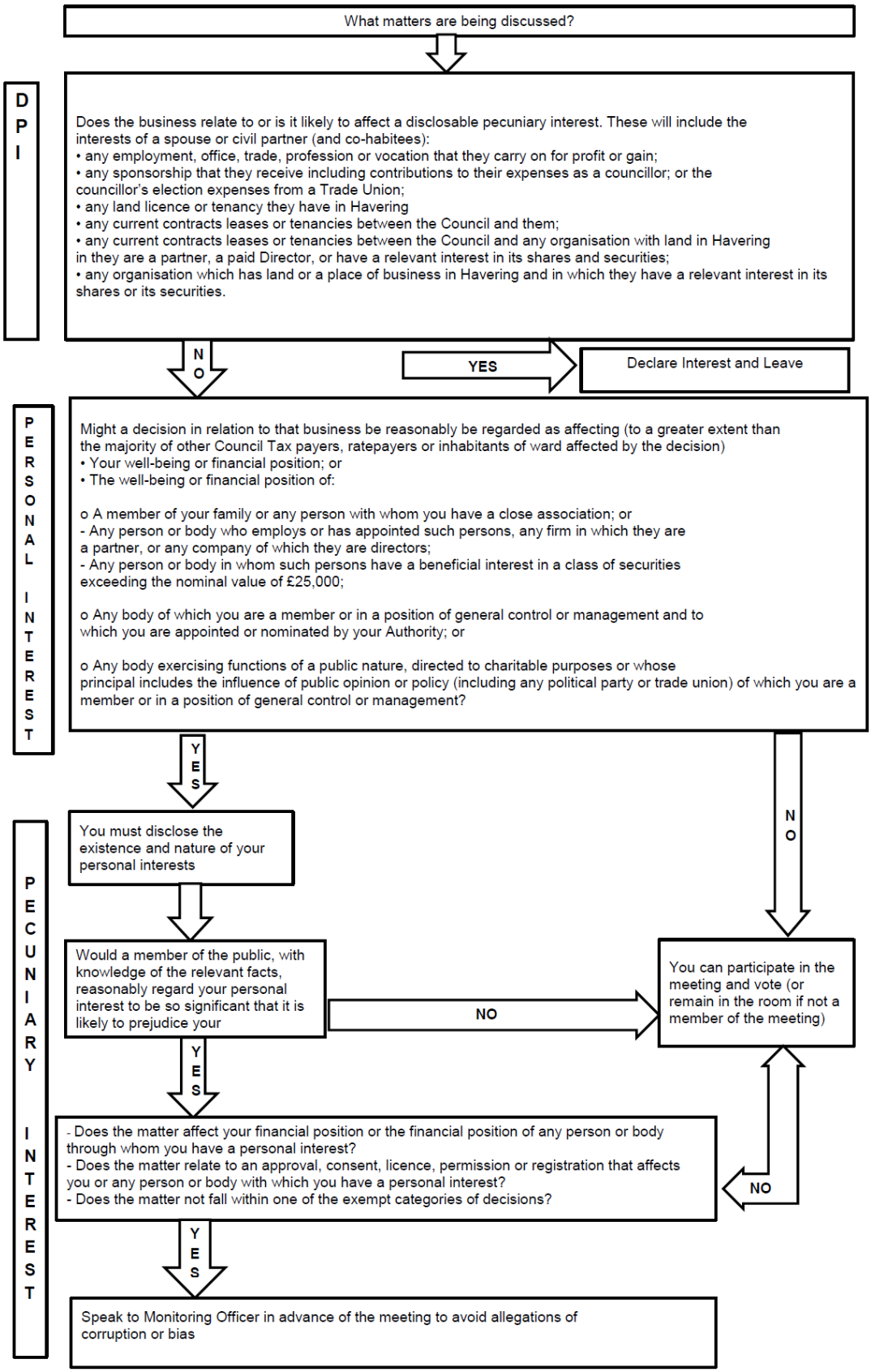
Havering's Health and Wellbeing Board (HWB) is a Committee of the Council on which both the Council and local NHS and other bodies are represented. The Board works towards ensuring people in Havering have services of the highest quality which promote their health and wellbeing and to narrow inequalities 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

DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF



AGENDA ITEMS

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.

2 APOLOGIES FOR ABSENCE

(If any) – receive

3 DISCLOSURE OF INTERESTS

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

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

4 MINUTES (Pages 1 - 4)

To approve as a correct record the minutes of the Board held on 27 November 2019 and to authorise the Chairman to sign them.

5 MATTERS ARISING

To consider the Board's Action Log

6 HEALTH AND WELLBEING BOARD REVISED TERMS OF REFERENCE (Pages 5 - 10)

Report and appendix attached.

7 HEALTH AND WELLBEING STRATEGY CONSULTATION REPORT (Pages 11 - 16)

Report and appendix attached.

8 SOCIAL PRESCRIBING (Pages 17 - 20)

Report attached.

9 BHR JOINT STRATEGIC NEEDS ASSESSMENT (Pages 21 - 42)

Report and appendix attached.

10 HOMELESS PREVENTION AND ROUGH SLEEPER STRATEGY 2020-2025 (Pages 43 - 48)

Report attached.

11 THE NHS LONG TERM PLAN RESPONSE ACROSS ELHCP (Pages 49 - 70)

Report and appendix attached.

12 NORTH EAST LONDON PRIMARY CARE UPDATE (Pages 71 - 124)

Report and appendices attached.

13 HAVERING LOCAL ACCOUNT 2017/2019 (Pages 125 - 140)

Report and appendix attached.

14 DATE OF NEXT MEETING

The next meeting will take place on 25th March 2020.

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MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD Committee Room 3B - Town Hall 27 November 2019 (1.00 - 2.45 pm)

Present:

Elected Members: Councillor Jason Frost (Chairman)

Officers of the Council: Barbara Nicholls, Director of Adult Services and Mark Ansell, Director of Public Health

Havering Clinical Commissioning Group: Dr Atul Aggarwal, Chair, Havering Clinical Commissioning Group, and Steve Rubery, Director of Commissioning & Performance, BHR CCGs.

Other Organisations: Anne-Marie Dean Executive Chairman, Healthwatch Havering and Jacqui Van Rossum, Executive Director Integrated Care, NELFT

Also Present: Patrick Odling-Smee, Director of Housing, London Borough of Havering, Elaine Greenway, Public Health Consultant, London Borough of Havering, Rebecca Smith, Senior Commissioner & Projects Manager, London Borough of Havering and Shelley Hart, Chief Executive Officer, Havering Volunteer Centre.

All decisions were taken with no votes against.

The Chairman reminded Members of the action to be taken in an emergency.

35 **APOLOGIES FOR ABSENCE**

Apologies were received for the absence of Councillor Damian White, London Borough of Havering, Councillor Robert Benham, London Borough of Havering, Councillor Nisha Patel, London Borough of Havering, Andrew Blake-Herbert, Chief Executive, London Borough of Havering, Robert South, Director of Children's Services, London Borough of Havering, Ceri Jacobs, Managing Director, BHR CCGs, Fiona Peskett, Director of Provider Alliances, BHRUT and James Moore, Head of Delivery, Improvement and Transformation NHS England

36 **DISCLOSURE OF INTERESTS**

There were no disclosures of interest.

37 **MINUTES AND ACTION LOG**

The minutes of the meeting of the Board held on the 9th September 2019 were agreed as a correct record and signed by the Chairman.

The following was noted in respect of the action log:

- The consultation report was being finalised and the action log was signed off.

38 LOCAL AREA CO-ORDINATION

The report presented to the Board gave detail on the development of Local Area Co-ordination in Havering.

Members noted that the Co-ordinators will support people of any age who have problems including mental health, disabilities and social isolation. Co-ordinators aim to ensure individuals and families who do not need statutory services are supported to access social support within their local communities. Three Co-ordinators will be recruited in January 2020 who will start in Harold Hill. Co-ordinators will be recruited by the community; people who live in the local area choose who they would like to have as their Local Area Coordinator. Coordinators live in the local area and so understand what it is like to be a Havering resident, know the community and the people who live there. Members also noted that the Co-ordinators will build connections within the community and will signpost people to volunteering opportunities.

The Board stated that Local Area Co-ordination is a multi-agency partnership approach.

The Board noted the report and presentation.

39 COMPENDIUM CONNECTORS MODULE: SOCIAL PRESCRIBING

The report before the Board gave an update to the Social Prescribing Module launch in Havering.

The members of the Board noted that the Havering Volunteer Centre opened in 2015 and it now has over 4000 volunteers with 1 in 4 attaining paid employment. It was noted that the financial value of volunteering in Havering has been calculated to be approximately £13 million. It was also noted that the Volunteer Centre has connections to over 240 voluntary organisations.

The Board agreed that social prescribing reduces the stress on GPs, the NHS and other services and that it reduces loneliness and social isolation across all age groups. The Volunteer Centre's compendium connectors' module will firstly target Harold Hill, Romford and Rainham and will aim to create a socially connected Havering.

40 TOBACCO HARM REDUCTION DRAFT STRATEGY

The Board received a draft Tobacco Harm Reduction Strategy which provided an outline of the approach Havering should take to reduce the prevalence of smoking.

The Board noted that the Strategy aims to reduce the harm of smoking tobacco through:

- Smoke-free pregnancies,
- Preventing children from taking up smoking,
- Reducing exposure to second-hand smoking,
- Increasing the rate at which adults quit smoking, and;
- Protecting the esteem of smokers with mental health problems.

Members of the Board noted that smoking costs £4.6 million to Havering businesses per annum and the Board also noted that this has an impact on disposable income for households.

The Tobacco Harm Reduction Strategy was also presented as an exemplar for how future strategies might be presented to the Board.

It was agreed that strategies should describe between 4 and 12 key indicators of success, summarise information about the partnership that will deliver the strategy, and set out approximately four milestones for the forthcoming year. Authors will provide RAG updates on progress against the milestones for each HWB meeting.

41 ANY OTHER BUSINESS

There was no other business.

Chairman

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HEALTH & WELLBEING BOARD

Subject Heading:	Health and Wellbeing Board Terms of Reference
Board Lead:	Councillor Jason Frost, Chairman of Health and Wellbeing Board
Report Author and contact details:	Elaine Greenway, Consultant in Public Health, London Borough of Havering elaine.greenway@havering.gov.uk

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

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

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SUMMARY
Havering Wellbeing Board Terms of Reference have been revised to reflect the new Health and Wellbeing Board Strategy.
RECOMMENDATIONS
Health and Wellbeing Board members are asked to agree the Terms of Reference.
REPORT DETAIL
No further detail
IMPLICATIONS AND RISKS
None
BACKGROUND PAPERS
None

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Havering Health and Wellbeing Board

Terms of Reference

Background
Health and wellbeing boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population.

The Havering Health and Wellbeing Board (the Board) is a formal committee of the local authority charged with promoting greater integration and partnership between bodies from the NHS, public health and local government.

The Board has a statutory duty to produce a joint strategic needs assessment and a joint health and wellbeing strategy for their local population.

Responsibilities
The main responsibilities of the Board are to:
1. Agree the health and wellbeing priorities for Havering and oversee the development and implementation of a joint health and wellbeing strategy.
2. Oversee the development of the joint strategic needs assessment and the pharmaceutical needs assessment.
3. Ensure people in Havering have services of the highest quality which promote their health and wellbeing, narrow inequalities and improve outcomes for local residents.
4. Bring together key partners to implement the Health and Wellbeing Strategy.

Membership
Elected Members
- Four elected members in accordance with London Borough of Havering Constitution:
  - Lead member for Adults and Public Health
  - Lead member for Children's Services
  - Leader of the Council
  - Additional member nominated by the Leader

Officers of the Council

- Director of Public Health
- Director of Adult Social Care
- Director of Children's Services.
- Chief Executive
- Director of Housing
- Director of Regeneration

Havering Clinical Commissioning Group
- Four representatives

Other Organisations
- Primary Care Networks: One Clinical Director from each Network
- BHRUT representative
- NELFT representative
- Healthwatch Havering representative
- Voluntary and Community Sector representative (nominated by the Compact Steering Group)

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

In attendance
LBH Public Health Consultant and/or Public Health Support Officer (to support DPH in their HWB lead officer

Reporting and Governance Arrangements
- The Health and Wellbeing Board is a committee of the Council.

- The Board will receive regular progress updates from the following:
  - All groups responsible for delivering Health and Wellbeing Board strategy priorities
  - Transformation boards delivering health and wellbeing improvements across Barking and Dagenham, Havering and Redbridge
  - Other groups where the Health and Wellbeing Board has agreed to provide governance oversight, including:
    - Dementia Partnership Board

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

- The Leader of the Council will nominate a Chairman. Board members to nominate a Vice Chairman from among the health organisation representatives.

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

- Full members of the Board who are unable to attend a meeting should nominate a deputy who can speak and vote on their behalf.

- The Board is quorate when six members are present, providing that there is one representative from each of Elected Members, Officers of the Council, Havering Clinical Commissioning Group and Other Organisations.

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

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

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

- These terms of reference will be reviewed when a request is made and seconded by Health and Wellbeing Board members.

Signed ……..
(Chairman of the Health and Wellbeing Board)

Date: …….

Updated January 2020

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HEALTH & WELLBEING BOARD

Subject Heading:	Health and Wellbeing Strategy Consultation Report
Board Lead:	Mark Ansell, Director of Public Health, London Borough of Havering
Report Author and contact details:	Elaine Greenway, Consultant in Public Health, London Borough of Havering Elaine.greenway@havering.gov.uk

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

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

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SUMMARY
The Health and Wellbeing Board consulted organisations and residents on proposals for a new four year Health and Wellbeing Board Strategy during July and August 2019. The accompanying report summarises the main points that arose from the consultation and describes what the Board has agreed to do in response.
RECOMMENDATIONS
The Health and Wellbeing Board is asked to approve the report.
REPORT DETAIL
No further detail
IMPLICATIONS AND RISKS
None
BACKGROUND PAPERS
None

Health and Wellbeing Strategy Consultation

Draft Report

The Health and Wellbeing Board consulted organisations and residents on proposals for a new four year Health and Wellbeing Board Strategy. The consultation launched on 24 July and closed on 28 August 2019. The online consultation was published on Citizen Space, a web-based consultation tool. This report summarises the main points that arose and describes what the Board has agreed to do in response.

1. Responses received

In total, 218 responses were received

- 36 through face to face engagement at the Havering Show, 2 by email, the rest were completed online
- 8 organisations/services responded
- 210 individuals responded; 187 live, 86 work, 5 study in the borough. Numbers are greater than 210 as some respondents fit more than one category

2. Key messages

There was overall support for the strategy with a small number of responses that disagreed with some of the individual priorities

- In the main, organisations that responded agreed with the strategy and were willing to support its implementation
- The majority of individuals agreed with the approach and the individual priorities
- The level of interest in mental health and healthcare suggests that the relevant BHR transformation boards should consider how to raise awareness of BHR-wide strategies
- There were some general comments about lack of detail and specifics, which will be naturally addressed through the annual work programme of the Board, which will be published on the Council's website https://democracy.havering.gov.uk/ieListMeetings.aspx?CommitteeId=374%20

3. Responses from Organisations

Of the eight organisations that responded, seven said that they supported the strategy and wished to support its implementation, each citing one or more priority of particular interest to them. There were no themes that arose, but the individual and specific comments have been forwarded to relevant programme leads.

Box 1: What the Board will do:

- **No further action to be taken**

The organisation that did not support the strategy cited the lack of focus on active lifestyles which they said *"is now believed to be even more important to public health than reducing obesity."* They would be willing to support the development of a strategy that addressed this.

Box 2: What the Board will do:

The Board accepts that active lifestyles lead to wider benefits to health than just reducing obesity. However, the Board wishes to remain focused on a small number of priorities. It has been decided to revisit the strategy priorities after two years and if sufficient progress is made, then the topic of active lifestyles will be added as an additional priority. In the meantime, physical activity will continue to be promoted as part of usual business by the Council and partners.

4. Responses from Individuals

143 respondents agreed with the approach set out in the strategy, 24 did not agree, the rest chose not to answer. The following table shows the numbers of respondents who agreed/disagreed with the individual priorities.

Priority	*Agreed	*Disagreed
Help people with health problems into work	175	17
Anchor institutions making a difference	160	12
Homelessness	196	3
Obesity	183	13
Smoking	181	12
Healthy child settings	197	4
Regeneration benefits	196	6
Supporting people with complex needs differently	189	7
Health, housing, social care services working together	203	3

*where numbers do not add up to 210, this is because respondents either left blank, or entered "do not know".

There was further feedback on the topics of mental health, environmental factors, dementia, healthcare, and children and young people, as follows:

4.1 Mental health: Some respondents made mention of the importance of mental health and how this appeared to be missing. The draft strategy did state that there would be no duplication of programmes that are being taken forward on a 3 borough basis; mental health being one. It is assumed that this explanation was overlooked.

Box 3: What the Board will do:

- **Through this report, signpost to the work of the BHR Mental Health Transformation Board as presented to the Board in 2019:** https://democracy.havering.gov.uk/documents/g5878/Public%20reports%20pack%2013th-Mar-2019%2013.00%20Health%20Wellbeing%20Board.pdf?T=10
- **Continue to request annual reports from the BHR Mental Health Transformation Board which will be published with other HWB papers.**

4.2 Environmental factors: Seven respondents said that the strategy should include specific reference to environmental factors such as climate change, air quality, recycling and food safety.

Box 4: What the Board will do:

The Board recognises that environmental factors such as climate change and air quality are major threats to human health. There are local strategies and structures in place already to respond to the problems including the Council's Air Quality Plan which was approved by Cabinet in 2019 (see below) as well as the national Clean Air Strategy 2019. Nevertheless, when the HWBS is reviewed in two years' time, the topic of the environment will be considered again and could also be included as a Board priority.
https://democracy.havering.gov.uk/documents/s26783/Havering%20Air%20Quality%20Action%20Plan%202017_V6.pdf

4.3 Dementia: There was some interest in the topic of dementia.

Box 5: What the Board will do:

The HWB will continue to be a part of the local Dementia Strategy Steering Group's governance arrangements. HWN will also request regular updates of progress of the dementia strategy.

4.4 Healthcare: There were a number of comments about provision of healthcare – primarily primary care. A dozen or so comments were about length of waiting times for GP appointments, the St George Hospital site and provision of healthcare in south Hornchurch. A couple of comments were made about the need to improve stroke rehabilitation

Box 6: What the Board will do:

The Board will continue to publish a forward plan of the topics that are scheduled to be presented. These topics include the BHR Transformation Boards that are focusing on healthcare (including primary care)

4.5 Children and Young People: There were three comments about the importance of young people's health and wellbeing, including self-esteem, violent crime, and sexual health. It was said that safeguarding processes need to be considered when an adolescent reaches 18.

Box 7: What the Board will do:

- **Improving physical and mental health of children and young people is important for the Health and Wellbeing Board. The HWB is looking to deliver improvements through early years settings, schools and colleges (as indicated in the draft strategy).**
- **The BHR Children and Young People Transformation Board will be reporting to HWB on the progress it is making on CYP health and wellbeing.**
- **In June 2019, the Council's Cabinet agreed the establishment of Havering's Safeguarding Adolescent Hub, and will be developing its approach to Transitional Safeguarding with partners in 2020. The Board is assisting in raising awareness of new the arrangements by signposting to the relevant decision paper through this report:**
  https://democracy.havering.gov.uk/ieListDocuments.aspx?CId=153&MId=6187

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HEALTH & WELLBEING BOARD

Subject Heading:	Havering Federation: an update on Social Prescribing in Havering
Board Lead:	
Report Author and contact details:	Dr Meera Kalathara, Havering Health Board member

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

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SUMMARY

The Health and Wellbeing Board received two items in November 2019 about Local Area Co-ordination and social prescribing. Havering Federation 9on behalf of primary care networks) has been asked to present to the Board the progress that has been made by Primary Care Networks in developing GP social prescribing in Havering.

NHS ten-year plan requires established primary care networks (PCN). Social prescribing link workers will work as a key part of the PCN multidisciplinary team. Social prescribing can help PCNs to strengthen community and personal resilience and reduces health and wellbeing inequalities by addressing the wider determinants of health, such as debt, poor housing and physical inactivity, by increasing people's active involvement with their local communities. It particularly works for people with long term conditions (including support for mental health), for people who are lonely or isolated, or have complex social needs which affect their wellbeing.

There will be four PCNs across havering general practice landscape. All four PCNs are in the process of exploring best options to commission social prescribing service. To date, two of the four PCNs are in advanced stages of procuring the service from third sector. The PCNs are required to commission the service as soon as possible to demonstrate readiness.

However, mindful of the need to engage with the borough , a joint meeting between the Health and Local Authority is planned towards the end of January to explore local options. Further update on the outcome of the meeting will be provided at the next meeting,

Havering Health GP Federation is acting in the supporting capacity. Havering Health is facilitating discussions where possible to support the PCNs in their development phase.

RECOMMENDATIONS

For the Board to note progress update, taking into account reports received in November 2019 regarding Local Area Co-ordination and Compendium Connectors.

REPORT DETAIL

Nothing further to add

IMPLICATIONS AND RISKS

None
BACKGROUND PAPERS
None

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HEALTH & WELLBEING BOARD

Subject Heading:	Progress with Barking, Havering and Redbridge Joint Strategic Needs Assessment
Board Lead:	Mark Ansell, Director of Public Health
Report Author and contact details:	Mark Ansell, Director of Public Health mark.ansell@havering.gov.uk; ext. 1818

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

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

The Report describes progress made with the development of a JSNA for the developing BHR health and social care system and suggested next steps.

RECOMMENDATIONS

Members are asked to consider and comment on the first draft of the BHR JSNA and proposed next steps.

REPORT DETAIL

The Integrated Care Partnership Board requested a JSNA for the developing BHR health and social care system in the summer of 2019. A first draft has now been produced by the Public Health teams of the 3 boroughs in conjunction with the various Transformation Boards working to improve care within the developing BHR system.

It is structured around the King's Fund's population health model that presents population health outcomes as standing on four pillars: -

- The wider determinants
- Health related behaviours
- The communities / places in which we live
- Integrated health and social care services

The analysis regarding the health and social care services pillar is further subdivided into separate sections regarding each of the Transformation Boards. Each section seeks to provide a brief summary of the needs of the population based on an analysis of a small dashboard of metrics relevant to that topic; drawing on relevant policy and national evidence where necessary.

Recommendations are made regarding actions on the part of the health and social care system to address the needs identified. The analysis and recommendations are deliberately high level and made with the intention of identifying priorities for action not to inform detailed action planning.

Commentary and recommendations regarding the first three pillars are made at borough level, as the Council is the lead agency for local action in most instances, with health partners engaging via borough level Health and Wellbeing Boards. Commentary and recommendations regarding the health and social care system relate to the whole of the BHR system as partners are agreed that the overall approach should be consistent across the whole area.

The executive summary (attachment 1) attempts to capture the major factors affecting population-level health outcomes and the implications for health and social care services in a single overarching narrative.

Further development of the JSNA will be iterative, with each edition better than the last. Areas for development in 2020 include additional analysis and commentary regarding: -

- the health needs of the population at locality level. The JSNA includes dashboards containing locality level data where these can be determined. In the coming year, public health teams will work with PCNs and other stakeholders leading the delivery of services at locality level to produce a summary of the health needs of the population served and priorities for action.
- the needs of specific priority groups e.g. people with a learning disability
- primary, urgent and planned care
- patient / service user experience

In addition to the JSNA profiles; officers from the three boroughs and BHR CCGs have reviewed how the information contained might be made available in the form of an online data visualisation / mapping tool to enable interested parties to further interrogate the information held within the BHR JSNA and bring the data to life. An options appraisal has been undertaken and Local Insight chosen as being the best fit with local needs in terms of functionality, adaptability, cost and level of maintenance required.

Local Insight comes prepopulated with over a 1000 different open source indicators that the supplier refreshes regularly. These can be grouped into bespoke collections e.g. the BHR JSNA dataset, structured in line with the population health model, and analysed for locally determined geographies e.g. localities, where the underlying data allow. In addition, locally sourced data can be added and presented in the same way. The tool itself is relatively intuitive and easy to use, both for the developer and the end user. The necessary licences will be purchased during December and the tool should be up and running in early spring.

Next steps

1. DsPH / colleagues will present the JSNA profile to the ICPB, H&WBs and BHR Transformation Boards with request that they: -
   - identify any errors that need to be remedied before publication of the 2020 edition the BHR JSNA
   - suggest any gaps that they would hope to see addressed in subsequent iterations of the JSNA
   - review their current work programme against the recommendations made in the JSNA and comment on the rationale for any significant gaps or areas of divergence.

2. Council and BHR CCGs officers to collaborate to get the Local Insight operational by early spring.

3. DsPH / colleagues to develop brief statements about the needs of each locality with PCNs / other relevant stakeholders for inclusion in the 2021 JSNA

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4. Going forward, each of the Boards identified above is asked to build consideration of the JSNA recommendations and how the JSNA might be strengthened into their respective annual work programmes.

Progress with next steps

1. The draft JSNA was presented to the ICPB in December 2019. It was well received. The following additions were made to the proposed next steps set out above: -

- That the recommendations made within the JSNA should be cross checked against the priorities identified in the Healthy London Partnership's Health and Care Vision for London[1].
- An owner should be indicated for each recommendation.
- Relevant Boards should be asked to confirm that the recommendations are being (or will be) addressed or explain why action isn't planned at this time.
- Develop a reporting mechanism to monitor progress against the recommendations made.
- Devise a means of monitoring and reporting on changes in relevant key outcome measures.

2. The draft JSNA was subsequently presented to the BHR Health and Care Cabinet. Again the document was well received; members felt that social care issues needed further development.

IMPLICATIONS AND RISKS

Health and Wellbeing Boards have a statutory obligation to develop a JSNA. The BHR JSNA complements but does not replace existing borough based JSNA documents and is consistent with the Board's intention to participate fully in BHR wide arrangements where this is likely to result in better outcomes and experience of care for local residents.

Commissioners of health and social must consider the JSNA but it has no direct role in decision making at locality, borough or tri-borough level.

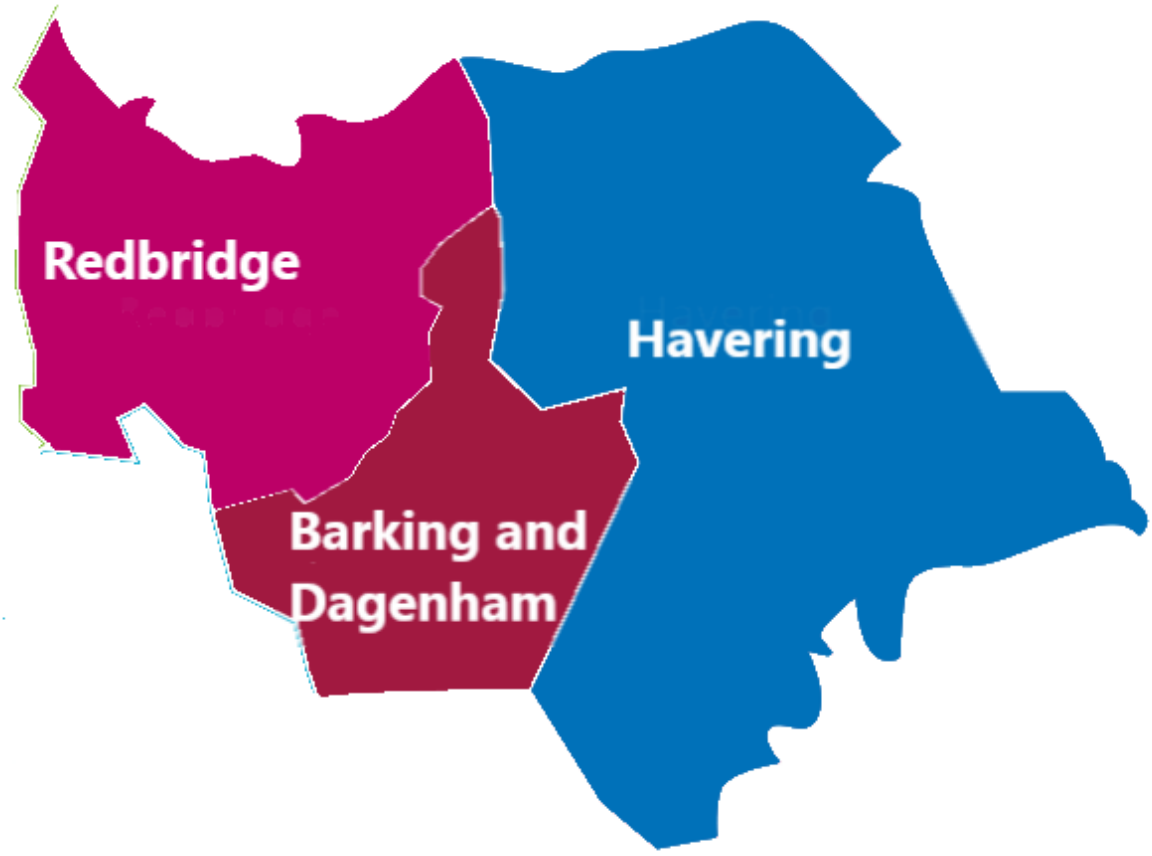
BACKGROUND PAPERS

Executive Summary and Recommendations from draft 2020 BHR JSNA.

[1] https://www.healthylondon.org/vision/

Barking & Dagenham, Havering and Redbridge Joint Strategic Needs Assessment 2020

Executive Summary and Recommendations



The **BHR JSNA 2020** is a first attempt at creating a single view of the challenges facing the partners represented at the BHR Integrated Care Partnership Board (ICPB) if they are to improve the health and wellbeing of people resident in the three boroughs and their experience of the health and social care system.

The differences between the three boroughs e.g. in terms of population structure, diversity, levels of disadvantage etc. are marked and are explored in the detail of the JSNA profiles. Nevertheless, the major challenges faced by the health and social care system are similar in all three boroughs and it is these overarching issues that are summarised here.

There has been significant **population growth** in all three boroughs in recent years. Even greater growth, equivalent to the population of another borough, is predicted in the next 20 years. Population increases will be particularly high in areas identified for largescale house building including Barking Riverside, Rainham, Romford and Ilford. New developments may have a significantly different (e.g. younger) demographic than the existing community. Otherwise, the existing population is projected to age; the very elderly cohort, with the most complex health and social care needs will see the greatest growth.

Life expectancy has improved steadily over the last few decades but more recently the **rate of improvement has slowed** if not stopped entirely and much of the additional years of life achieved are marred by ill-health and dependency on health and social care services. Moreover, there are **marked inequalities** in health outcomes between communities and population groups. The conditions causing most premature mortality are different to those causing the bulk of ill-health and disability.

Attaining good health for all is not in the sole gift of health and social care services. The health of future generations will be determined by the extent to which they:

- are born into loving, secure families and enter school ready to learn;
- are encouraged to aim high and achieve the best they can in school, further and higher education; to attain the qualifications and skills that will equip them for later life
- gain good employment that pays enough to enable them to participate fully in their community
- have safe, secure housing that adapts to their needs as they change through life
- live in communities that:
    - make healthier choices the easy and obvious choice
    - offer support and encouragement throughout life but particularly in times of need, including periods of physical and mental ill health and in old age
- and finally have access to high quality health and social care services proportionate to their needs.

To emphasise the many factors affecting health outcomes, the JSNA describes the needs of the BHR population in terms of **'four pillars of population health'**[1].

Population health outcomes			
The wider determinants of health	Our health behaviours and lifestyles	The places and communities in which we live	An integrated health and care system

Various studies suggest that health and social care services contribute about 25% to the overall health of the population and immense benefit to individual patients. Nonetheless, existing models of care are failing to deliver further improvements in population health and are struggling to cope with the challenge of demographic change, with much more to come. In these circumstances far greater emphasis must be placed on **prevention** in its widest sense; extending beyond traditional approaches addressing harmful lifestyles and behaviours to shape the places and communities in which we live and address the fundamental determinants of health.

Addressing the **wider determinants of health** e.g. by improving educational attainment, employment opportunities or access to a safe secure home is undoubtedly the most effective means of securing good physical and mental health in the long term.

The JSNA highlights opportunities for health and social care services to contribute directly to improve the life chances of local residents as a whole e.g. by fulfilling their role as **'anchor institutions'** at the centre of the local community and economy; as well highlighting the need to help particularly vulnerable groups e.g. patients with physical and mental illness to gain or maintain employment and a home.

The **places and communities** in which we live affects our health in a variety of ways. Currently living in cities inevitably increases exposure to **air pollution**, which causes significant harm to health. Local partners can minimise their direct contribution to air pollution; put in place the infrastructure to enable residents to switch to electric vehicles and public transport or better still walk and cycle, choosing routes that minimise their exposure to pollutants.

Plans for **regeneration** offer a unique opportunity to design in health, giving current and future residents better access to green space and community assets that build social networks and community cohesion. In addition, these plans are a means to tackle some of the problems facing the health and social care system e.g. they could deliver a step change in the quality of community and primary care facilities or provide

[1] Buck et al. A vision for population health: Towards a healthier future. Kings Fund 2018

key worker housing to attract hard to recruit health and social care professionals to live and work in BHR.

In working with residents to promote healthier **lifestyles and behaviours,** we must recognise that our day-to-day decisions are shaped by how and where we live. **Smoking** has become far less common than previously and is increasingly limited to disadvantaged communities and specific population groups (e.g. people with serious mental illness) where efforts should now be focused. More recently, **vapeing** has helped many more people to stop smoking and partners should actively encourage this trend.

However, for an increasingly high proportion of residents, **obesity** begins in childhood and will continue throughout life, greatly increasing their lifetime risk of a range of conditions including diabetes, CVD, cancers and MSK problems. Obesity will not be solved by simple advice to eat more healthily; we need to employ **a whole system approach** using all the levers available to assist residents to get a better balance between calories consumed and energy expended.

The lead agency for local action regarding the first three pillars will be Councils working with partners at borough level. NHS agencies have the opportunity to maximise the potential health benefits of relevant plans via participation in each borough's **Health and Wellbeing Board**[2].

The analysis of the challenges facing the local **health and social care system**[3] is structured around the life course.

Population growth results in additional pressure on all services. The problem is particularly acute for **maternity services**, which have finite capacity and are already close to that limit. Social disadvantage and increases in levels of maternal obesity result in a significant number of complex pregnancies. Therefore, in addition to action to improve further maternal and infant outcomes, action is needed to create additional capacity for low risk, midwife led deliveries in the community so hospital capacity can be focused on higher risk pregnancies.

Happily, most children are born in good health. Nonetheless, maternity and **health visiting services** offer essential support to all parents at a time that inevitably brings new and sometimes significant challenges. In addition, they can identify those families that are struggling, thereby enabling **early intervention** e.g. to ensure children are ready to learn by school age or to build parental confidence regarding the management of minor childhood illness and injury.

[2] To facilitate this, the JSNA comes in three variants; each presenting a bespoke analysis for one of the constituent boroughs within the BHR system regarding the wider determinants, lifestyle related behaviours and health related aspects of place and community.

[3] The JSNA commentary provides a single analysis regarding the whole BHR health and social care system as overarching priorities and policy will be agreed for the system as a whole. In addition, data are provided at borough and locality level to inform decisions regarding how BHR policy will be implemented locally.

A small proportion of children are born with or develop significant and lifelong problems. Children with **Special Education Needs and Disability** (SEND) may need support from health, social care and education professionals. The most common type of need is mild to moderate learning disability followed by speech, language and communication needs. The needs of a subset of children are captured in an **Education, Health and Care Plan** (EHCP). Autistic Spectrum Disorder is the most common primary need identified in EHCPs. Recent changes in legislation and understandable increases in parental expectations have combined to make SEND an area of financial concern to local government. Some children with particular needs have to be bussed long distances, at great expense, to specialist provision or in exceptional cases are in residential placements out of borough. Greater cooperation between boroughs may enable the creation of more specialist capacity, closer to home and at lower cost.

The mental health of children and young people (CYP) is a significant and growing concern. **Children and Adolescent Mental Health Services** (CAMHS) capacity is increasing significantly in response but even so, only a minority of CYP with a diagnosable condition will be under the care of specialist services at any point in time. Further effort is needed to improve the capability of GPs to support CYP with mental health problems and engage services commissioned by schools to make the most of overall capacity and ensure that cases are escalated when needed. In addition, there is a need to build the resilience of our CYP and give their parents, teachers, social workers etc. the skills and knowledge to identify and help CYP with mental health problems.

Exposure **to Adverse Childhood Experiences** (ACEs) greatly increases the risk of poor physical and mental health in later life, as well as a variety of other negative outcomes for the individual and wider society. Action to minimise exposure to ACEs and early intervene early to minimise harm when they occur must be a part of any holistic approach to prevention.

The **safeguarding** of CYP must be a priority for all partners. In most circumstances, it remains in the best interest of the child that they remain under the care of their parents with additional support. However, for some CYP, the best option is that they be taken into care. **Looked after children** (LAC) are likely to have had complex and difficult childhoods. Many will have mental health problems; often coupled with poor educational attainment. Their long-term life chances are significantly poorer than the norm. Support to LAC should extend beyond timely access to excellent treatment and care to include support in the longer term with housing and opportunities to gain employment e.g. in health and social care services.

Successful **transition** from children's to adult services is crucial to accommodate the changing needs of young people over time. Moreover, their eligibility for services and the team providing their care is also likely to change. Thorough and early planning is essential.

One in four adults experience **mental illness** and the total harm to health is comparable to that caused by cancers or CVD. Hence, it is right that the NHS is now committed to giving mental health parity of esteem with physical health. As with physical ill health; the burden of disease shows marked inequalities and there are significant opportunities to **prevent** mental illness throughout the life course. The impact of the wider determinants on mental health is particularly marked. Factors like debt, unemployment, homelessness, relationship breakdown and social isolation predispose to mental illness. Action to address the wider determinants can aid recovery but people with mental health issues, particularly serious mental illness are much less likely to be have stable accommodation or be in work. A coordinated, proactive approach on the part of multiple agencies is necessary. People in the **criminal justice system** and **street homeless** have particularly complex problems often including concurrent mental illness and drug and alcohol dependency. A relatively small number of patients live with **serious mental illness**. Priorities for action include a timely and effective response to **crisis** and action to reduce the **gap in life expectancy** between people with SMI and the population as a whole. A far bigger number of people are living with a common mental health condition. The ongoing development of **IAPT** has greatly increased the provision of talking therapies but further work is needed to increase uptake and achieve outcomes comparable to the best. At the same time; action is needed to increase the capacity and capability of **primary care** to better support the bulk of people living with mental health problems. Alongside improvements in care, action is needed to tackle stigma; build resilience and improve awareness of effective self-help options.

Cancers, with CVD, remains the big killer. A significant proportion of all cases are caused by avoidable risk factors like smoking, obesity and alcohol and hence are essentially preventable. **Early detection** remains the key to improving survival. Further effort is needed to increase public awareness of the early signs and symptoms of cancer and increase participation in screening programmes. Additional capacity, dependent on both more equipment and professional staff, is needed to facilitate **timely diagnosis and treatment**. As survival improves – and the incidence of disease increases with population ageing, more people are **living with and beyond cancer**; sometimes with significant ongoing health problems associated with treatments received.

Many people are at increased risk of developing **cardiovascular disease** (CVD) due to a combination of lifestyle and physiological risks factors. A significant proportion do not know they are at high risk of heart attacks and stroke. This despite the fact that **NHS health checks** are regularly offered to residents to identify this very risk.

This illustrates a more general observation that the number of people known to have a range of **long term conditions** (LTCs) is considerably lower than expected indicating that a large number of cases remain **undiagnosed and untreated**. Hence our approach to the identification of residents with or at risk of a range of LTCs needs to be improved; making more of NHS health checks; complemented by

community based, opportunistic interventions to engage people who don't normally attend their GP and ensuring that GPs regularly check patients with one condition for other LTCs – as they tend to share the same risk factors.

There is also strong evidence suggesting that a proportion of people with an LTC diagnosis miss out of one or more interventions that would reduce their risk of disease progression. Further improvement in the management of common LTCs is necessary to maximise the benefits of **secondary prevention**.

A small but growing proportion of residents live with **multiple LTCs**. Existing services struggle to meet their complex needs and as a result they frequently attend A&E and/or have unplanned hospital admissions. Although small in number, a disproportionate amount of resource is expended achieving less than satisfactory outcomes.

Similarly, **frail, older people** are at high risk of admission to hospital. Admission can lead to a rapid decline in physical abilities, equivalent to a year's additional age for each day of admission. Such deterioration can very quickly make a return home impossible.

Taken as a whole, the current model of health care results in large numbers of A&E attendances and unplanned hospital admissions in response to both relatively minor complaints and more significant crises. In both cases, many of these contacts are avoidable. More significantly, the current model is failing to improve population health outcomes; gives patients a poor experience of care and is unviable financially. A significantly different approach to organisation and delivery of health and social care is required.

We need to make better use of information to inform **population health management** as well as the clinical management of the individual patient. Stratification of the population by life stage and complexity of need will improve the planning and delivery of services for specific patient cohorts:

- **People who are generally well** who will benefit from primary prevention interventions to maintain good health; with more intensive support where people are currently well but at risk of developing LTCs.
- **People with long term conditions**; who in addition to the primary prevention interventions above, will benefit from early identification and treatment of LTCs, personalised care planning, self-management support, medicine management and secondary prevention services.
- **Older people with complex needs or frailty**; who in addition to the interventions above this cohort would benefit from a case management approach offering integrated, holistic, personalised, co-ordinated care with a high degree of continuity.

In each case, the precise interventions and delivery mechanisms will vary through the life course and in response to social factors.

The NHS Long Term sets out a very clear path for the redesign of services. It pledges to end the distinction between primary care and community services. Rather it envisages a new model, delivered within **localities** by general practices acting together as **Primary Care Networks (PCNs), with community teams, social care, hospitals and the voluntary sector working together** to help people with the most complex needs, to stay well, better manage their own conditions and live independently at home for longer. At times of crisis, a new NHS offer of **urgent community response and recovery support** will act as a single point of access for people requiring urgent care in the community; provide support within two hours of a crisis and a two-day referral for **reablement** care after discharge. **Residents in care homes,** some of the most vulnerable patients will benefit from guaranteed NHS support providing timely access to out of hours support and end of life care when needed.

The extension of **personalisation** from social care to health care services will see the whole package of care brought together in a care and support plan reflecting the needs and assets, values, goals and preferences of the individual.

Development of personalised care plans is an opportunity to reset the relationship between professional and client focusing less on deficits and what they need by way of services and more on what they can do and the **assets** available to them including family and wider social networks. The role of health and social care being to provide any additional support and / or aids necessary, for a limited period, to return them to their former level of functioning and independence.

Developing the multidisciplinary and multiagency team necessary to deliver this new model of care for complex patients; involving non-professional peer support and voluntary sector input in addition to professional and statutory health and care staff will be an immediate and significant challenge for emerging locality teams.

But better management of complex patients will not of itself improve health outcomes and achieve a sustainable balance between the needs of a growing and ageing population and the capacity and capability of local health and social care services.

Greater capacity will be needed if the far bigger group of residents with or at risk of a LTCs are all to be identified and thereafter managed in line with best practice. The introduction of **new professional groups** e.g. clinical pharmacists and physician assistants to complement GPs and practice nurses will help. As will better coordination and collaboration between practices working within PCNs; facilitated by improvements to **premises** and **IT**.

Innovative methods will be needed to identify residents who are at risk of disease who currently don't engage with general practice. The use of wearable technology will enable people to better understand and take more control over the management of their health.

Equally, health professionals and public will need to recognise the impact of personal circumstances and place on health and look beyond health care for more effective

ways of improving wellbeing. Strong links between general practice, other statutory services such as housing and the DWP, the community and voluntary sector within the locality should be are an essential element of locality working. The development of an effective **social prescribing** function; whereby patients are actively encouraged to access other forms of support will maximise the likelihood of success e.g. with 1:1 support from a care navigator. Partners and the community itself will also need to consider the assets available relative to needs and how any gaps may be filled[4]. Approaches such as **local area coordination** may strengthen the capacity of communities to identify and support vulnerable people and hence reduce pressure on statutory services.

Currently, many thousands of residents miss potentially lifesaving interventions such as immunisation, cancer screening or NHS health checks. Others will delay seeking help when they notice changes to their body that subsequently turn out to the early signs of cancer. Continued action is needed to improve knowledge and awareness e.g. the 'be clear on cancer' campaign and remove any barriers to engagement e.g. by offering screening and health checks outside of working hours or in the workplace.

However, people's decisions about engagement with health services and more widely regarding behaviours that affect health are not made in isolation but rather are shaped by the place where they live; prevailing cultural norms, their previous experiences and aspirations for the future.

The development of locality-based health and social care services is an opportunity to adopt a holistic approach to prevention that seeks to address **all four pillars of the population health model** throughout the life course e.g. by minimising exposure to and the harm caused by adverse childhood experiences; identifying and intervening with children at risk of arriving at school ill-equipped to learn; raising aspiration and incomes by creating apprenticeship opportunities for young people in disadvantaged communities and LAC; helping people with physical and mental health problems into work or to maintain a safe, secure home; reducing social isolation amongst older people etc.

[4] The JSNA currently describes the need for health and social care services at BHR and borough level. Data are provided at locality level and in the coming year, Public Health Services intend to work with developing locality teams to identify priorities for each.

Recommendations

From section 3. Population Health Outcomes

Recommendation 1: *All partners should participate in borough level H&WBs and take the opportunity to ensure there are robust plans in place regarding all four pillars of the population health model.*
Recommendation 2: *Plans regarding integrated health and social care services (pillar 4) should give the same priority to the prevention and / or treatment of conditions resulting in ill health and disability as for conditions causing premature death.*

From section 4. The wider determinants of health

Recommendation 3*: Work together to mitigate the worst harms of street homelessness and help those affected with the ultimate aim of enabling them to maintain suitable permanent accommodation.*
Recommendation 4: *Ensure Councils / NHS providers work with the DWP to offer residents excluded from employment due to disability and / or ill health including mental illness the opportunity to gain confidence, skills, work experience and ultimately secure employment.*
Recommendation 5: *Encourage health and social care professionals and patients / residents to consider the extent to which problems with employment, poverty, housing etc. are the underlying cause and / or exacerbate a presenting health issue and therefore might benefit from social prescribing[5] in addition to or instead of the tradition medical response.*
Recommendation 6: *Develop social prescribing as an effective alternative / adjunct to existing health and social care options. This should include action to identify and strengthen community capacity and self-help options, as well as an effective signposting function and bring together NHS, council and CVS stakeholders.*
Recommendation 7: *Encourage councils, NHS providers, colleges etc. to become 'anchor institutions' within the BHR patch maximising the contribution they make to the local community over and above the direct provision of services.*

From Section 5. Our Health Behaviours and Lifestyles

Recommendation 8: *Focus additional efforts in disadvantaged communities and / or cohorts known to have high prevalence of smoking e.g. people with mental health problems*.
Recommendation 9*: Ensure that smokers who wish to quit can continue to access counselling support and pharmaceutical aids, including prescription only medication where clinically indicated.*

[5] https://www.kingsfund.org.uk/publications/social-prescribing

***Recommendation 10**: Actively promote vaping as a safer alternative to continuing to smoke.*
***Recommendation 11:** Contribute towards the aspiration of a smoke free society by 2030 e.g. by continuing the de-normalisation of smoking in public spaces and homes; minimising the recruitment of new smokers through work with schools, rigorous enforcement of age related sales regulations and minimising access to cheap smuggled or counterfeit tobacco.*
***Recommendation 12**: Ensure that there is a comprehensive whole system approach to tackling obesity across BHR as a whole.*
***Recommendation 13:** Partners should work to:* • *increase participation in drug and alcohol treatment, particularly the latter.* • *improve the offer to people with drink and drug dependency and additional mental health problems* • *effectively support people with drink and drug problems who are street homeless* • *reduce and prevent harm to children and families arising from parental drink and drug problems.*

From Section 6. The Places and Communities in which we live

***Recommendation 14**: Work together to minimise the direct contribution of health and social are services to air pollution; put in place the infrastructure / encourage residents to switch to electric vehicles and public transport, or better still, walk and cycle, choosing routes that minimise their exposure to pollutants.*
***Recommendation 15**: Assess the strengths and weaknesses of the overall public estate at locality level and consider the development of shared community hubs providing a range of statutory services, including health and social care, where this allows the maintenance / improvement of services.*
***Recommendation 16:** Ensure plans and policies shaping regeneration and housing growth e.g. borough level Local Plans serve to build healthier communities not simply additional housing. A formal health impact assessment of the Local Plan may help in this regard.*
***Recommendation 17**: Put in place processes to share learning from the healthy new town project at Barking Riverside*.
***Recommendation 18**: Ensure that the housing needs of residents with specific needs e.g. relating to frailty, mental illness, physical and learning disabilities etc. are an integral part of plans for housing growth and regeneration.*
***Recommendation 19:** Consider if / how key worker housing might be made available to attract hard to recruit health and social care professionals into the BHR patch.*
***Recommendation 20**: Building on regeneration plans in the three boroughs; develop an effective approach to promote the benefits of living in Barking, Havering and Redbridge as part of collective effort to fill hard to recruit health and social care vacancies.*

***Recommendation 21**: Consider the need for / design of additional support to build social networks and community capacity particularly in areas identified for very large housing development and / or population churn.*
***Recommendation 6:** Develop social prescribing as an effective alternative / adjunct to existing health and social care options. This should include action to identify and strengthen community capacity and self-help options, as well as an effective signposting function and bring together NHS, council and CVS stakeholders.*
***Recommendation 22**: Ensure that the health and social care system contributes fully to efforts to tackle violence in all its forms but particularly with regard to domestic violence and the protection of vulnerable adolescents.*

From Section 7. Integrated Health and Social Care

Maternity Services (recommendations need renumbering!)

***Recommendation 40:** Enhance continuity of carer (CoC) ensuring as many women as possible receive midwife-led continuity of carer initially prioritising those identified as most vulnerable and high risk.*
***Recommendation 41:** Strengthen personalised care and choice; increase the proportion of women with a personalised care plan, initially prioritising disadvantaged and vulnerable women whilst offering all women information and choice on place of birth.*
***Recommendation 42:** Continuously improve maternal safety including by full implementation of the second version of the Saving Babies' Lives Care Bundle and work with Public Health to help expectant mothers to stop smoking to meet the national ambition to halve the rate of stillbirths, neonatal deaths, maternal deaths and intrapartum brain injury by 2025.*
***Recommendation 43**: Improved quality of postnatal care for all women including enhanced support to vulnerable women (e.g. perinatal mental health, drug and substance misuse) and focusing on infant feeding.*
***Recommendation ??**: Review the capacity of maternity services with regard to low risk and complex pregnancies to ensure it keeps pace with recent / future population growth. (Additional recommendation)*

Children & Young People

***Recommendation 23:** Undertake a rolling programme of reviews to ensure that the capacity of universal services e.g. health visiting, community paediatrics, therapies, Speech and Language etc. within BHR is adequate given the pace and scale of CYP population growth.*
***Recommendation 24:** The Maternity and CYP Transformation boards should receive and formally respond to the BHR Child Death Review annual report each year.*

Recommendation 25: *Ensure opportunities to maximise awareness and uptake of free preschool education and childcare are taken e.g. via e-red book, regular contacts with health professionals including midwifery, health visiting and with general practice.*
Recommendation 26*: Increase joint assessments by early years settings and health visitors; ensure that anonymised aggregate data from 2 – 2 ½ year checks undertaken using the ASQ3 are available to inform health service planning and interventions to improve school readiness. HV to implement a failsafe follow up procedure to capture all children eligible for the 2 year offer*
Recommendation 27: *Use data from 2-2 ½ year checks to identify population groups and or communities at greater risk of being non-school ready and the reasons why; to inform the development and targeting of evidence based interventions to enable parents and child care staff to support children back on to a trajectory towards school readiness. Use the same data set to ensure that there is adequate provision for children with more significant problems requiring timely assessment and care from relevant specialist health care services.*
Recommendation 28*: As part of a comprehensive approach to building greater aspiration and education achievement particularly in disadvantaged and / or otherwise vulnerable groups - consider the potential contribution of health and social care providers e.g. outreach to schools and career fairs; workplace experience; apprenticeships; career paths from less skilled lower paid roles into better paid, professional health and social care roles etc.*
Recommendation 12*: Ensure that there is a comprehensive whole system approach to tackling (childhood) obesity across BHR as a whole.*
Recommendation 29: *Encourage early years settings and schools to maximise the health and wellbeing benefit to children and young people in their care through participation in the relevant Mayor for London scheme or similar.*
Recommendation 30: *Work with schools to provide better support to pupils at risk of exclusion.*
Recommendation 31: *Put in place mechanisms to share learning from joint working between EIF and LBBD. Ensure that the outcomes from the multi-agency working around Emotional Wellbeing and Mental Health (including family interventions and targeted support for vulnerable cohorts) are taken forward.*
Recommendation 32: *Adopt a public health approach to tackling serious youth violence.*
Recommendation 33: *Review the delivery of childhood immunisation in BHR with the aim of increasing uptake to levels necessary to achieve herd immunity.*
Recommendation 34: *Work to increase delivery of 0-5 healthy child mandated checks.*
Recommendation 35: *The CYP Transformation Board should support the development of joint working in support of better CYP safeguarding as requested.*
Recommendation 36: *CYP transformation board to champion improved partnership working to better meet the needs of CYP with SEND including joint reviews to better direct resources and options on Pan BHR commissioning to facilitate best use of scarce clinical resources.*

Recommendation 37: *CYP and MH Transformation Boards should work to:* *- increase CAMHS capacity and strengthen links with other providers* *- develop the capacity and capability of professionals in universal services to support children with mental health problems and their families* *- support children and their families to be more resilient*
Recommendation 54*: Ensure there are comprehensive plans to prevent suicide. These should include (a) support to people bereaved by suicide and (b) systems to record episodes of self-harm and for subsequent follow up in the community.*
Recommendation 38: *Consider how health visiting, children centres and other early years providers can work together to strengthen the ability of parents to manage minor childhood illness and injury (and their confidence to do so).*
Recommendation 39: *Implement the existing plans developed to improve asthma care in BHR.*

Mental Health

Recommendation 40: *Investigate whether groups at higher risk of mental ill health are proportionally represented at all levels of mental health service provision.*
Recommendation 41*: Raise public awareness of mental ill health, tackle associated stigma and strengthen personal resilience e.g. by making use of 'Every Mind Matters' resources and self-help aids giving particular consideration to groups who appear less likely to seek help e.g. LGBT and BAME residents.*
Recommendation 42*: Promote the Making Every Contact Counts (MECC) approach by providing training to front facing staff across the wider partnership to promote awareness of mental health issues including stigma, suicide prevention and the benefits of Talking Therapies.*
Recommendation 43*: Improve understanding of public perceptions of Talking Therapies and how it be can promoted and delivered to maximise participation and successful completion and thereafter improve the promotion and delivery of Talking Therapies based on this insight.*
Recommendation 44*: Develop the capacity and capability of primary care to manage patients with common mental disorders and integrate consideration of mental health into the management of other care groups known to be at high risk of mental health problems.*
Recommendation 45*: Develop partnerships between primary care, specialist mental health services, other statutory services and the VCS at locality level to provide holistic support addressing the wider determinants as well as health and social care needs of people with mental health problems. An effective social prescribing function will assist patients to engage with relevant support.*

Recommendation 46: *Improve and increase joint working between mental health services and drug and alcohol services, including use of the CPA where appropriate, to improve outcomes for patients with dual diagnosis.*
Recommendation 47: *- Mental health and substance misuse services to work with relevant Council services to effectively outreach to and support the street homeless.*
Recommendation 48: *Review arrangements for those in contact with the criminal justice system, including ex-prisoners and their access to mental health services, and mental health service provision for offenders served with community orders, particularly for those subject to Alcohol Treatment Orders and Drug Rehabilitation Requirements*
Recommendation 49*: MH services should consider whether more people might benefit from a CPA and where a CPA is in place, work to improve the proportion in settled accommodation and in employment.*
Recommendation 50: *MH services; social care and housing should consider the scope to further improve the proportion of patients on the CPA in settled accommodation.*
Recommendation 51: *Statutory services across BHR should be encouraged to offer people with health problems including mental health problems the opportunity to gain employment.*
Recommendation 52*: Review the management of patients in crisis ensuring there is adequate place of safety provision given population growth and increasing complexity of needs. Investigate where interventions might have previously prevented escalation to crisis and use the lessons learned to improve mental healthcare.*
Recommendation 53: *Improve the management of physical health of patients with SMI; ensure all get an annual health check and improve effectiveness of support available to assist with lifestyle change – starting with smoking.*
Recommendation 54*: Ensure there are comprehensive plans to prevent suicide. These should include (a) support to people bereaved by suicide and (b) systems to record episodes of self-harm and for subsequent follow up in the community.*

Cancer

Recommendation 56: *Work with young people, parents and schools, as well as local providers to maximise uptake of HPV for boys and girls.*
Recommendation 57*: - Continue to work to increase uptake of cervical screening by offering extended hours in general practice and bowel screening with the roll out of FIT[6] testing for diagnosing colorectal cancer.*
Recommendation 58*: Continue efforts to raise awareness of signs and symptoms of cancer with the public and healthcare professionals.*

[6] https://www.cancerresearchuk.org/health-professional/screening/bowel-screening-evidence-and-resources/faecal-immunochemical-test-fit#FIT2

***Recommendation 59**: Continue to deliver sustained Cancer Waiting Time targets and implement and thereafter achieve the new 28-day Faster Diagnosis Standard (FDS)*[7]
***Recommendation 60**: Implement the national optimal cancer pathways*
***Recommendation 61:** Deliver personalised care for all cancer patients, resulting in improved patient experience and outcomes; specifically embed stratified pathways*[8] *for prostrate, breast and bowel cancer patients.*
***Recommendation 62:** Work towards a step-change in patients' and clinical professionals' understanding of cancer, with it being thought of as a Long-Term Condition.*

Long term conditions

***Recommendation 63:** Council to work with PCNs and individual practices to increase the offer and uptake of NHS health checks.*
***Recommendation 64:** Consider if / how novel approaches to opportunistic screening in the community might serve to engage an additional cohort of patients who do not take up the offer of a health check*
***Recommendation 65:** Increase range of support options available to assist patients found to be at high risk of CVD to achieve behaviour change. Collate all available support in a resource to facilitate planning following delivery of health checks.*
***Recommendation 66:** Maximise participation by eligible patients resident in BHR in the NDPP*
***Recommendation 67:** Improve the diagnosis and management of LTCS; consider the approach employed to improve diabetes care in LBBD. Given the common risk factors for a number of LTCs, patients with an existing condition should be checked regularly for other LTCs*

Recommendation 68: *Agree system wide arrangements for the management of complex, unstable multi-morbidity including*

- *An approach to population segmentation to identify the appropriate cohort of patients*
- *Consistent community provision across BHR and common pathways between primary, community and secondary care; social care and the voluntary sector Agreement and clarity of roles, enabling professionals to work at the top of their license*
- *Processes to facilitate multidisciplinary working e.g. opportunity to review complex cases by a MDT*

[7] https://www.england.nhs.uk/cancer/early-diagnosis/

[8] https://www.england.nhs.uk/wp-content/uploads/2016/04/stratified-pathways-update.pdf

Older people and frailty

Recommendation 69: *Maintain efforts to further increase the completeness of dementia diagnosis and the information and support available to patients and their families*
Recommendation 70: *Ensure the BHR Falls prevention pathway currently in development is consistent with national guidance and effectively implemented.*
Recommendation 71: *Ensure that the BHR Older People and Frailty Prevention offer currently in development is comprehensive, addressing socio-economic and behavioural risk factors and the early identification and management of modifiable conditions*
Recommendation 72: *Ensure that patients at risk of frailty are systematically identified; effectively supported to stay well; and receive urgent additional help in times of crisis.*
Recommendation 73: *Further improve the reablement offer in all three boroughs to maximise the proportion of patients who return home and stay home after admission to hospital.*
Recommendation 74: *Develop plans to implement the Enhanced Health in Care Homes (EHCH) model to all care homes in BHR.*
Recommendation 75: *Strengthen end of life care to increase the proportion of people who are supported to die with dignity in their usual place of residence.*

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HEALTH & WELLBEING BOARD

Subject Heading:	Homeless Prevention and Rough Sleeper Strategy 2020-2025
Board Lead:	Patrick Odling-Smee
Report Author and contact details:	Darren Alexander, Assistant Director 01708434434

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

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

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SUMMARY

1.1. The report sets out the Council's draft Homelessness and Rough Sleeping Strategy 2020 - 2025 that will be consulted until 10th February 2020. It builds on progress of the implementation of the Homeless Reduction Act and highlights some of the key actions that are proposed be taken by the Council and its partners to help prevent and address homelessness.

1.2. This report is a statutory requirement for local authorities, reiterated in guidance provided by the Ministry of Housing, Communities and Local Government (MHCLG) following the Homelessness Reduction Act 2017 as well as the MHCLG Rough Sleeper Strategy 2018.

1.3. The draft strategy includes a number of key priorities which are supported by a range of actions and recognises the importance of partnership working, including across council departments, statutory and voluntary agencies.

RECOMMENDATIONS

2.1 Board is asked to:

- Provide a steer on other key issues that are to be reflected in the strategy not already considered

- **Note** that the outcome of the consultation will inform and shape the final Strategy and its future priorities before final approval is sought from Cabinet.

REPORT DETAIL

3.1. This report presents Havering's draft Homelessness and Rough Sleeping Strategy showing how the Council and its partners will continue to work to prevent homelessness for those at risk and provide support when homelessness occurs. The Council has chosen to integrate the Rough Sleeping Strategy with the homelessness strategy into one document as the two areas are inextricably linked together.

3.2. The proposed strategy is aligned with the vision and objectives set out in Havering's Corporate Plan 2019/20 and Havering's draft Joint Health & Wellbeing Strategy 2019/23. It relies on the Council using its collective resources and expertise to prevent and address homelessness in the borough.

3.3. This vision is underpinned by the following four key priorities which have corresponding actions:

- Managing homelessness demand through effective pathways - we want to stop people from becoming homeless and reduce the use of temporary accommodation.
- Supporting our vulnerable residents - we will support those experiencing the crisis of homelessness, helping them to recover and regain their independence
- Ending rough sleeping by 2022 – we will halve rough sleeping by 2021 and eradicate it by 2022.
- Increasing the supply of affordable housing and reducing the use and cost of temporary accommodation – we will continue to invest in developing genuinely affordable housing in the borough and work with private landlords to improve access to affordable and good quality accommodation

3.4. These priorities were informed by a review of homelessness in the borough that

identified a number of key issues as summarised in the paragraphs below.

3.5. The number of households in temporary accommodation has steadily increased since 2013/14 due to changes in the local housing market and a lack of affordable accommodation at or below Local Housing Allowance (LHA) rates. There was a reduction in 2018/19 which was largely driven by changes since the introduction of the Homelessness Reduction Act 2017 that strengthened prevention activities and the provision of comprehensive housing options services to local residents.

3.6. The most frequent reasons for homelessness are eviction by family, loss of private rented accommodation, and domestic abuse. The Council has invested in preventative services that seek to support people to remain in their existing home including:

3.6.1. employing Community Outreach Housing Solutions Officers who offer mediation and conciliation for families in their home environment;
3.6.2. services to support those who have experienced domestic violence like the Independent Domestic Violence Advocates (IDVAs);
3.6.3. Havering Women's Aid refuge provision to reduce the risk to victims; and
3.6.4. the Council is also supporting households to access alternative private rented accommodation with financial assistance where required.

3.7. Our early intervention model is increasingly geared to helping people help themselves by identifying and resolving the root causes of their problems before they become critical. The Council is committed to continuing to prevent families from becoming homeless and, where this is not possible, support them to relieve their homelessness situation.

3.8. There is a very high demand for social housing in Havering. The Council has approximately 2,000 households waiting for Council homes with approximately 400 homes to let each year. The demand is highest for 1, 2 and 3 bedroom homes. Housing market pressures and the continuing unaffordability of housing in the borough will result in an ongoing increase in demand for support services to prevent homelessness.

3.9. Using the levers at the Council's disposal, we are seeking to address the issues surrounding the supply of both affordable housing and available properties within the private rented sector. The Council's ambitious regeneration programme will provide a significant number of new, much needed homes across the borough, over the next 10 years. However, in the short term, the transitioning of existing tenants from properties earmarked for regeneration will create some permanent supply challenges but also opportunities for homeless households to be housed, albeit temporarily, in the resulting empty properties.

3.10. At the same time, it is recognised that the private rented sector has a role to play in addressing the supply and demand imbalance. However, regulating the sector ensures that private rented properties offer residents a choice of safe, quality and well-managed accommodation. The key priorities are to reduce anti-social behaviour from rental properties which are caused by poor management, and improve housing standards. The Council acknowledges that the majority of landlords operate their businesses professionally and that the private rented sector can provide high quality housing options for local people.

3.11. The introduction of selective licensing in Romford Town and Brooklands wards and the extension of the additional licensing scheme by including the remaining six wards currently not covered; Cranham, Upminster, St Andrews, Emerson Park, Hacton and Hylands, will allow the Council to focus action against landlords who ignore their responsibilities whilst providing a light-touch approach for compliant

landlords.

3.12. The action the Council and its partners have taken to date has delivered significant reductions in the numbers of rough sleepers in the borough. We recognise that, despite having low rough sleeping numbers in comparison to most London boroughs, the Council still needs to develop a more proactive response to tackling this issue, especially within Romford Town Centre. The agencies already work closely together to support vulnerable people however we need to improve this because new rough sleepers continue to present, as do others arriving in Havering from neighbouring boroughs. There are also a number of entrenched rough sleepers who are hard to reach due to the complexity of their issues, in particular drug and alcohol abuse and mental health problems. We have clear and genuine aspirations to halve rough sleeping numbers in Havering by 2021 and eliminate rough sleeping in the borough by 2022, ahead of national targets.

3.13. Housing and homelessness are recognised as determinants of public health and critical to increasing the life expectancy of people living in Havering. The homelessness review highlights the additional support needs from a number of vulnerable groups and the draft strategy links with the Health and Wellbeing Board's objectives to improve health and social care outcomes through integrated services, especially for those suffering from mental health and substance misuse.

3.14. Building on the successful joint working between housing, mental health support agencies and substance misuse agencies, the draft Strategy proposes to develop activities already underway, led by the Council's various partners who support homeless households, while also seeking to be more ambitious in key areas to improve further outcomes over the coming years.

3.15. We recognise that dealing with homelessness is complex and numbers can be unpredictable, so we are not complacent. We need to keep our plans under review to respond to variations in demand or increases in the level of rough sleeping in future. The Council therefore will view this strategy as a "live" document, which will be subject to regular review to make sure Havering effectively responds to and addresses issues of homelessness.

IMPLICATIONS AND RISKS

4.1 Financial implications and risks:

The action plan, which is in Section 9 of The Homelessness and Rough Sleeping Strategy, does contain cost implications, but the majority of these can be managed within existing Housing Demand budgets or by making use of existing grants. The Regeneration and Supported Housing Programme actions are being led by other services within the Council and the associated costs will be addressed by them. The exception to this is the re-modelling of the hostels which will be subject to a separate Executive Decision once the new model has been agreed and the costs and the funding sources have been identified.

4.2 Legal implications and risks:

(i) Section 2 of the Homelessness Act 2002 ("HA 2002) requires local housing authorities to review homelessness in their district and to formulate and publish a strategy based on the results of the review. It is accordingly a statutory requirement for the Council to have a published homelessness strategy and a failure to do so would present a [illegible] challenge to the Council.

(ii) Section 1(4) HA 2002 requires a new strategy every 4 years. The proposed strategy is for 4 years, and subject to annual review, so is compliant with this requirement.

(iii) Chapter 7 Housing Act 1996 ("HA 1996") contains a local authority's statutory homelessness obligations. Sections 1(5) and 1(6) of HA 2002 require housing and social services authorities to take the homelessness strategy into account when exercising their functions.

(iv) Section 214A Housing Act 1996 (as amended by Homelessness Reduction Act 2017) ("HA 1996") provides that the Secretary of State may from time to time issue codes of practice relating to homelessness or the prevention of homelessness. In accordance with section 182(1) of the HA 1996 Act, local housing authorities and social services authority are obligated to have regard for the Secretary of State for the Ministry of Housing, Communities and Local Government's Homelessness Code of Guidance in exercising their functions relating to homelessness and the prevention of homelessness. Failure to have regard to the Code would again potentially give rise to legal challenge to the Strategy.

(v) The Homelessness Reduction Act 2017 came into effect from 3 April 2018 and requires that local housing authorities must take reasonable steps to either maintain or secure accommodation for eligible applicants threatened with homelessness.

(vi) Following the Homelessness Reduction Act 2017, a new Code of Guidance was issued by the Secretary of State to include the prevention duties as required by the HRA 2017.

(vii) Chapter 2 of the Code of Guidance relates to homelessness strategies and reviews.

(viii) Clause 2.4 of the Guidance states that the homelessness strategy should take account of the additional duties introduced through HRA 2017. The proposed strategy does so by including prevention as Priority 1 of the action plan.

(ix) The Code references Health and Social Care Act 2012 that requires a local authority to take such steps as it considers appropriate for improving the health of people in the area, including those who are homeless or at risk of homelessness. The Code focuses on having a multifaceted approach to homelessness and threatened homelessness with involvement of relevant departments and partner agencies.

(x) Paragraph 2.10 of the Code states that housing authorities "must" consult public or local authorities, voluntary organisations or other persons as they consider appropriate before adopting or modifying a homelessness strategy. Paragraph 5.2 of this report sets out those people, departments and organisations who will be consulted and encompasses a wide range of consultees in compliance with the requirement under the Code.

4.3 Human Resources implications and risks:

There are no Human Resource implications arising from the decision to consult with residents and all affected stakeholders on the draft strategy as these will be delivered through existing resources.

4.4 Equalities and Health implications and risks:

The outcome of the consultation will inform the Equality and Health Impact Assessment which will accompany the final version of the Homelessness and Rough Sleeping Strategy. Where necessary, the Service will set out an action plan to mitigate any adverse impacts identified.

BACKGROUND PAPERS

Homeless Prevention and Rough Sleeper Strategy Consultation:
https://www.havering.gov.uk/info/20001/housing/614/homelessness/1

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HEALTH & WELLBEING BOARD

Subject Heading:	The NHS Long Term Plan response across ELHCP. How we plan to deliver on our commitments.
Board Lead:	
Report Author and contact details:	Mark Scott, Deputy Director of Transformation PMO, ELHCP, markscott3@nhs.net

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

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

We (East London Health & Care Partnership) submitted a response to NHSE/I on the Long Term Plan on 15th November 2019, which is available on this web link https://www.eastlondonhcp.nhs.uk/ourplans

This pack contains an update on the overall development of our response to the LTP. This update outlines progress to date, future planned engagement and our approach to delivery and reporting.

This pack also contains a delivery report on our current progress in delivering key elements of the plan. This report sets out the high-level governance for implementing the plan and provides a short progress report based across four thematic priority areas:
1. Improving population health
2. System change and integration
3. Priority areas for improving outcomes
4. Enablers supporting work programmes

We are actively monitoring LTP metric trajectories, and have included an update on these areas in the pack.

RECOMMENDATIONS

The Havering Health and Wellbeing Board is asked to note the next steps in developing our response to the LTP, as well as note the ELHCP LTP Implementation Update.

REPORT DETAIL

These papers will be taken to CCG Governing Bodies, Trust Boards, Borough Partnership Boards and Health and Wellbeing Boards during January and February.

We will also be producing a short, public-facing version of the LTP response to be published in January.

The LTP response provides strategic direction across ELHCP and for local systems.

Local implementation of the LTP should provide the following benefits for local people:

- don't notice organisational boundaries – it is all one health and care system working together to provide the best care
- are supported to stay well
- can access the best care possible in modern, fit for purpose facilities
- can view their patient record online, and are confident it is stored securely
- access care provide by skilled, motivated, kind staff with a culture of continuous improvement
- benefit from world class research and innovation which means earlier diagnosis and more effective treatments.

A key part of our LTP response is to refocus towards prevention and population wellness, and a component of our population health approach will be to address health inequalities and wider determinants of health.

There will be an equality impact assessment undertaken of the LTP response in collaboration with other London STPs.

Further detail in accompanying report

IMPLICATIONS AND RISKS

Overall, it is a key strategic priority for all our partner organisations to manage financial risk in a different way, given the projected increases in demand for services and the available resources and capacity.

There are components of transformation funding across the LTP, which will be used to drive improvements and delivery of key metrics.

The two main areas of risk for LTP implementation are finance and workforce.

- Finance will be addressed via the 2020/21 system operating planning processes.
- There will be a detailed review on workforce brought to the March 2020 STP Executive, to ensure the proportionate level of oversight is given to this key enabler.

BACKGROUND PAPERS

None

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East London Health & Care Partnership

The NHS Long Term Plan

How we plan to deliver on our commitments

January 2020

Simon Hall
Director of Transformation

NHS Long Term Plan

- The NHS Long Term Plan was published in January 2019 and sets out an ambitious vision for the NHS over the next ten years and beyond.
- It outlines how the NHS will give everyone the best start in life; deliver world-class care for major health problems, such as cancer and heart disease, and help people age well
- We have been working locally to plan how we will deliver the Long Term Plan's commitments over the next five years. We are calling this our Strategy Delivery Plan (SDP)
- On 15 November we submitted our document to NHS England as a draft because of the pre-election purdah period.
- This draft is now on our website www.eastlondonhcp.nhs.uk/ourplans/ to allow people the opportunity to have their say on the content.
- A summary version is in development and will be shared online.

Engagement On The Plan

East London Health & Care Partnership

- The plan is a working document, and we are also developing a plain English summary and easy read version
- Undertaking formal engagement on our LTP response at key stakeholder meetings: ELHCP and CCG forums, Health & Wellbeing Boards, Integrated Care Partnerships, Overview and Scrutiny Committees and Provider Boards
- Reviewing our commitments across the LTP and developing tailored engagement plans for our programmes
- A rolling lunch and learn programme for CCG staff, to be extended to provider and local authority teams
- Engagement through an ELHCP public newsletter and the launch of a regular stakeholder briefing

Delivery and reporting

East London Health & Care Partnership

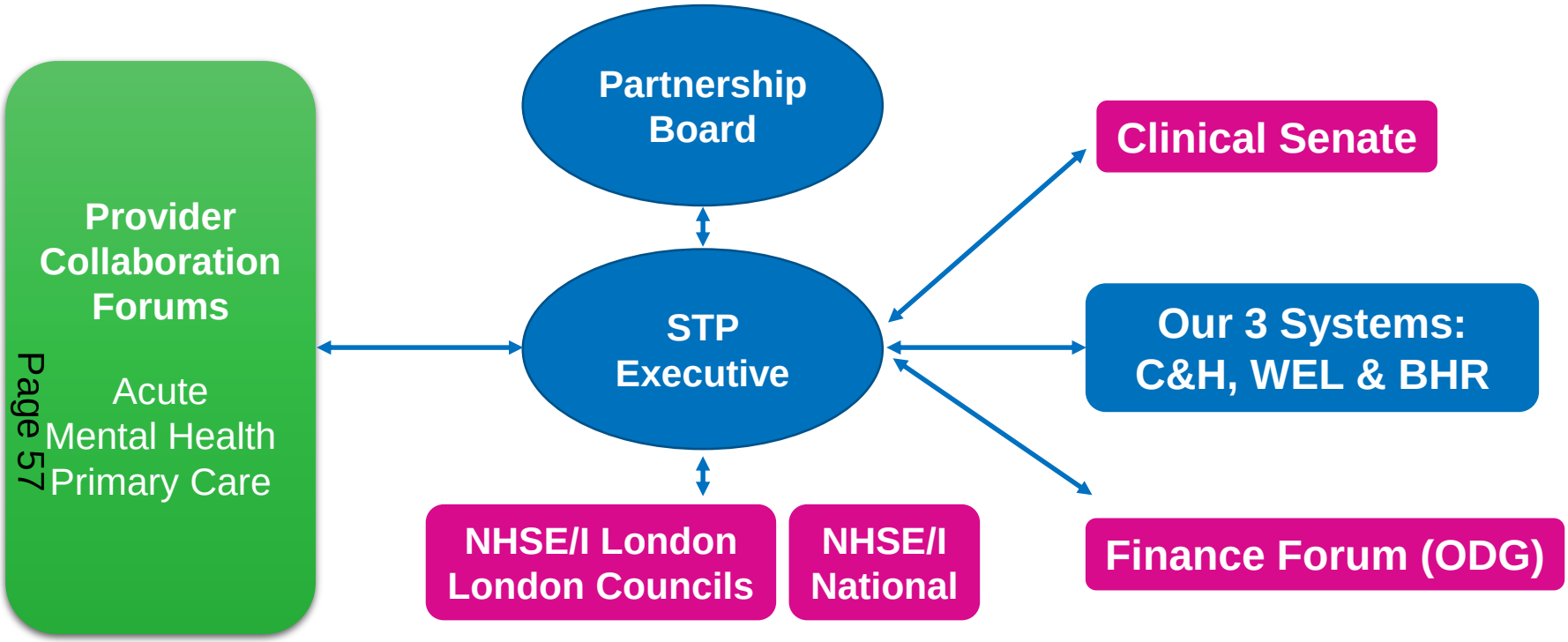
- Agree an accountability framework with each part of our ICS in order that we are all clear on what is being delivered where
- Work more closely with our elected representatives, particularly to secure integrated service delivery and to provide independent scrutiny
- Report annually on progress and what we've achieved

The following slides highlight our planned high-level governance and programme approach, as well as existing progress reporting and planned trajectories

Our governance (at high level)

East London Health & Care Partnership

Bringing together the way we work at a north east London level



Programmes

Improving population health

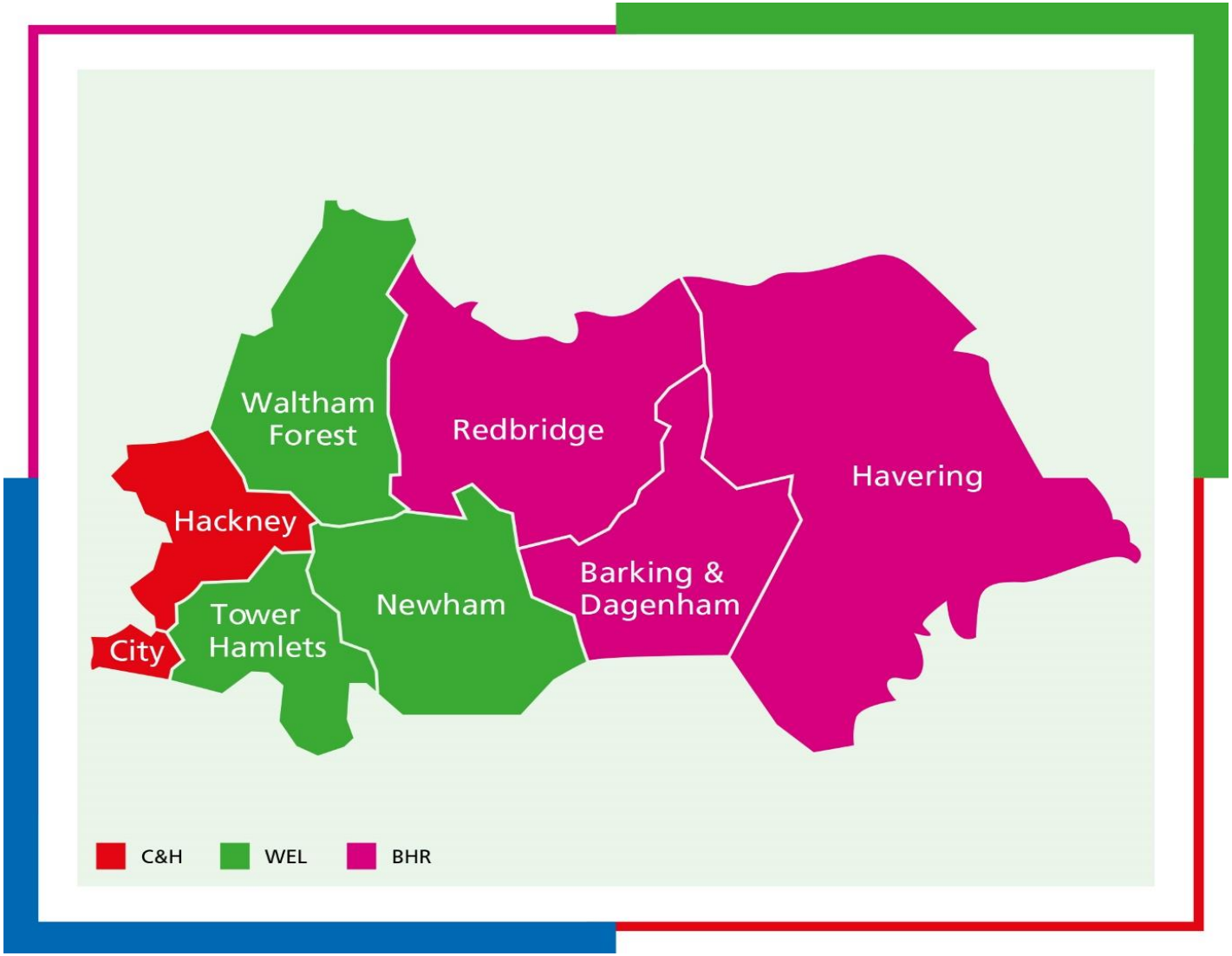
Priority areas for improving outcomes

System change and integration

Enablers

Our three Local Systems

East London Health & Care Partnership



Visual representation of how our system works

East London Health & Care Partnership

Our basic principle is that decisions about health and care take place closest to the resident/family as possible, and only where there is good reason to do so will programmes operate at NEL level.

We will need to recognise that NEL ICS will be the vehicle for Transformation Funding, and therefore need a governance process to reflect this going forward.

Programmes of work

East London Health & Care Partnership

Improving Population Health

- Prevention
- Health inequalities
- Wider determinants of health e.g. housing, poverty
- Personalised care

System Change And Integration

- Primary/community care
- Urgent and emergency care
- Improving planned care and outpatients
- Provider collaboration
- Mental health

Priority Areas for Improving Outcomes

- Cancer
- Learning disabilities and autism
- Children and young people
- Maternity
- Medicines optimisation
- Major LTCs
- End of life care

Enablers Supporting Work Programmes

- Workforce
- Digital
- Estates
- Demand and capacity – business intelligence
- Research and innovation

Improving population health

East London Health & Care Partnership

Population Health

Developing an ELHCP approach to population health will be a priority during 2020, with the following activities planned:

- An in-depth review into how we can strategically influence the development of new infrastructure, particularly around areas of significant re-generation, to maximise the population health impact. This will be brought through our ELHCP forums in January, with an STP Executive discussion planned for February.
- A review and re-launch of our prevention work stream through a workshop with Directors of Public Health during January.
- We will be bringing a proposed outline approach to population health to the STP Executive in March, taking into account best practice from national and regional work. There is also a planned engagement event in June, at which prevention and population health will be a headline topic.

Personalisation

- A review is currently underway to align the personal health budgets (PHBs) and social prescribing elements of the programme more closely. This will result in a new personalisation group across ELHCP from February, and there will be an event in March. We have also secured a resource from NHSE/I to assist us with this alignment going forward.
- A specific programme to improve the take up of PHBs in the BHR system will go live during January 2020, and it is hoped to extend learning from this initiative (with NELFT) at our stakeholder event.
- We propose an in-depth review of the personalisation programme at the April STP Executive.

System change and integration

East London Health & Care Partnership

Primary and Community Care

- Developed 48 Primary Care Networks (PCNs) across NEL
- Support by targeted organisational development and transformation funding
- Digital accelerator programme for WEL system established, as well as training hub board for PCN workforce

Improving Planned Care and Outpatients

- Range of improvement actions being implemented
- Performance vs constitutional standards (RTT/Diagnostics) challenged at BH & BHRUT.

Urgent and Emergency Care

- Current focus on managing winter pressures through funded support initiatives
- Ensuring grip during winter through VIPER meetings and following activities: working to right time/right place by digital assessment, bookings & communications, expanding appropriate care pathways criteria and further UEC integration testing.

Mental Health

- Good progress developing LTP for mental health and transformation plans via funding
- Challenges persist in achieving IAPT trajectories, CYP, out of area placements and perinatal access across parts of NEL

Priority areas for improving outcomes

East London Health & Care Partnership

Better start in life

- Mature local maternity system meeting national trajectories; no current midwifery vacancies
- Plans for ongoing CPD via cross-site rotational programmes to further support retention
- Review current/future activity across sites to develop sustainable maternity/neonatal service
- Children/young people's programme managing transitions into adult services priority for 2020 together with developing personalised care

Living well and long term conditions management

- Cancer focusing on smooth transition to new north east London operating model, but will need to ensure performance metrics return to trajectory during Q4
- Diabetes transformation funds successfully utilised, diabetes dashboard showing improvements across NEL on key metrics
- Cardiovascular prevention group in development, to share learning and support systems to prepare for STP-level transformation funding
- Medicines optimisation supported many transformation projects and plans greater links with primary care networks to enhance recruitment/retention of pharmacy workforce in PCNs.

A better end to life

- Local hospices to receive non-recurrent allocation of £875k to improve adults/children's end of life services.
- ELHCP match-funding bid for children's end of life care made to NHS E/I (awaiting outcome).

Enablers supporting work programmes

East London Health & Care Partnership

Workforce, Digital and Estates: ELHCP has well developed enabler programmes, with delivery across a range of initiatives. Main areas to highlight are:

- ***Digital:*** maximising impact of 'One London' investment will be priority area, as well as preparing organisations for introducing Patient Held Records
- ***Estates:*** introducing infrastructure plan and phased capital pipeline key priorities. Also ensuring development of health promoting environments at forefront of strategic planning approaches for NEL "new town" developments.
- ***Workforce:*** excellent progress implementing initiatives with stakeholders but scale of the recruitment and retention challenges remain significant with detailed STP Executive review in March 2019 and consideration to be given on how support and progress can be monitored on an ongoing basis given the importance of this enabler programme.

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Demand and Capacity – Business Intelligence

- Strategic planning currently happening individually by providers, and the Provider Collaboration forums have identified that there is a gap at system level.
- A demand and capacity mapping across all of NEL has been agreed, commencing in January 2020 initially focusing on acute services and taking into account population growth projections for the next 10-20 years.
- This mapping will be expanded to mental health and community services over the next few months.

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Metrics Reporting

Outline of metrics by programme area

The metrics are currently based on planned trajectories, existing baseline monitoring and tracking to begin in early 2020

Improving Population Health: Funding And Metrics

Ref	Measure	Area	Target	Compliant
EN1	Personal health budgets	PHB	Varies by CCG	Y
EN3	Personalised care and support planning	PHB	Varies by CCG	Y
EN2	Social prescribing referrals*	Social Prescribing	Varies by CCG	N

Enablers Supporting Work Programmes: Metrics

Ref	Measure	Area	Target	Compliant
ED21	Cybersecurity	Digital	100% by Y5	Y

* **Referrals below trajectory due to lower than expected forecast numbers of link workers in place. Review of recruitment and retention of link workers to take place, reporting to February ELHCP personalisation group**

System change and integration: Primary care and acute services metrics

Ref.	Measure	Area	Target	Compliant
ED16	Proportion population with access to online consultations	Pcare	75%	Y
ED20	Proportion population registered to use NHSApp	Pcare	30%	Y
EM3	Learning Disability Registers/Annual Health Checks by GPs	Pcare	75%	Y

Ref.	Measure	Area	Target	Compliant
EM23	Ambulance Conveyance to ED	Acute	TBC	N/A
EM24	Delayed Transfers of Care	Acute	National Level	Y
EM25	Length of stay for patients in hospital for over 21 days	Acute	TBC	Y
EM16	Mental Health Liaison in general hospitals meet “core 24” service standard	Acute	70% in 23/24	Y

System change and integration: Mental health metrics

Ref.	Measure	Area	Target	Compliant
EA3	IAPT roll-out *	MH	50%	N
EH9	Access Children/Young People's Mental Health Services	MH	Varies by CCG	Y
EH12	Inappropriate adult mental health Out of Area bed days	MH	0 from 2021/22	Y
EH13	Annual physical health check in severe mental illness	MH	60%	Y
EH15	Women accessing specialist perinatal mental health service	MH	TBC	Y
EK1a	Inpatient care learning disability/autism: CCG commissioned	MH	<30	Y
EK1b	Inpatient care learning disability/autism: Sp Com commissioned	MH	<30	Y
EK1c	Inpatient care learning disability/autism: CCGs/NHS England for children	MH	15 children <30	Y
EH17	People accessing Individual Placement and Support	MH	TBC	Y
EH18	EIP Services achieving Level 3 NICE concordance	MH	95% by 23/24	Y
EH19	People receiving new models integrated primary/community care for severe mental illness	MH	Varies by CCG	Y
EH20	24/7 crisis provision for children and young people	MH	100% by 23/24	Y

* **Review of prevalence to take place, as NEL has higher prevalence and greater IAPT trajectories based on most recent calculations. Appraisal and benchmarking of NEL IAPT services (finance and service model) to be undertaken, including benchmarking against other services, to understand variance against trajectory.**

Priority areas for improving outcomes: Metrics

Ref.	Measure	Area	Target	Compliant
ES1	Patients directly admitted to stroke unit within 4 hours	Acute	80% 23/24	Y
ES2	Applicable stroke patients are assessed at 6 months*	Acute	>60% 23/24	N
ER1	People supported by NHS Diabetes Prevention Programme	Diabetes	Varies by CCG	Y
EP1	One Year Survival from Cancer	Cancer	Set by CA	Y
EP2	Proportion of cancers diagnosed at stages 1 or 2	Cancer	Set by CA	Y
EQ1	Still birth rate	LMS	TBC	Y
EQ2	Neo-natal mortality rate	LMS	TBC	Y
EQ3	Percentage of women placed on a maternity continuity of care pathway	LMS	TBC	Y
EQ	Brain Injury Rate	LMS	Undefined	Y

* **It is expected that there will be compliance against this trajectory from 20/21 onwards. There will be a review of reporting on this metric via the stroke database (SNAP), as well a review of post-discharge stroke pathways and service capacity, to provide assurance of future compliance against this metric.**

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HEALTH & WELLBEING BOARD

Subject Heading:	North East London Primary Care Strategy
Board Lead:	Mark Ansell
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The subject matter of this report deals with the following themes of the Health and Wellbeing Strategy

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

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SUMMARY

An STP primary care strategy is a key requirement under NHS long term plan and the final strategy has been submitted to NHSE on 30th June 2019.

The attached strategy is based on 7 existing NEL primary care strategies and NHS long term plan requirements. It has been extensively discussed with the stakeholders across the system and care has been taken to clearly define where this strategy sits within our STP, regional and national context and how it links with other enabler programmes such as digital, estates and integrated care.

The strategy outlines the primary care transformation programme in three key work streams (Quality & Efficiency, New Models and Workforce), our challenges and how we plan to achieve our vision. Furthermore, it outlines 15 aspirations in addition to NHS LTP requirements to be delivered by 2021 across NEL.

The strategy has been approved by all seven CCG's governing bodies.

RECOMMENDATIONS

For information only.

REPORT DETAIL

1. Introduction and Background

1.1 The purpose of this report is to introduce the NEL Primary Care Strategy and its delivery requirements within local and national context.

1.2 The NHS Long Term Plan (LTP) was published on 7th January and outlined an STP primary care strategy as a key requirement. The draft strategy and appendices (attached) was developed with key stakeholders across the system and incorporate all seven primary care strategies across NEL.

2 Consultation

The Strategy is based on existing strategies across north east London, which had been developed via local stakeholders' engagement, including local authorities.

3 Mandatory Implications

3.1 Joint Strategic Needs Assessment

The strategy provides a strategic direction for consistent development of primary care across north east London to enable each place to deliver their local priorities.

3.2 Health and Wellbeing Strategy

The strategy emphasises on reducing health inequalities across NEL through a dedicated quality improvement work stream across the system. It is developed around the fundamental principle of placed based care across NEL to ensure primary care is at the centre of local communities, building relationships and partnerships with health and care providers and voluntary sector. Early diagnosis and intervention for cardiovascular disease is supported through national Directed Enhanced Service, starting in April 2020.

3.3 Integration

The primary care development as outlined in the strategy will provide the platform for sustainable partnerships among local stakeholders to deliver place-based person-centred care with multi-disciplinary teams at the heart of this approach. This also sets the localities up for multiple levels of integration (from clinical to system).

IMPLICATIONS AND RISKS

Not Applicable

BACKGROUND PAPERS

Not Applicable

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Primary Care Strategy

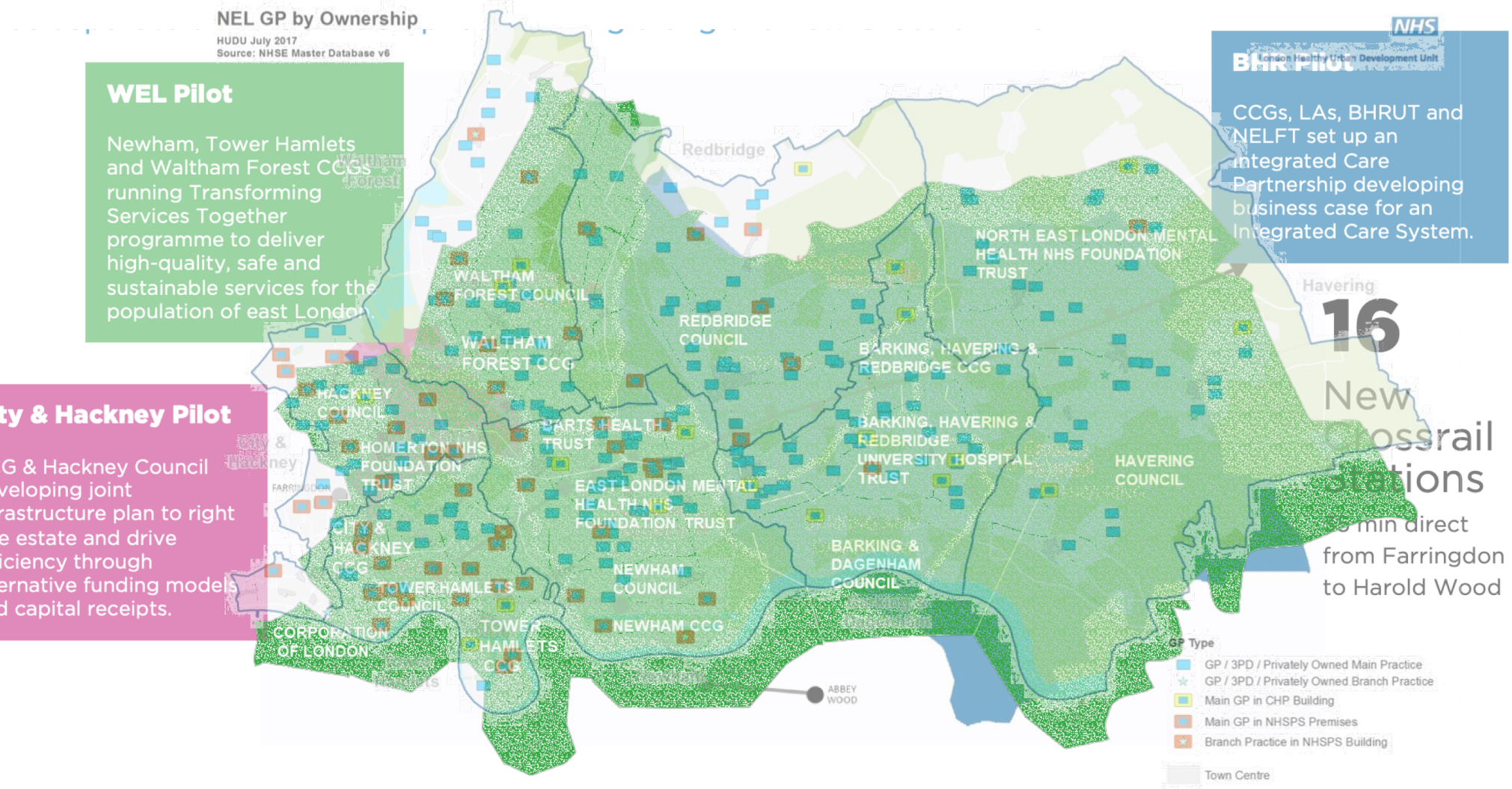
NORTH EAST LONDON

Strengthening Primary Care in North East London

May 2019

East London Health & Care Partnership

Key requirement of LTP
based on 7 existing primary care strategies
Common thread of place based person centred care
combined with NHS Long term plan requirements
Emphasises on the development and maturity of primary care mainly in NMs of working - quality improvement - workforce also considering supporting pc to increase capability and capacity to dleiver person centred care



Our Chairs - Clinical Commissioning Groups

East London Health & Care Partnership

Dr Atul Aggarwal
Chair, Havering
Clinical Commissioning Group

Dr Mark Ricketts
Chair, City and Hackney
Clinical Commissioning Group

Sir Sam Everington
Chair, Tower Hamlets
Clinical Commissioning Group

Dr Jagan John
Chair, Barking & Dagenham
Clinical Commissioning Group

Dr Anwar Khan
Chair, Waltham Forest
Clinical Commissioning Group

Dr Anil Mehta
Chair, Redbridge
Clinical Commissioning Group

Dr Muhammed Naqvi
Chair, Newham
Clinical Commissioning Group

East London Health & Care Partnership

”Person-centred, integrated and comprehensive care delivered by sustainable general practice, that forms the cornerstone of our integrated care systems”.

North East London Primary Care Vision

Purpose and Content

This document builds on individual primary care strategies and progress made in each borough against GPFV delivery in north east London and sets out a vision for primary care in NEL. It outlines the plan for continuing delivery against GPFV and sets key deliverables against NHS long term plan by 2021. The strategy is also a response to NHS long term plan requirement of an STP/ICS primary care strategy to ensure the sustainability and transformation of primary care and general practice as part of the overarching STP priorities to improve population health; and which engages CCGs and primary care providers in its implementation.

Table of Contents

Foreword

Our journey towards integrated care systems started in 2016, when 20 organisations in North East London came together to develop a sustainability and transformation plan. Our joint vision and priorities formed the basis of our partnership working across organisational boundaries and placed general practice and our population at the heart of future integrated care systems in north east London.

We remain committed to the sustainability of our list-based primary care services and will ensure a consistent high quality primary care service across NEL. General practice is the bedrock of our integrated care systems and with the publication of NHS long term plan (LTP), we will ensure that our federations and networks are mature and ready to deliver population based outcomes contract by 2020.

We have many assets in primary care. Our clinical leadership's experience, innovation and commitment to make tangible differences for patient's care is exemplary. Our staff remain motivated and enthusiastic to deliver change despite sometimes working in ambiguity. Our relationships across organisations are going from strength to strength and we are on the road to successfully improve the health and well being of our population.

It is no secret that we need better coordinated services, delivered efficiently with best value for money. The core of this ambition starts in primary care, integrating into community, social and voluntary services with acute hospitals only dealing with complex cases. We have come a long way in meeting some of our challenges but many remain.

Over the next two years, we are faced with unprecedented pace of change in primary care. It is not only challenging our way of working, but also the way we approach things.

Ceri Jacob
Managing Director, BHR CCGs
SRO, NEL Primary Care

Anwar Khan
CCG Chair, Waltham Forest
CRO, NEL Primary Care

No doubt, it will be difficult but it's also exciting. We will need to push our boundaries, challenge our abilities and support each other to develop new skills.

This strategy builds on the existing seven primary care strategies across NE London and gives us a framework for delivery as outlined in GPFV and NHS LTP. Our core values of placed based person centred care remains the same, but we now have more support to deliver our vision.

Our vision of making NE London a place with consistent high quality of care, a dedicated, motivated and multi-skilled workforce with the healthiest and happiest population in England is getting closer to realisation but we can only achieve this by continuing to work together and support each other.

Executive Summary

In October 2014, the *NHS Five year forward View* set the strategic direction for health economies in England and made primary care a priority with a promise of new funding. Subsequent national and regional (London) frameworks reinforced the primary care objectives and in January 2019, the NHS long term plan was published outlining a blueprint for NHS for the next 10 years with focus on prevention, improving services for patients and finally abolishing the divide between primary and community services.

The NEL STP *(published in 2016)* outlined six key priorities to be addressed collectively across NEL, delivered through a place based care model embedded in primary care, seamlessly integrated with community services.

Our Challenges

NEL is an area with significant health and wellbeing challenges. Our population is set to grow by 18% in the next fifteen years, and five out of our eight boroughs are in the lowest quintile for deprivation in the UK. Health inequalities are high, with many residents challenged by poor physical and mental health driven by factors such as smoking and childhood obesity. People frequently move around the patch and are highly dependent on secondary care.

Adding to the above, a reducing workforce in primary care *(more than 25% of GPs being beyond retirement age in one borough),* rising demand in GP appointments, varied primary care quality across NEL *(87% rated good vs 92% for London STPs),* considerable variation across NEL in no. of GPs per 10k population ratio *(4.5 in Redbridge – 6.5 in City & Hackney)* and varied levels of historic investments in primary care makes our challenges unique and places significant pressure on our local services.

Furthermore, our total system financial challenge in a *'do nothing*' scenario would be **£578m** by 2021. Achieving ambitious 'business as usual' cost improvements as we have done in the past would still leave us with a funding gap of **£336m** by 2021. To help reduce this gap, we have identified a range of opportunities and interventions through the STP, with primary care the key enabler.

Where we are

A primary care stocktake was undertaken in June 2018 to give us a clear picture of our progress. This strategy and the three delivery work streams for Quality and Efficiency, New Models and Primary Care Workforce are a direct result of the stocktake recommendations.

Our primary care vision is "**Person-centred, integrated and comprehensive care delivered by sustainable general practice, that forms the cornerstone of our integrated care systems".**

Quality - Since 2015, substantial clinically led progress has been made in primary care development across north east London. Practices have been engaged in various resilience and QI programmes, significantly improving primary care quality across NEL (evidenced by improved CQC practice ratings in NEL).

New models – Over the last 10-15 years, general practice has undergone a major shift to a more collaborative and scaled-up way of working. Across NEL, geographically aligned practices are generally grouped together to lay the foundations of our integrated care systems. These groupings are locally referred to as *neighbourhoods, clusters or localities,* covering 30k-80k population with an overarching GP membership organisation *(Federation)* in each borough to potentially deliver economies of scale and better coordinated care.

We expect our localities to form primary care networks as outlined in the NHS Long Term Plan (LTP), which not only endorses this primary care network working, but has also included it in GP contracts for 2019/20 onwards. This requires a greater pace of change in primary care than before and close working between commissioners and providers.

Across NEL, transformational funding has been used to improve primary care providers' governance, IT, network development and quality improvement. Boroughs such as City and Hackney and Tower Hamlets are leading the way in provider development and we are making sure that other boroughs are benefiting from their experience and good practice.

Through New Models work stream, we need to establish how best our network populations fit with the NHS LTP requirement of 30k-50k and corresponding primary care network workforce.

Furthermore, work is in progress to achieve full coverage for online consultations, explore digital innovations and extended access across NEL.

Workforce – An analysis of primary care staff FTE per 100,000 population highlights the scale of the challenge facing NEL in primary care workforce. In NEL, admin (non-clinical), direct patient care, GPs and nurses are on average 16%, 40%, 14% *(with the exception of City and Hackney and Tower Hamlets)* and 62% less than the England average.

To mitigate against these challenges, we have undertaken an in depth analysis of GP recruitment and retention issues through literature reviews and focus groups and developed a NEL GP retention framework, which has formed the basis of various GP retention schemes across NEL.

Executive Summary

Number of primary care admin staff have already been trained in different skills including sign posting, social prescribing and helping patients with self care. Additional training has been provided to support GPs in admin tasks and further training is planned across NEL.

International GP recruitment has not been as successful as initially planned, however, further recruitment is in progress in collaboration with NHSE and HEE.

Achieving our Vision

An ELHCP Primary Care Transformation Team has been set up to support delivery of the three main delivery work streams as mentioned above, and two task and finish groups *(Finance and Governance included in appendix V).* A primary care transformation board ensures governance and accountability to the STP and a provider forum provides insights and feedback from the primary are provider landscape. The work streams include delivery of NHS long term plan as well as local ambition and vision, especially support and development of primary care networks to deliver new GP network contract and Directed Enhanced Service (DES).

Not withstanding the requirements outlined in GPFV, NHS LTP and specifically GP network contract DES, we are also committing ourselves to 5 key aspirations in each of the delivery work streams to ensure a solid foundation for a sustainable delivery. *Our success measures are included in appendix IV.*

Quality and Efficiency – We will strengthen primary care by embedding a quality Improvement culture across NEL;

Quality improvement has been the main focus across NEL and while patients have access to a number of excellent, high quality primary care services across NEL, as a whole, north east London needs to make significant progress to ensure consistent high quality and equality of access.

Our 5 quality aspirations to be delivered by 2021;

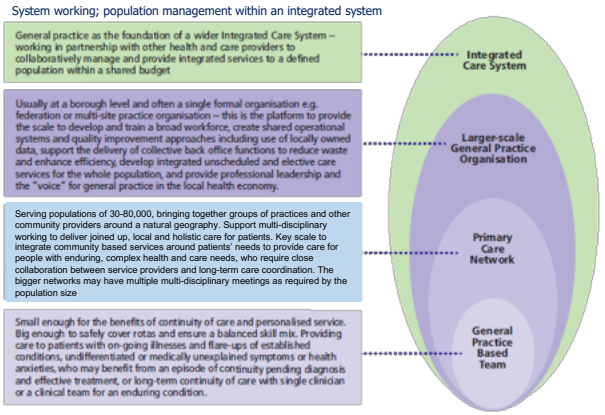
- We will aim to achieve a CQC rating of good or outstanding for 95% of practices in each borough.
- We will aim to have at least one QI expert per network
- We will ensure workflow optimisation in each practice across NEL
- We will develop a NEL wide QI methodology to ensure consistent quality across the STP
- We will aim to implement best practice key principles for at least 5 care pathways across NEL within the available local resources to ensure consistent access and quality of services

We will bring our learnings from the various QI initiatives across NEL under quality and efficiency work stream and support each other in the delivery of consistent high quality care across NEL.

New models - We will develop new models, optimising digital innovations, at-scale working and learnings from new developments to deliver population based comprehensive care.

During 2018/19, considerable work has been done to form the basis of new ways of working across NEL. We have adopted the system working outlined in '*Strategic commissioning framework – next steps'* with GP federations development being fundamental to the delivery of network contracts.

We will continue our progress towards provider maturity, ensure network development as outlined in NHS LTP and explore new and innovative models of care through new models of care work stream.



Our STP primary care estates strategy outlines the development of good quality, cost effective flexible estates infrastructure to support the delivery of new models of care over the next 5-20 years. Even though our hospitals and primary care premises are at full capacity, we have around 60% free capacity in our community estates. We will explore maximising this capacity through new models.

As well as the practice redesign work facilitated by the Digital Accelerator site (Waltham Forest) and the requirements set out in the latest GP contract, some of the key developments underpinning the future ways of working in Primary Care are;

- Expanding the use of e-Referral Service to include other specialities in acute, community and mental health services
- Expansion of the east London Patient Record (e-LPR) into BHR and connecting to the rest of London via the 'One London' Local Health and care record exemplar
- Comprehensive use of electronic ordering of pathology and radiology
- Redesign of Outpatients including the use of 'Advice and Guidance' and the e-LPR

Executive Summary

Our 5 new models aspirations to be delivered by 2021;

- We will have mature federations in each borough delivering population based outcomes via networks
- Each network will have evidence of their response to their population demographics and needs
- Network Clinical Directors will be represented at appropriate system levels to reduce unwarranted inequalities
- We will have standard policies and procedures for all federations, so that all staff are treated and supported equally
- In addition to online consultations, we will have at least one more digital tool (e.g. online referrals) in each practice

- The roll out of NHSMail, access to patient records including discharge summaries and Co-ordinate My Care in nursing homes
- Expanded use of Co-ordinate My Care to support patients towards the end of their life

Primary care workforce - We will make NE London a desirable place to work and train in primary care.

During 2018/19, our focus has been on understanding and developing GP and GPN retention and recruitment models.

We will continue to implement our learnings for GPs and GPNs recruitment and retention across NEL and will expand our focus on wider primary care workforce recruitment and development as outlined in NHS long term plan.

We will work closely with the new models group to develop flexible network based workforce operational models across NEL.

Although there has been a consistent improvement in primary care data quality including GPNs across NEL with percentage of practices requiring estimation (NHS Digital) dropping from 26.7% in September 2015 to 8.4% in September 2018, the data quality will need to improve further to enable effective workforce modelling.

Alignment with wider system programmes

Since the development of NEL STP, there are multiple integration and improvement programmes running across the 7 CCGs. These programmes are delivering a wide range of national and local priorities with patient centred comprehensive care as a consistent theme across all. Across NEL, integrated care programmes have been bringing primary, community and secondary care closer together by redesigning pathways and embedding new ways of working.

Our 5 workforce aspirations to be delivered by 2021;

- We will aim to implement a local salaried portfolio scheme for new and existing GPs across all boroughs
- We will ensure continuous professional development opportunities for each professional category across NEL
- HEE and local CEPNs will develop an STP primary care workforce training hubs at locality level to support the development and realisation of educational programmes for primary and community care workforce at scale
- We will model our future primary care workforce requirement to ensure proactive recruitment.
- We will develop innovative primary care employment models via workforce modelling tool.

It is crucial for us to ensure that the integrated care developments closely align with primary care networks developments across NEL to achieve our vision of General Practice as the cornerstone of our integrated care systems.

We will ensure that we work closely with the wider system programmes to avoid duplication and underpin the culture change in NEL.

Without the complete alignment and collaborative working with wider system programmes we will not be able to deliver our vision fully and are in danger of delivering success in patches.

To deliver our vision and meet the financial challenge, we not only have to keep the pace of change but also explore the avenues beyond our individual organisational boundaries. This demands collaboration and transparency between commissioners and providers at an unprecedented level and we believe that through growing relationships and trust in NEL, we can meet this challenge.

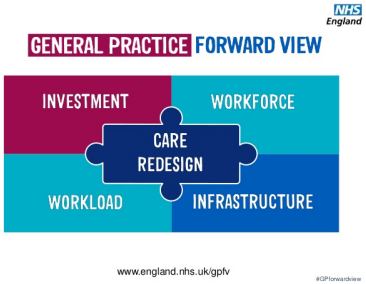
Jane Lindo
Director of Primary Care
North East London STP

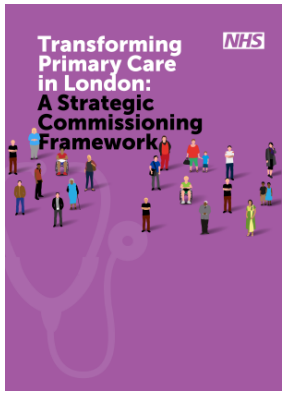
East London Health & Care Partnership

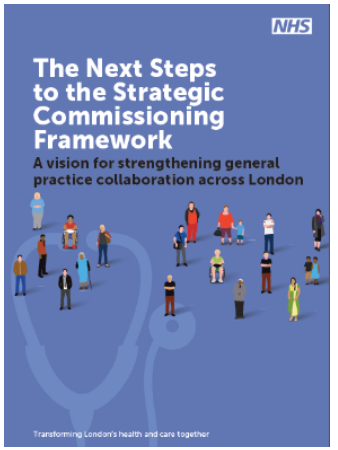
CHAPTER 1

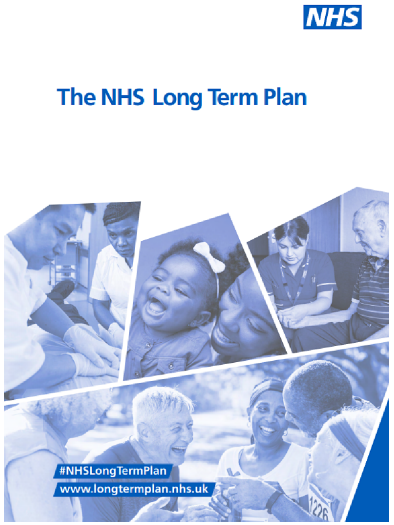
Context and Vision

- National Context
- London Context
- Local Context
- Our Vision









National Context

In line with the FV and GPFV, on 7th January 2019, *NHS long term plan (LTP)* was published outlining a blueprint for NHS for the next 10 years with focus on prevention, improving services for patients and finally abolishing the divide between primary and community services.

Furthermore, the GP network contract and Directed Enhanced Services (DES) specifications were published on 29th March 2019, with three key parts;

1. National Network Service Specifications
2. National schedule of Network Financial Entitlements
3. Supplementary Network Services

Key primary care headlines from the LTP are:

- ✓ Increased funding by at least £4.5bn by 2023/24
- ✓ Development of Primary Care Networks (PCNs) based on neighbouring GP practices covering 30-50k population
- ✓ Development of multidisciplinary integrated community teams aligned with primary care networks, comprising a range of staff including GPs, pharmacists, district nurses, Community geriatricians, dementia workers, allied health professionals, joined by social care and voluntary sector
- ✓ On-going training provided for multidisciplinary teams
- ✓ Community health crisis response service to deliver the service within 2 hours of referral in line with the NICE guidelines. Reablement care to be delivered within 2 days of referral to patients who are judged to need it
- ✓ PCNs to receive a new 'shared savings' scheme to benefit from reduction in A&E avoidable attendances and admissions
- ✓ Individual practices to enter into a multi-year network contract as an extension to their existing contract and have designated network fund through which all resources will flow
- ✓ CCGs to add all locally enhanced services' contracts to network contracts
- ✓ Enhanced health in care homes vanguard scheme to be fully rolled out – linking PCNs to care homes with named GP support for all patients and networks collaborating with emergency services on out of hours care
- ✓ All patients to have the right to access GP consultations via telephone or online within five years
- ✓ LTP funding made available for tackling health inequalities
- ✓ NHS 111 to start booking into General Practice as well as refer on to community pharmacies from 2019
- ✓ Development of a single multidisciplinary Clinical Assessment Service (CAS) within integrated NHS 111
- ✓ 111 Clinical advice service to act as single point of access for patients, carers and health professionals for integrated urgent care and discharge from hospital care, by 2023
- ✓ Social prescribing, a personal health budget and new support for managing their own health in partnerships with patient's groups and voluntary sector.
- ✓ PCNs to assess their local population by risk of unwarranted health outcomes and working with local community services to provide support to people who most need it
- ✓ By 2020, five geographies, including London, will deliver a longitudinal health and care record platform linking NHS and local authority organisations, three additional areas will follow in 2021
- ✓ In 2020/21, people will have access to their care plan and communications from their care professionals via the NHS App; the care plan will move to the individual's LHCR across the country over the next five years
- ✓ By 2023/24 every patient in England will be able to access a digital first primary care offer

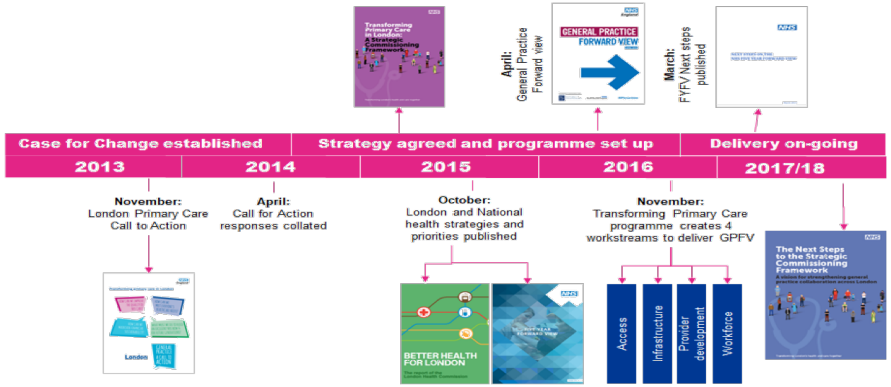
The LTP is further supported by the *NHS planning guidance for 2019/20 operational plans*, emphasising the existing commitments in FYFY will continue to be implemented up to 2020/21.

Locally, in North East London, primary care networks' development will be covered under *'Framework for PCN development – next steps'* document.

London Context

There has been a significant focus on the need for change in primary care over the last 5 years. London Health Commission published its report *Better Health for London* in October 2014 alongside *NHS Five year Forward View*. Both reports set out several overlapping objectives for primary care.

London has also ben working on how some of the challenges faced by general practices can be mitigated. In 2015, *Transforming Primary Care in London: A Strategic Commissioning Framework* was launched. *(The document journey shown in diagram below)*



The *framework* highlighted three characteristics needed for general practice to thrive and deliver the care that patients need and value.

1. Proactive care – supporting and improving the health and wellbeing of the population, self-care, health literacy, and keeping people healthy.
2. Accessible care – providing a personalised, responsive, timely and accessible service.
3. Coordinated care – providing patient-centred, coordinated care and GP-patient continuity.

The framework includes several area of focus to support delivery of the specification *(shown in the diagram)* and sets out an ambitious and attractive vision of general practice that operates without borders, and in partnership with the wider health and care system. A patient and their GP should be at the heart of a multidisciplinary effort to deliver patient-centred coordinated care. This should occur in general practices which are recognised as centres in each neighbourhood, developing community resilience and supporting Londoners to stay as well and as healthy as possible.

Models of Care	• This area proposes collaborating across groups of practices, and with other partners
Commissioning	• This area outlines the importance of supporting commissioners to work together and support to CCGs taking on co-commissioning
Financial Implications	• This includes the estimated cost shift towards Primary Care required to deliver the new specifications, and the year on year funding shift to achieve this (see next slide)
Contracting	• This area looks at contractual considerations of delivering the specifications e.g. contracting at a population level
Workforce Implications	• This area looks at the need for the right roles and skills in a practice and as part of a wider team
Technology Implications	• This area looks at the ways technology could be used to deliver the specifications and maximising its use to support empowerment and innovation
Estates Implications	• This area references the findings of the London Health Commission in terms of the variability of Primary Care estate and recommendation for investment
Provider Development	• This area outlines the importance of supporting providers to deliver the specifications and some of the potential areas for development
Monitoring and Evaluation	• This area outlines ways in which tools (largely already existing) can be used to support faster adoption of best practice, as well as for commissioner assurance

The Framework focuses on ‘function’ not ‘form’ and sets out a new patient offer for all Londoners that can only be delivered by primary care teams working in new ways and by practices forming larger primary care organisations. These organisations will need to be aligned to a shared geography in support of a population health model with other health, social, mental health, community and voluntary organisations.

The next steps to the strategic commissioning framework 2018 document sets out a vision for strengthening general practice collaboration across London and outlines two main types of collaborative arrangements between practices; Large scale general practice models (LGPOs) and Primary Care Networks (PCNs).

Local Context

East London Health & Care Partnership

STP Vision

During 2016, 20 organisations across NEL have worked together to develop a *Sustainability and Transformation Plan (STP)*. The joint vision adopted is:

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.
2. To develop new models of care to achieve better outcomes for all, focused on prevention and out-of-hospital care.
3. To work in partnership to commission, contract and deliver services efficiently and safely.

STP Priorities

- The right services in the right place: Matching demand with appropriate capacity in NEL
- Encourage self-care, offer care close to home and make sure secondary care is high quality
- Secure the future of our health and social care providers. Many face challenging financial circumstances
- Improve specialised care by working together
- Create a system-wide decision making model that enables placed based care and clearly involves key partners
- Using our infrastructure better

STP Delivery Model

- Integrate primary, community & social care
- Primary care at scale with developed networks
- Well informed population re available services
- Coordinated care for complex patients

Our shared framework for better care and wellbeing

Digital technology underpinning the model

Our Primary Care Vision

"Person-centred, integrated and comprehensive care delivered by sustainable general practice, that forms the cornerstone of our integrated care systems"

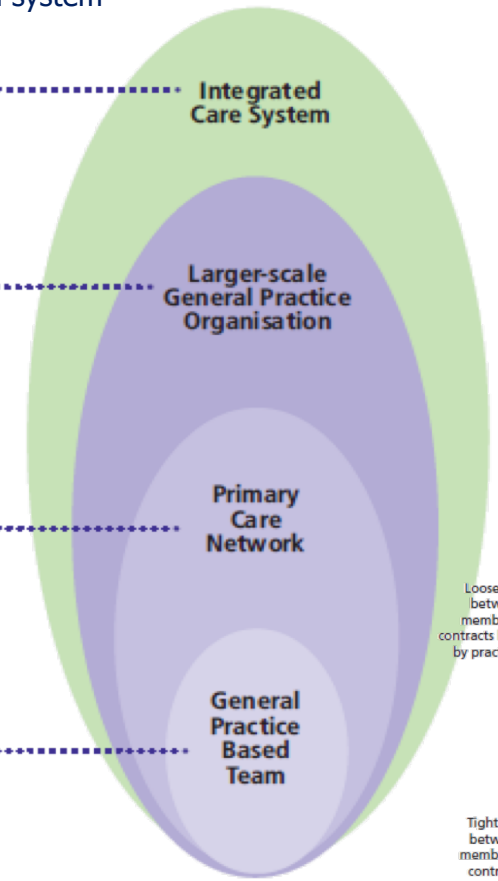
System working; population management within an integrated system

General practice as the foundation of a wider Integrated Care System – working in partnership with other health and care providers to collaboratively manage and provide integrated services to a defined population within a shared budget

Usually at a borough level and often a single formal organisation e.g. federation or multi-site practice organisation – this is the platform to provide the scale to develop and train a broad workforce, create shared operational systems and quality improvement approaches including use of locally owned data, support the delivery of collective back office functions to reduce waste and enhance efficiency, develop integrated unscheduled and elective care services for the whole population, and provide professional leadership and the "voice" for general practice in the local health economy.

Serving populations of 30-50,000, bringing together groups of practices and other community providers around a natural geography. Support multi-disciplinary working to deliver joined up, local and holistic care for patients. Key scale to integrate community based services around patients' needs to provide care for people with enduring, complex health and care needs, who require close collaboration between service providers and long-term care coordination.

Small enough for the benefits of continuity of care and personalised service. Big enough to safely cover rotas and ensure a balanced skill mix. Providing care to patients with on-going illnesses and flare-ups of established conditions, undifferentiated or medically unexplained symptoms or health anxieties, who may benefit from an episode of continuity pending diagnosis and effective treatment, or long-term continuity of care with single clinician or a clinical team for an enduring condition.

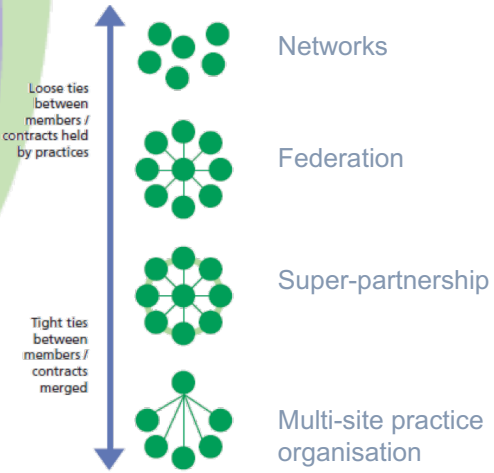


Appendix VI shows various levels of integrated health and care system in NEL and highlights the primary care development under this strategy.

Collaborating to Strengthen General Practice

- A strong general practice voice in the provider landscape
- Strengthened practice resilience
- Effective system partnerships
- On-going quality improvement
- Economies of scale
- Workforce development
- New population based approaches to care
- Innovative approaches to care provision
- Adopting new technology

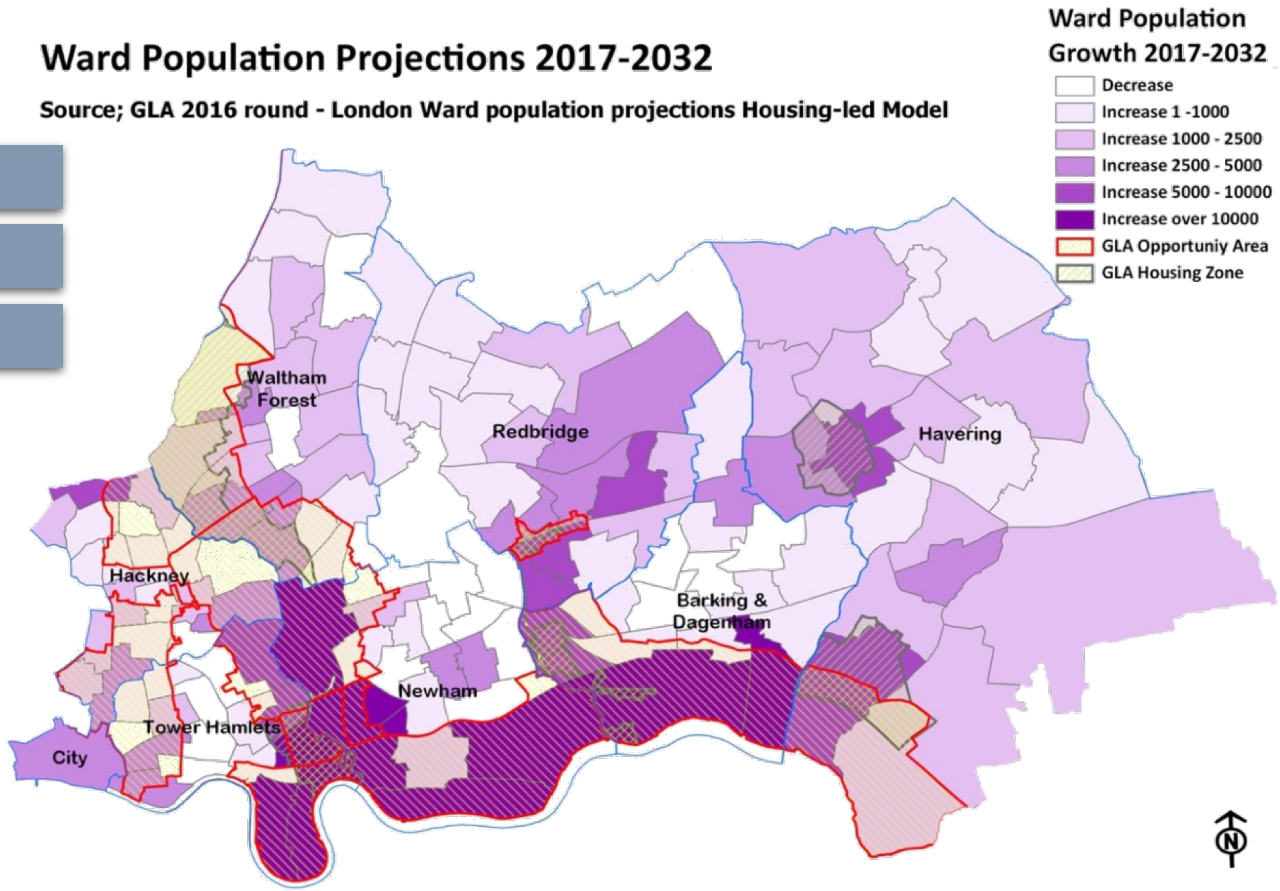
Large Scale GP Organisational Forms



CHAPTER 2

Our Challenges

- Our Challenges as a System
- Our Challenges in Primary Care
  - Quality & Efficiency
  - New Models
  - Primary Care Workforce



Our Challenges as a System

East London Health & Care Partnership

- North East London STP consists of 8 boroughs and covers a population of over 2 million people
- High health inequalities with many residents challenged by poor physical and mental health, life expectancy & life lived with poor health
- Significant projected increase in population of about 345,000 by 2031 *(6.1% in 5 years, 18% over 15 years)*, equivalent of an extra borough
- Challenge in securing the primary care workforce with example of more than 25% of GPs being beyond retirement age in one borough
- Highly mobile population with significant dependence on secondary care and high practice list turnover, generating even more demand
- Significantly below national average on Patient Survey for success in getting an appointment and ease of getting through on the phone
- Highly diverse population with varying healthcare needs.
- Significant deprivation *(5 of the 7 boroughs are in the worst index of multiple deprivation quintile)*
- Higher rates of obesity among children starting primary school than the averages for England and London
- Demand for appointments rising with GP consultation rates increasing, especially for over 74s (*see references for research study)*
- Varied primary care quality across NEL *(87% rated good vs 92% for London STPs)*
- High variation across NEL in no. of GPs per 10k population ratio *(4.5 in Redbridge – 6.5 in C & H)*
- Considerable variation in historic investment and staffing levels in primary care across NEL
- System financial challenge of £578m by 2021

Health and wellbeing challenges

Demographics

- There is significant **deprivation** (five of the eight STP boroughs are in the **worst Index of Multiple Deprivation quintile**). Estimates suggest differentially high growth in ethnic groups at increased risk of some priority health conditions.
- There is a significant **projected increase in population** of 6.1% in five years and **18% over 15 years**. This population is also highly mobile, with residents who frequently move within and between boroughs.
- There are significant health inequalities across NEL and within boroughs, in terms of **life expectancy** and **years of life lived with poor health.**

Wellbeing

- NEL has higher rates of **obesity among children** starting primary school than the averages for England and London. All boroughs have cited this as a priority requiring system-wide change across the NHS as well as local government.
- **Health inequalities** remain a significant issue in NEL with diabetes, dementia and obesity all disproportionately affecting people in poverty.
- NEL has generally high rates of **physically inactive adults.**

Long-term conditions

- There is an increased risk of mortality among people with **diabetes** in NEL and an increasing 'at risk' population. The proportion of people with Type 1 and Type 2 diabetes who receive NICE-recommended care processes is variable. Primary care prescribing costs are high for endocrine conditions (which includes diabetes).
- **Cancer screening uptake** is below the England average and emergency presentation is 5% higher than the national average.

Mental health

- With a rising older population, continuing work towards early diagnosis of **dementia** and social management will remain a priority. Two of seven CCGs are not hitting the **dementia diagnosis target.** Right Care analysis identified that for NEL, rates of admission for people aged over 65 with dementia are poor.
- Most CCGs, but not all, are meeting **Improving Access to Psychological Therapies (IAPT) access targets.**
- Parity of esteem has not yet been achieved across NEL.
- Acute mental health indicators in the Mental Health task force report identify good performance, however **concerns have been identified with levels of new psychosis presentation.** Further work is required to quantify and respond to challenges such as **high first episode psychosis rates.**
- There is a **low employment rate** for those with mental illness.

Our Challenges in Primary Care

The implementation of our framework for better care and wellbeing as outlined in our STP and the delivery of NHS long term plan, require a radical transformation of primary care to lead the progression and development of a successful Integrated Care Systems across NEL.

- At present primary care is under unprecedented strain, nationally demand for appointments has risen about 13% over the last five years, recently there has been a 95% growth in the consultation rate for people aged 85-89.
- In response to a BMA survey of 3,000 GPs last year, over half of respondents consider their current workload to be unmanageable or unsustainable; and over half rated their morale as low or very low.
- The primary care workforce is aging and facing a 'retirement bubble' which has the capability to put the system under greater strain.
- Currently there is little support for struggling GP practices, with an increased number of practices facing closure or serious viability issues.
- Significant unwarranted variation in outcomes between practices is a concern, there is little standardisation of practice and collaboration between GPs is very variable.
- Although aligning back office functions have been explored, economies of scale have yet to be delivered in practice.
- Primary care workforce data quality is inconsistent, which is fundamental to any workforce modelling, future planning and developing new models
- Estates, a key enabler of primary care transformation, is not fully aligned with the programme. Acute and GP premises close to 100% utilisation, however, only 40% of community assets being currently used.

Quality & Efficiency

- Lowest overall ratings and lower number of practices rated as good, 87%, compared to other London STPs average of 92%.
- Implementation of productive workflow optimisation in each practice across NEL.

New Models

- Large scale provider organisations' maturity across NEL
- Primary Care Networks development based on progress to date across NEL
- Local Primary Care Networks governance, operational and delivery models
- Additional network workforce recruitment and ways of working
- Online consultations implementation in each practice across NEL
- Primary Care Networks alignment with community services and digital innovations
- Digital innovations exploration
- GP extended access delivery by network
- 100% community assets utilisation (current 40%)

Primary Care Workforce

- Retention and recruitment for primary care workforce
- Wider primary care workforce average per 100,000 population considerably lower than England average

East London Health & Care Partnership

CHAPTER 3

Achieving Our Vision

What we will do …

- Achieving our vision – snapshot
- Quality & Efficiency
- New models
- Primary Care Workforce

Health & Care Community Teams + Primary Care

How will we achieve our vision?

East London Health & Care Partnership

Our delivery Work streams

Quality & Efficiency

- Strengthening primary care by embedding a quality Improvement culture across NEL – Practices to undertake formal QI programmes
- Supporting practices with workload by delivering 10 High Impact Actions
- Access hubs & practices linking into new Integrated Urgent Care service

Recruit & retain workforce

- Local initiatives to support retention such as careers fares for newly trained GPs
- Make north east London a really desirable place to train and work in Primary Care
- Workforce modelling - developing new roles across at scale primary care teams: E.g. physicians assistants, clinical pharmacists, portfolio careers for new GPs.

News models At-scale working

- Developing at scale providers for key role in Integrated Care Systems – leading on QI agenda
- Developing Primary Care Networks for population health approach
- Delivering extended access and digital solutions
- Maximising existing estates in line with developing models and expanding east London patient record to all NE London practices

Task & Finish Groups

Finance & Governance

- Identify value for money initiatives and NEL wide enhanced services
- Greater collaboration across CCGs – consistent approach to delegated primary care commissioning

Enablers

New ways of commissioning – Ensuring best value for money in line with our strategic objectives and vision

Estates – Ensuring that there is sufficient capacity within primary care estates

Digital – Maximizing use of digital technology to manage demand and increase information access to clinicians

Communication – Ensuring NEL wide communication to share best practice

Working with integrated care programmes to ensure Integrated care systems' readiness at all levels

Workforce Data - Ensuring high quality data for modelling

East London Health & Care Partnership

We will strengthen primary care by embedding a quality Improvement culture across NEL

We will ensure a quality improvement culture through;

- ✓ Regular training for staff and support for appraisals and revalidations
- ✓ Regular communication, sharing good practice across NEL, and using individuals and trained QI experts.
- ✓ Business Intelligence, reviewing clinical outcomes (CEG), supporting assessment of patient experience and evaluation of staff satisfaction
- ✓ Infrastructure support in the form of web-based support, online resources (software and licences)
- ✓ Involving patients as partners in evaluating and improving care at the network level.
- ✓ Establishing quality improvement values for each network
- ✓ Creating opportunities for engagement and sharing at network level
- ✓ The use of information to drive improvement
- ✓ We will work with the new quality improvement domains to ensure consistency across NEL

Our top five aspirations to be delivered by 2021:
✓ We will aim to achieve a CQC rating of good or outstanding for 95% of practices in each borough by 2021.
✓ We will aim to have at least one QI expert per network by 2021
✓ We will ensure workflow optimisation in each practice across NEL
✓ We will develop a NEL wide QI methodology to ensure consistent quality across the STP.
✓ We will aim to implement best practice key principles for at least 5 care pathways across NEL within the available local resources to ensure consistent access and quality of services

Through Quality Improvement schemes, we will;

- Reduce unwarranted inequalities in health outcomes
- Reduce health inequalities of equitable services by addressing variation
- Provide right care at the right time in the right place
- Ensure network clinical directors lead the quality improvement plans across networks
- Enable GPs to spend more time with patients
- Support our practices to better manage their workload and work more efficiently
- Embed a culture of improvement and innovation across NEL
- Increase multi-skill professionals in practices

Achieving Our Vision – **New models**

East London Health & Care Partnership

We will develop new models, optimising digital innovations, at-scale working and learnings from new developments to deliver population based comprehensive care.

What are we trying to do?

- ✓ Put in place seamless care (for both physical and mental health) across primary care and community services.
- ✓ Develop primary care networks (PCNs) with wide-reaching membership including community pharmacy, optometrists, dental providers, social care providers, voluntary sector organisations, community services providers and local government, led by groups of general practices.
- ✓ Deliver care as close to home as possible, with networks and services based on natural geographies, population distribution and need rather than organisational boundaries.
- ✓ Integrate more clinically-appropriate secondary care in primary care settings aligned with PCNs.
- ✓ Ensure PCNs form the core of our integrated care systems and PCN clinical leads are appropriately represented across the health and care system in NEL
- ✓ Assess population health - focusing on prevention and anticipatory care – with other system partners.
- ✓ Promote and support self-care wherever appropriate
- ✓ Build from what people know about their patients and their population
- ✓ Because we want to make a tangible difference for patients and staff alike, with:
  - improved outcomes and an integrated care experience for patients;
  - more sustainable & satisfying roles for staff, & development of multi-professional teams
  - a more balanced workload

Achieving Our Vision – **New models**

East London Health & Care Partnership

We will develop new models, optimising digital innovations, at-scale working and learnings from new developments to deliver population based comprehensive care.

Key features – NEL Primary Care Network

Network Functions

- ✓ Improve equity, access and quality
- ✓ Address variation/unmet need
- ✓ Joined up services in terms of components of care and who is providing it
- ✓ Proactive so focussed on prevention and predictive interventions for those at risk
- ✓ Sharing control e.g. personalised care, self care
- ✓ Educator/deliver health and well being
- ✓ Harness wider community assets through effective collaboration and navigation

Key Participants

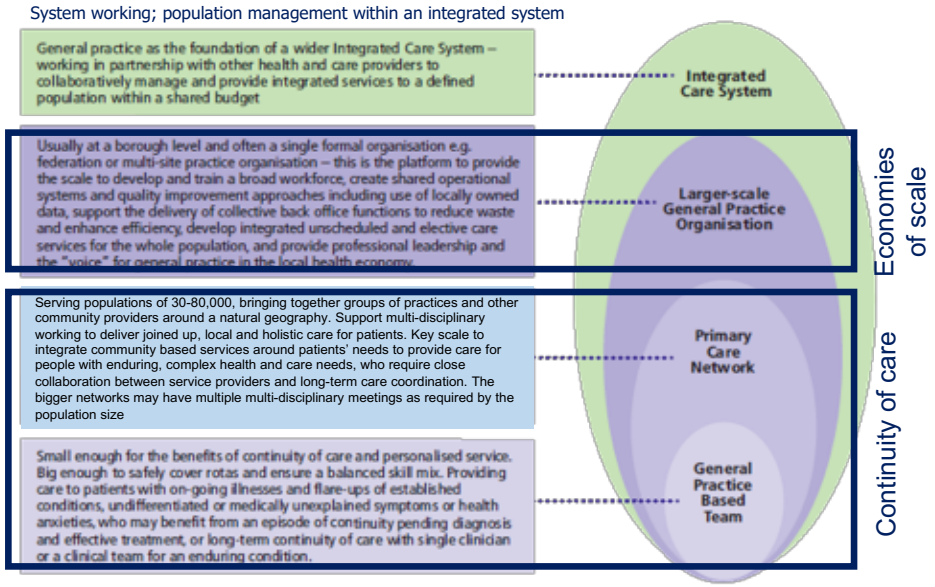
- ✓ General practice/Federations
- ✓ Social care providers
- ✓ Community health service providers
- ✓ Mental health services
- ✓ Wider primary care e.g. pharmacy
- ✓ Care homes
- ✓ Voluntary sector
- ✓ Linkages to services provided to wider population e.g. hospitals, integrated care etc
- ✓ Other community organisations

Enablers

- ✓ Analytics (understand variation, demand & capacity modelling)
- ✓ Workforce development, recruitment and retention
- ✓ Shared decision making structures
- ✓ Systematic approach to QI
- ✓ Connected IT and data sharing
- ✓ Pooled resources
- ✓ Commissioning and contractual approaches
- ✓ Approach to estates – some services may be provided in hubs to greater population than individual practice

Outcomes for Networks

- ✓ To be set at system, borough and network level involving residents, patients/users, partners
- ✓ Focussed on improving the health and well being of the population through integrated models of care and ways of working
- ✓ Based on population health and needs analysis
- ✓ DES defined service specification



In addition to NHS long term mandated deliverables;

Our top five aspirations to be delivered by 2021:
✓ We will have mature federations in each borough delivering population based outcomes via networks
✓ Each network will have established their top 2 domains focus based on population needs and analysis
✓ Network Clinical Directors will be represented at appropriate system levels to reduce unwarranted inequalities
✓ We will have standard policies and procedures for all federations, so that all staff are treated and supported equally
✓ In addition to online consultations, we will have at least one more digital tool (e.g. online referrals) in each practice

Achieving Our Vision – **Primary Care Workforce**

East London Health & Care Partnership

We will make NE London a desirable place to work and train in primary care

- ✓ We will use the existing workforce modelling tool to understand the approximate requirement of primary care workforce in NEL.
- ✓ We will define the future composition of our primary car workforce based on local baseline, workforce modelling, new models and population needs.
- ✓ We will work closely with new models of care group to develop a recruitment and retention model for wider primary care workforce.

Our top 5 aspirations to be delivered by 2021:

- ✓ We will aim to implement a local salaried portfolio scheme for new and existing GPs across all boroughs
- ✓ We will ensure continuous professional development opportunities for each professional category across NEL
- ✓ HEE and local CEPNs will develop an STP primary care workforce training hubs at locality level to support the development and realisation of educational programmes for primary and community care workforce at scale
- ✓ We will model our future primary care workforce requirement to ensure proactive recruitment
- ✓ We will develop innovative primary care employment models via workforce modelling tool

GP recruitment and retention

- We will implement our retention model across NEL to provide GPs with appropriate support in managing their workload and give them flexible career options
- We will implement learnings from GP workshops for new graduates and ensure a stable pipeline across NEL
- We will work closely with NHSE and HEE to provide necessary training and support for internationally recruited GPs

GPN recruitment and retention

- We will work in close collaboration with NHSE and HEE to implement GPN 10 point action plan across NEL
- We will ensure an attractive career pathway for existing and new nurse graduates in NEL
- We will bring together the findings from our GPN diagnostic work and focus groups, with key consideration given as to how we both support existing GPN leaders as well as develop and introduce a new cadre of GPN leaders across our system.

Primary Care multidisciplinary workforce

- We will develop wider primary care workforce as outlined in NHS long term plan
- From 2019, each network should have one clinical pharmacist and one social prescriber.
- From 2020, addition of first contact physiotherapists and physicians associates.
- From 2021, all of the above will increase and community paramedics will be introduced.
- by 2024 a typical network will receive 5 clinical pharmacists, 3 social prescribers, 3 first contact physiotherapists, 2 physicians associates and 1 community paramedic.

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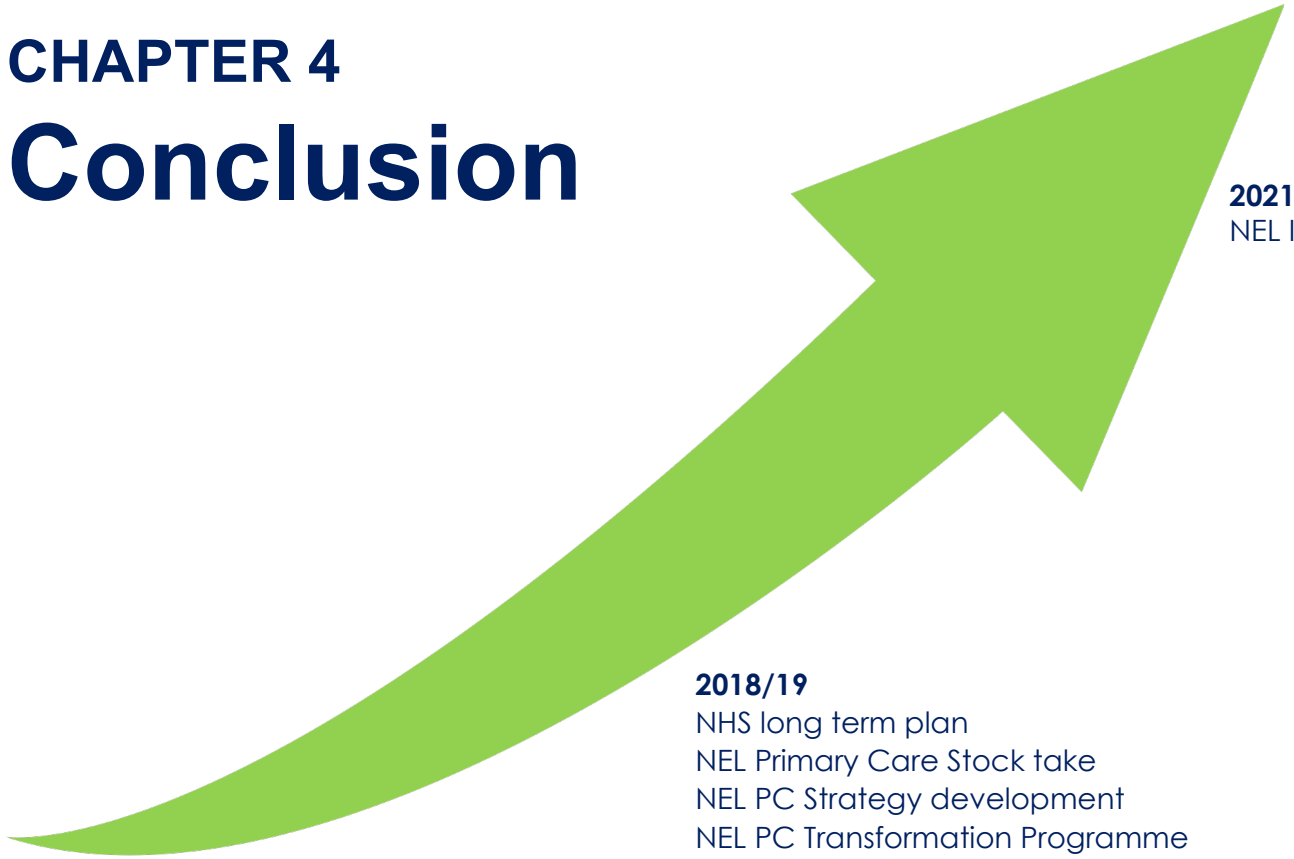
CHAPTER 4
Conclusion



2016
GPFV
STP development
NEL QI Programme start

2018/19
NHS long term plan
NEL Primary Care Stock take
NEL PC Strategy development
NEL PC Transformation Programme
NEL Network development plan
NEL PC workforce strategy

2021
NEL Integrated Care Systems

Conclusion

Primary care is the cornerstone of NEL Integrated Care System with general practice at its heart. Since the Five Year Forward View and subsequent national and regional publications, all stakeholders in NEL have come together and started laying the foundations of an integrated care system by improving all aspects of our primary care.

- ✓ Governance has been streamlined through joint strategic posts and matrix management
- ✓ Working groups have been established with collective memberships to design, develop and share initiatives and learning with each other
- ✓ Joint working and collaboration have increased between providers and commissioners with everyone signing up to one vision
- ✓ Relationships have grown stronger across NEL through close working and dedication of all staff to deliver the best quality of care to our population
- ✓ A central NEL Primary care team has been established with a mandate to support delivery of GPFV and NHS LTP - primary care transformation across NEL
- ✓ Local primary care strategies have been reviewed and brought together under this strategy (NEL Primary Care Strategy), ensuring a joint vision
- ✓ Care quality has been improved considerably since 2015, as evidenced by CQC practice ratings
- ✓ Various initiatives under high impact actions are still in progress
- ✓ Primary care clinical leads have thoroughly engaged with the process and have been integral to the quality improvement
- ✓ Local workforce recruitment and retention have been forensically examined and an NEL wide retention framework has been developed
- ✓ Wider workforce development and models of care are under development
- ✓ Close working relationships with national bodies have been developed, ensuring the alignment of local and national strategic direction

Despite considerable progress, we recognise that we have a long way to go to achieve our vision of delivering high quality seamless care, enabled by new workforce models, better use of estates and resources and connected data and innovative digital technology with General Practice delivering core services and ensuring continuity of care for each individual in our population.

This strategy will provide us with our programme and delivery direction over the next 5 years until 2023/24. To achieve our ambition outlined in this strategy we need to ensure that we have clearly defined interdependencies with other programmes and strategies, such as joint commissioning strategy, joint estates strategy, Joint digital plan and strategy, NEL integrated care programme and Integrated urgent emergency care deliverables.

We need to build on our progress by creating a ‘learn not blame’ culture and support each other every step of the way. We need to develop joint structures build on strong relationships and not the other way round.

We will need a strong communication plan to not only ensure shared learning across NEL but also to highlight our successes and connect skills and talents across the board.

This transformation should result in our population having easy access to primary care through multiple mediums such as 111, digital solutions (online consultations etc.) and traditional in person appointments. The integration with community teams (integrated programmes) and network working will form a cocoon of services around our populations provided on need basis. Acute and emergency services will be provided to the most in need patient and we will have established community links in primary care to address social isolation and loneliness through voluntary and community sector.

We are excited to face the challenges ahead and continue to improve health and well being of our population.

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East London Health & Care Partnership

Primary Care Strategy

NORTH EAST LONDON

Strengthening Primary Care in North East London

Appendices

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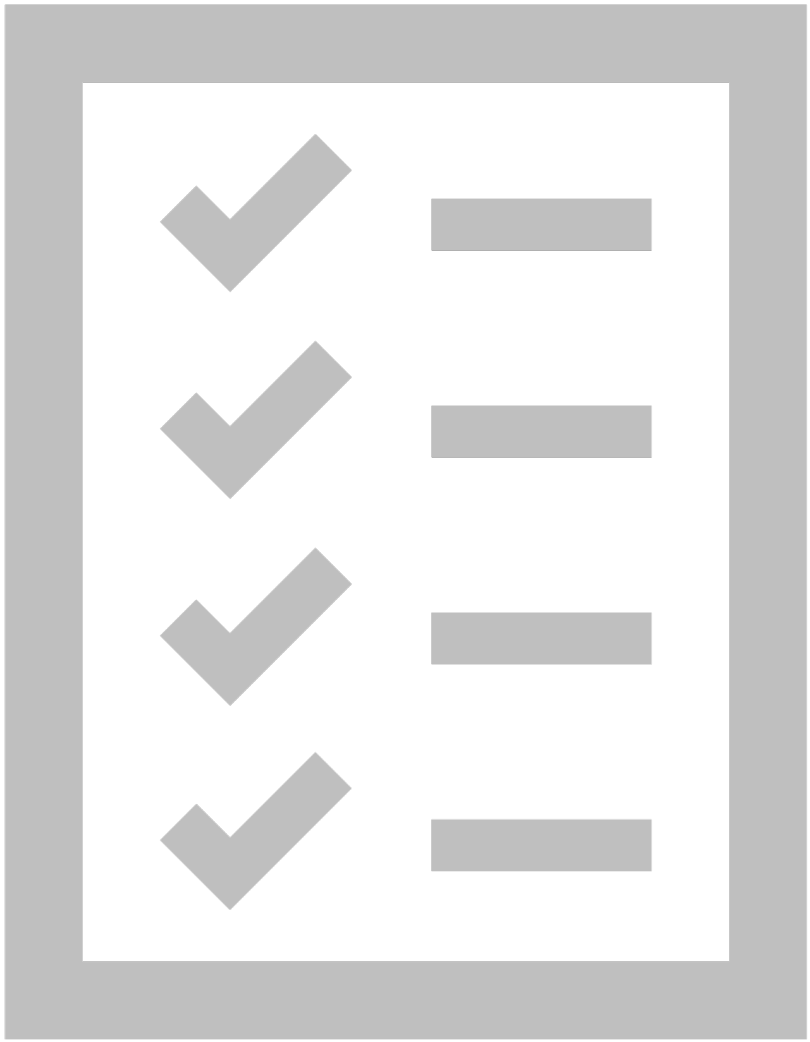

Appendix I
Primary Care Strategies Focus across NEL

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All strategies are focussed on delivering 5YFV and GPFV, which includes high quality of care, extended access, new models of care and workforce development.

Development of new models of care, digital technology and provider maturity is varied across north east London. The NEL wide primary care strategy brings these strategies together and focus all areas in delivering the same goal, while acknowledging the different starting points for each borough.

NHS Newham CCG
Federation: Newham health Collaborative
Networks: 8 clusters (51 GP Practices)
GPFV Total Transformation Funding: £1,760,812.75

Developing primary care services to meet demand now and into the future (2013 strategy refresh – 2017)
The strategy supports the development of sustainable primary care services, which can meet demands now and into the future in line with 5YFV and GPFV. Highlights six key areas:
Building resilient primary care services
Integrating local healthcare systems
Improving population health
Investing in primary care facilities
Developing a sustainable workforce
Using technology to improve patient care
Implementing the primary care strategy

NHS Redbridge CCG
Federation: Healthbridge Direct
Networks: 4 Networks (45 GP Practices)
GPFV Total Transformation Funding: £1,491,960.95

Transforming Primary Care in Havering – a strategy for the development of general practice and place based care 2016-2021
The vision is to combine primary care with other community-based health and social care into a place-based care model with productive general practice at its foundation and GPs overseeing care for their patients. Each of the localities in Redbridge where neighbouring GP practices work together will be a 'place', and the vision is therefore to establish locality-based care across all health and social care services for the populations within those geographical localities.

NHS City & Hackney CCG
Federation: City & Hackney GP Confederation
Networks: 8 Neighbourhood's (43 GP Practices)
GPFV Total Transformation Funding: £1,511,161.35

Primary Care Strategy 2015
City and Hackney aims to:
- Be in the top 5 CCGs London in terms of quality
- Be an attractive place to work for existing and new primary care staff
- Deliver safe services
- Have services that are resilient by being productive, efficient, safe and value for money
- Have services that are of high quality and offer comprehensive patient support
- Have services that are accessible
- Reduce health inequalities
- Have services in primary care which integrate with other commissioned services

GP Federation representing all 43 Practices.

NHS Tower Hamlets CCG
Federation: Tower Hamlets GP Care Group
Networks: 8 Networks (36 GP Practices)
GPFV Total Transformation Funding: £1,217,346.56

Main Priorities in Primary Care are:
- Making Tower Hamlets the best place to work, and the best place to receive care: Enabling quality improvement in practice (EQUIP) programme.
- Building resilience in general practice
- Delivering the GP Forward View
- Primary care patient engagement

NHS Havering CCG
Federation: Havering Health Ltd
Networks: 3 Networks (44 GP Practices)
GPFV Total Transformation Funding: £1,458,151.16

Transforming Primary Care in Havering – a strategy for the development of general practice and place based care 2016-2021
The vision is to combine primary care with other community-based health and social care into a place-based care model with productive general practice at its foundation and GPs overseeing care for their patients. Each of the localities in Havering where neighbouring GP practices work together will be a 'place', and the vision is therefore to establish locality-based care across all health and social care services for the populations within those geographical localities.

NHS Barking & Dagenham CCG
Federation: Together First
Networks: 3 Networks (38 GP Practices)
GPFV Total Transformation Funding: £1,375,357.86

Transforming Primary Care in Barking and Dagenham Strategy 2015-2020
The vision is to combine primary care with other community-based health and social care into a place-based care model with productive general practice at its foundation and GPs overseeing care for their patients. Each of the three existing localities in Barking and Dagenham where neighbouring GP practices work together will be a 'place', and the vision is therefore to establish locality-based care across all health and social care services for the populations within those geographical localities.

NHS Waltham Forest CCG
Federation: Waltham Forest GP FedNet
Networks: 0 Networks (44 GP Practices)
GPFV Total Transformation Funding: £1,449,906.34

Primary Care Strategy 2015-2020 (v2 2017)
Vision: 'To put patients at the centre of everything that we do by using their experience to shape care pathways, improve service delivery and ensure value for money'. The delivery of the vision is based on the development of GP Federation to support delivery of the shift of care and improvement in the quality of primary care.

Appendix II
Our Challenges in Primary Care

The implementation of our framework for better care and wellbeing as outlined in our STP, require a radical transformation of primary care to lead the progression and development of a successful out of hospital health and care system in NEL.

Key issues:

- At present primary care is under unprecedented strain, nationally demand for appointments has risen about 13% over the last five years, recently there has been a 95% growth in the consultation rate for people aged 85-89.
- In response to a BMA survey of 3,000 GPs last year, over half of respondents consider their current workload to be unmanageable or unsustainable; and over half rated their morale as low or very low.
- The primary care workforce is aging and facing a 'retirement bubble' which has the capability to put the system under greater strain.
- Currently there is little support for struggling GP practices, with an increased number of practices facing closure or serious viability issues.
- Significant unwarranted variation in outcomes between practices is a concern, there is little standardisation of practice and collaboration between GPs is very variable.
- Recent study showing older patients consulting more, with the oldest age group (aged > 74 years) consulting almost four times as often as those in the reference group (aged 5-14 years).

Our main challenges are summarised below;

Quality and Efficiency

NHS England has initiated a number of different initiatives under primary care quality improvement programme. Over the last two years, substantial clinically led progress has been made in primary care development across north east London. Practices have been engaged in resilience and QI programmes and have used transformation funding to strengthen new primary care structures for future integrated care delivery. Some boroughs are further ahead in their organisational and operational transformation as compared to others.

"Although different practices will find different actions best address the pressures they are facing, there are some that are commonly assessed as particularly promising. The evidence and case studies around productive workflows show the diverse application of this action, and potentially high impact from often relatively straightforward changes. GPs surveyed by the RCGP also showed positivity towards this. Additionally, active signposting, developing the team, supporting self-care and social prescribing show signs of positive impact, redirecting patients to the most appropriate support, and with benefits likely from implementing some or all of these actions together." *(RCGP; Spotlight on 10 High Impact actions)*

While patients have access to a number of excellent, high quality primary care services across all CCGs, as a whole, north east London needs to make significant progress to ensure equality and address these gaps.

Within north east London there are examples of how quality improvement initiatives have been used in partnership between commissioners and providers to deliver some good outcomes – e.g. some of the best outcomes nationally under Quality Outcomes Framework (QOF) in Tower Hamlets and City and Hackney and Quality Improvement (QI)initiatives supported by UCLP in Newham, BHR and East London Foundation Trust. We will work together to deliver equality for people in NEL drawing on available best practice.

Primary care quality improvement has been a key priority across NE London and a number of QI programmes (including 10 high impact actions) have been undertaken since 2015. The impact of quality focus is evident from the reduction in practices rated as 'inadequate' and 'require improvement' to a correspondingly increase in practices rated as 'good or outstanding' (*see table 1 on the next page).*

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- In **Tower Hamlets**, a practice based QI initiative aimed at reducing DNAs noticed a 20% reduction in Nurses DNAs and 30% reduction in GPs DNAs across 25 practices.
- In **Waltham Forest**, NHSE General practice quick start programme helped 16 practices. Thornfield trained 80 staff in clinical correspondence handling and went into 20 surgeries to help set up the process and protocols
- In **Newham**, 11 staff are currently being trained as QI experts and 58 medical assistants trained across all practices for handling clinical correspondence.

Despite considerable quality improvements, NEL has the lowest overall ratings and lower number of practices rated as good 87%, compared to other London STPs averages of 92%. Furthermore, with the exception of Tower Hamlets, inadequate and requiring improvements ratings for 2018 have slightly deteriorated in some boroughs, which, does not necessarily reflect a change in trend but nonetheless requires further support to continue improvement in quality across NE London.

We need to not only continue the quality improvements programmes, but substantially increase our efforts to ensure at least 95% of our practices in NE London are rated good or outstanding by 2021 and primary care quality is consistent across all practices.

Table 1: NE London CQC Practice ratings Dashboard

Practices rated **'INADEQUATE'**

Borough	No. of Practices	2015	2017	2018
Barking & Dagenham	40 (2019 = 35)	16%	5%	0%
City and Hackney	44 (2019 = 42)	0%	0%	0%
Havering	40 (2019 = 43)	4%	9%	2%
Newham	50 (2019 = 49)	14%	6%	8%
Redbridge	47 (2019 = 42)	5%	3%	0%
Tower Hamlets	41 (2019 = 35)	0%	0%	0%
Waltham Forest	42 (2019 = 40)	10%	0%	4%

Practices rated **'REQUIRES IMPROVEMENT'**

Borough	No. of Practices	2015	2017	2018
Barking & Dagenham	40 (2019 = 35)	21%	19%	18%
City and Hackney	44 (2019 = 42)	10%	0%	2%
Havering	40 (2019 = 43)	38%	12%	13%
Newham	50 (2019 = 49)	24%	14%	12%
Redbridge	47 (2019 = 42)	30%	15%	12%
Tower Hamlets	41 (2019 = 35)	7%	3%	0%
Waltham Forest	42 (2019 = 40)	30%	13%	8%

Practices rated **'GOOD or OUTSTANDING'**

Borough	No. of Practices	2015	2017	2018
Barking & Dagenham	40 (2019 = 35)	63%	76%	82%
City and Hackney	44 (2019 = 42)	90%	100%	98%
Havering	40 (2019 = 43)	58%	79%	85%
Newham	50 (2019 = 49)	62%	80%	80%
Redbridge	47 (2019 = 42)	65%	82%	88%
Tower Hamlets	41 (2019 = 35)	93%	97%	100%
Waltham Forest	42 (2019 = 40)	60%	87%	88%

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New Models

Over the last 10-15 years, general practice has undergone a major shift to a more collaborative and scaled-up way of working. At scale organisations have grown, changed and taken on different forms. As noted in NHS England's 2016 GP Forward View (GPFV) document, it is becoming more common to see practices working together collaboratively, in both formal and informal ways, with a set of common objectives to serve larger populations. NHS England reports that larger organisations have more opportunity, effectiveness and flexibility in providing services as well as interacting with community health, social care and voluntary services.

Across NEL, practices are generally grouped into networks (neighbourhoods, clusters) covering varied levels of population. An overarching GP membership organisation (Federation) also exists in each borough to potentially deliver economies of scale and better quality of care resulting in improved patient care.

Provider Maturity

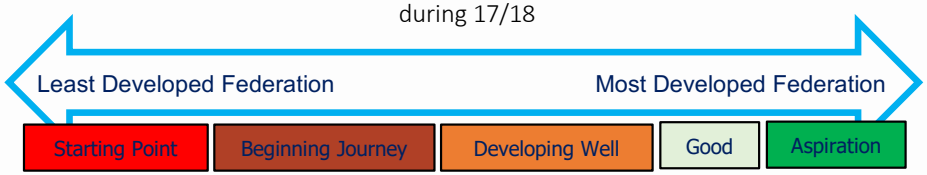
However, in some boroughs, we have work to do achieve well defined networks. GP Federations are also at varied levels of maturity in terms of their wider organisational capabilities to provide at scale working, system partnerships and digital solutions. For example, GP Federations in City and Hackney and Tower Hamlets are among the leading at-scale organisations across England, whereas, federations in Waltham Forest and Newham require rapid improvements to be in a position to support their primary care networks in delivering NHS long term plan.

Over the last year, we have used transformation funding from NHS England to support GP organisations in becoming sustainable and increasing their ability to undertake outcomes based contracts at network levels. Funding has been utilised for;

Governance Reviews

Across NEL, three federations (WF, B&D, Redbridge) have undertaken internal governance reviews, developed local vision and strategies in line with overall NEL and London Strategic Commissioning Framework and introduced new and improved governance structures and standard operating procedures.

All at-scale providers in NEL made progress against NEL development framework during 17/18



Quality Improvement

Four federations (C&H, B&D, Redbridge, Newham) have delivered actions in QI infrastructure (e.g. facilitators, champions & IT systems for QI) - this is a key area as federations take on responsibility for delivering the QI agenda from external QI providers.

Alignment of back-office support

Across NEL, concrete steps have been taken to explore economies of scale; For example, consolidation of management support to networks for doing things once instead of multiple times, releasing of resources to support at scale projects (TH), a collation of a central repository of policies and procedures for practices (C&H and WF).

Practice & network level support

Engagement Expert GDPR support for practices (C&H), developing and implementing communication plans (C&H, Redbridge), procurement of a practice survey to gauge views of member practices on the federation (C&H). Funded neighbourhood engagement events/workshops (C&H).

IT infrastructure

Introduction of EMIS Enterprise/data sharing across two federations (Waltham Forest/Newham). Migration of all GP practices in B&D to the EMIS GP clinical system.

Introduction of new staff

Following governance & OD reviews Recruitment of key staff into new structures/posts have taken place across four federations (WF, B&D, Redbridge, Tower Hamlets).

East London Health & Care Partnership

Network Development

Networks development is fundamental to the delivery of NHS long term plan along with network based wider primary care workforce. Given the different maturity stages of our networks across NEL, we will ensure the support required to enable networks to deliver outcomes based contracts via federations. It is important to note that primary care networks are not just groups of practices, but include wide-reaching membership including community pharmacy, optometrists, dental providers, social care providers, voluntary sector organisations, community services providers and local government, led by groups of general practices.

To deliver our vision of person-centred, integrated and comprehensive care delivered by sustainable general practice means that we will have to develop seamless pathways between services across organisational boundaries and always keep people's needs at the forefront of every discussion.

Practices across NEL are generally grouped together in networks, also called neighbourhoods or clusters. However, in some boroughs the network association among practices is not strong enough to take advantage of at scale working. The governance and leadership accordingly requires further development.

Furthermore, we need to make sure that we have a seamless interface with integrated care programmes across NEL. For example, how will the wider network primary care workforce, mandated under NHS long term plan, engage with existing integrated community teams.

We need to fully understand our networks' maturity through federations and accordingly put a plan in place to ensure networks fully understand the needs of their local population and are in a position to deliver outcomes based contracts through multidisciplinary teams, while ensuring seamless working with integrated care programmes across NEL.

We have developed a local provider maturity evaluation framework to assess organisational capabilities and at-scale maturity of federations across NEL. This will enable us to put in place a detailed support plan to ensure providers are ready to deliver an outcomes based contract via networks.

Across NEL, extended access is a considerable risk *(as shown below).*

Initiative	B&D	C&H	Hav	NH	RD	TH	WF
GP Access* (additional mins of extended access)	28	32	23	18	20	18	13
Online Consultation Systems	14%	21%	11%	49%	32%	97%	57%

GP Access (additional 30 mins of extended access)

The General Practice Forward View published in April 2016 set out plans to enable clinical commissioning groups (CCGs) to commission and fund additional capacity across England to ensure that, by 2020 everyone has improved access to GP services including sufficient routine appointments at evenings and weekends to meet locally determined demand, alongside effective access to out of hours and urgent care services.

In order to be eligible for recurrent funding, commissioners will need to demonstrate they are meeting seven core requirements for improving access: Timing of appointments, capacity, measurement, advertising and ease of access, digital, inequalities, effective access to wider whole system services

In September 2018, North East London extended access stock take was published by Healthy London Partnerships. The report made a number of recommendations under: Procurement, UCC pathway redirections, minutes per 1,000 and finance queries.

Online Consultation Systems

NHS England is using technology to empower patients and make it easier for clinicians to deliver high quality care and enabling patients to seamlessly navigate the service as part of its digital transformation strategy. The Online Consultation programme is a contribution towards this ambition.

As part of the General Practice Forward View, a £45 million fund has been created to contribute towards the costs for practices to purchase online consultation systems, improving access and making best use of clinicians' time.

Across NEL, there is currently varied use of online consultation systems with some boroughs ahead in their implementation for all practices. However, all boroughs currently have plans in place for a full roll out by the end of April 2019.

We are fully committed to deliver primary care networks as outlined in NHS long term plan and will need to;

- Ensure that our GP federations across NEL become fully matured at-scale providers.
- Develop networks of up to 30k to 50k population through federations to ensure delivery of population based comprehensive care through outcomes based network contracts with seamless integration with community services.
- Deliver GP access as per GPFV across NEL.
- Deliver 100% online consultations across all practices in NEL.

Primary Care Workforce

The General Practice Forward View committed to increase the number of doctors in general practice by a minimum of 5,000 by 2021, and increase in the number of health professionals by at least 5,000.

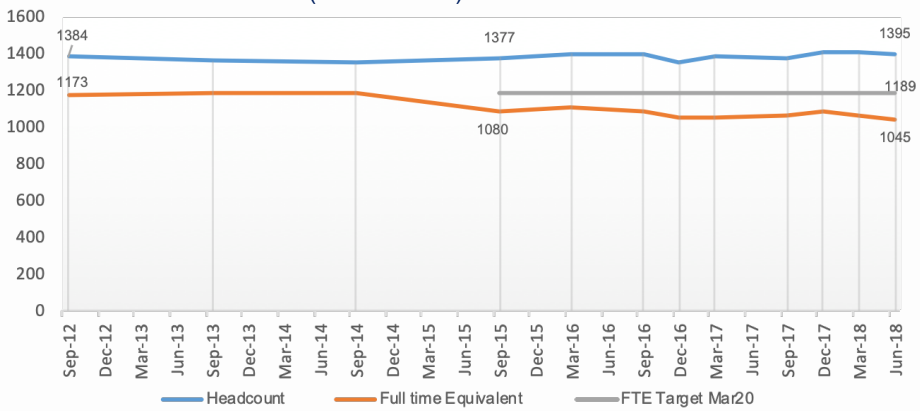
NEL GP Workforce

As at January 2019, NEL is 190 GPs short of our target of 1189 GPs by 2021. This includes 2 GPs (place in Waltham Forest) from the last round of international GP recruitment. Recent analysis shows that we have serious issues in recruiting and retaining our GP workforce in addition to 25% of GPs in one borough beyond retirement age.

Over the last year extensive literature reviews and data analysis have been undertaken to understand the GP workforce declining full time equivalent (FTE) numbers. The overall GP headcount across NEL has remained fairly consistent from 2012 to 2018, however, the FTE fell by 11%. Each borough's analysis shows a similar picture.

GP retention across NEL is a serious concern, especially when the GP trainee allocation has increased by 12.5% since 2015, whereas the FTE has decreased by 3% over the same period.

NEL GP Workforce Trend (2012 to 2018)



Please see appendix [ ] for a GP workforce trend dashboard for NEL (each borough).

In addition to the focus groups, extensive literature review has revealed four main factors having an impact on GP retention. Personal (9%), Administrative (12%), Stress (26%), Workload (53%). Furthermore, literature review on interventions for GP retention and recruitment suggests six main categories;

1. Experience
2. Finance/Contract
3. Health/Well being
4. Satisfaction/Flexibility
5. Reducing Workload
6. Education/Specialism

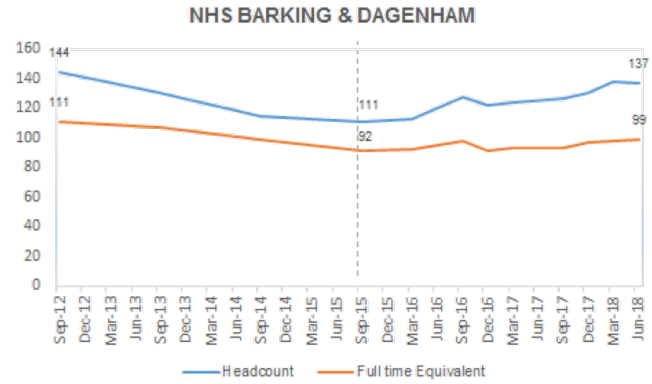
The above can be summarised into three main themes; Access to education/Protected CPD, strategies to reduce workload, increased opportunity for flexibility.

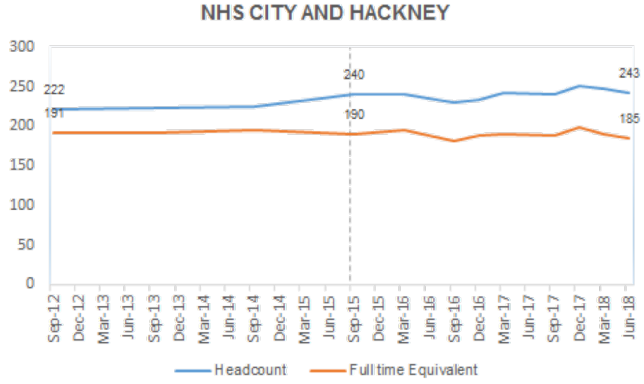
We need to fully understand GP workforce requirements in NEL through workforce modelling and develop portfolio careers for new and existing GPs.

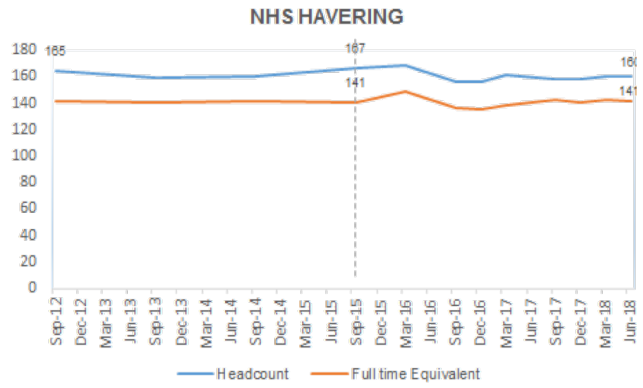
East London Health & Care Partnership

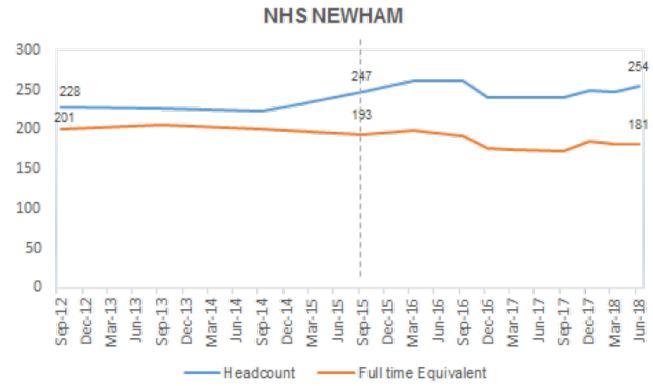
NORTH EAST LONDON GP WORKFORCE TREND DASHBOARD (Jun 2018)

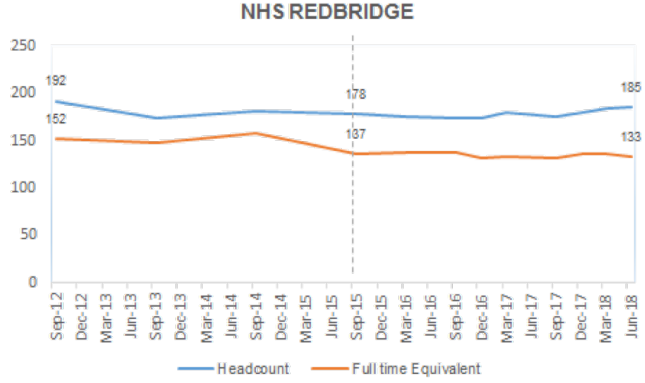
Headcount and Full Time Equivalent

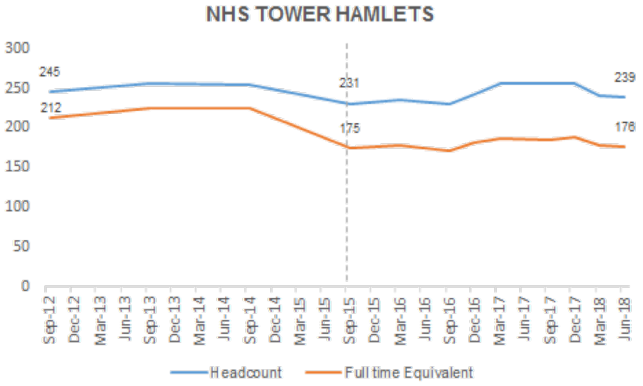


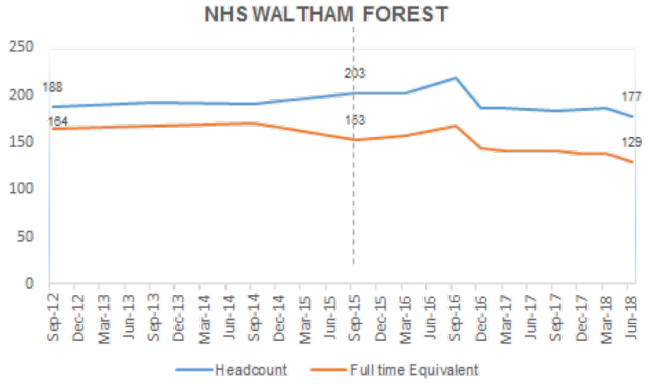


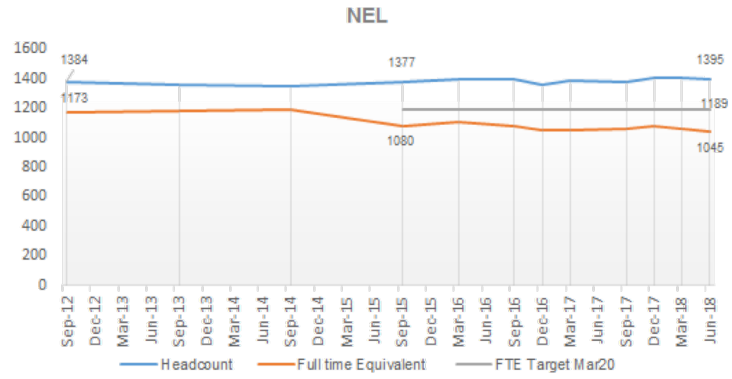












The Dashboard shows a similar picture across NEL. Overall GP headcount has remained fairly constant since Sep15, whereas FTE has been on a downward trend.

Detailed literature review along with a number of focus groups and professional analysis of the feedback has been undertaken to fully understand the reasons behind the decline *(see workforce slides for details)*

Source: NHS Digital
Note: The data does not include locums

East London Health & Care Partnership

GPN Workforce

Nurses play a bigger role than ever in the delivery of health and social care, and yet those working in general practice are part of a sector facing many changes and challenges. The general practice nursing workforce is aging with an ever increasing proportion approaching retirement and few coming into the profession to replace them. However, strong nursing teams will be essential if the intended benefits of the GP Forward View and NHS long term plan are to be realised and high quality care is to be delivered.

There is a severe lack of general practice nurses (GPNs) across NEL, evident from the comparison with nurses per 100k population in England. Only Tower Hamlets (23) are close to England (27 per 100,000 population) with other boroughs employing less than 50% GPNs in comparison *(see table on next page).*

To fully understand the lack of practice nurses in NEL, two focus groups were held amongst GP nurses in NE London with an aim to explore their day-to-day work experience, and to utilise findings to inform and develop strategies for further practice development. The Groups highlighted three key themes; *Empowerment, person-centred / holistic care, structure / standardisation / transparency.*

We need to fully understand our GPN requirements through workforce modelling and work with HEE to make GPN careers more attractive to new graduates.

Physician Associates (PAs)

Physician Associate (formerly known as Physician Assistant) is a rapidly growing healthcare role in the UK, working alongside doctors in hospitals and in GP surgeries. Physician Associates support doctors in the diagnosis and management of patients. Currently, PAs do not come under any regulatory framework, however, the government has recently announced that it will push forward with the regulation for Pas.

Across NEL, 28 students started QMUL in January 2018 with expected placements across the 7 boroughs. Currently, 21 students are graduating in March 2019 and are expected to take up placements within NEL.

We need to understand PA requirements in NEL and undertake PA workforce modelling in the context of new models.

Data Quality

Although there has been a consistent improvement in primary care data quality including GPNs across NEL with percentage of practices requiring estimation (NHS Digital) dropping from 26.7% in September 2015 to 8.4% in September 2018, the data quality will need to improve further to enable effective workforce modelling.

NEL Staff FTE per 100,000 patients - CCG, England

	Admin/Non-clinical	Direct Patient Care	GP	Nurses
ENG	110	21	58	27
B&D	93	15	46	18
C&H	99	16	63	18
HAV	102	16	50	19
NH	99	14	50	17
RED	82	13	45	11
TH	103	17	59	23
WF	90	15	48	16

Percentage difference (NEL v England)

	Admin/Non-clinical	Direct Patient Care	GP	Nurses
ENG	110	21	58	27
B&D	-18%	-40%	-26%	-50%
C&H	-11%	-31%	8%	-50%
HAV	-8%	-31%	-16%	-42%
NH	-11%	-50%	-16%	-59%
RED	-34%	-62%	-29%	-145%
TH	-7%	-24%	2%	-17%
WF	-22%	-40%	-21%	-69%

Source: NHS Digital

Appendix II
Our Challenges in Primary Care

East London Health & Care Partnership

Pharmacy

Further to clinical pharmacists under NHSE initiatives, many practices across NEL employ practice pharmacists in varied roles. There is also community pharmacist and hospital pharmacist resource, which could enhance the overall role of pharmacists in NEL integrated care system.

The development of the new model of care aligning all pharmacist resource together will be undertaken in new models group, however, we need to work closely with the group and other programmes (Integrated care) to help and support development of a recruitment and retention programme for primary care pharmacist resource.

Primary Care Wider Workforce

Furthermore, we need to develop our wider primary care workforce in the context of NHS long term plan based on multidisciplinary teams working at network levels. A quick analysis of primary care workforce data highlights the considerable difference between NEL and England staff FTE per 100,000 population per CCG.

It is evident that the current situation is not sustainable and a major shift in primary care staff recruitment and retention policy is required across all boroughs to deliver the NHS long term plan.

Appendix III
Enablers – Primary Care Estates

East London Health & Care Partnership

The vision for primary and community care

The highly variable quality of the out-of-hospital estate makes it challenging to improve facilities. A poor estate means poorer patient experiences, poorer working conditions for staff and lost opportunities to improve health and healthcare. To deliver the framework, it is expected that modern, state of the art facilities will be needed.

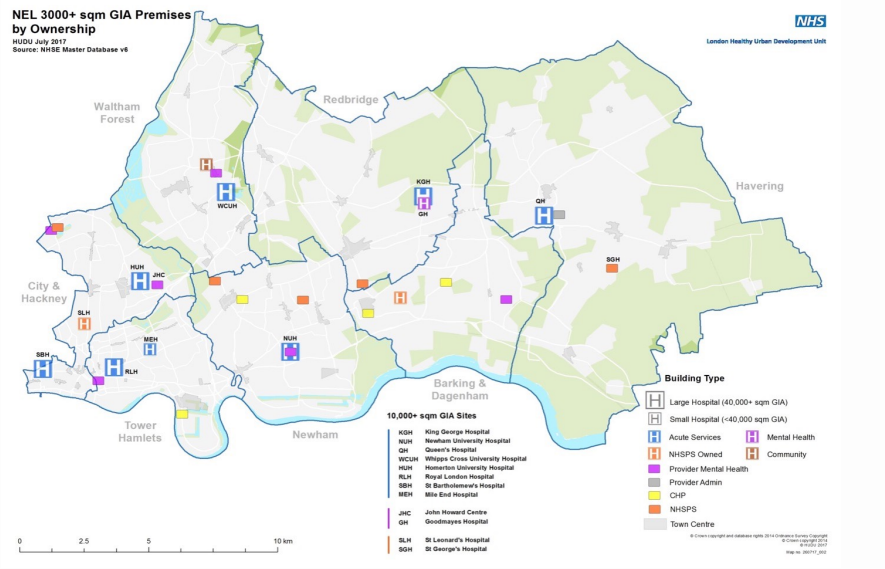
Redesigning primary care and community care will be key in order to create a high quality, safe and sustainable health care system.

Primary care in east London is too dependent on the traditional GP model.
Patients rarely seek help or advice from other health care professionals such as pharmacist or therapists leading to capacity problems.

Historical under-investment, little incentive to move and fragmented decision-making concerning the primary and out-of- hospital estate, have all contributed to a situation that means our current building and infrastructure do not meet either our current, or future needs.

There are examples of world-class primary care facilities, but too often they are used inefficiently. Without modern facilities, Practices will struggle to introduce the multi-disciplinary team working needed for integrated care.

General practice will need to gradually transition out of the existing estate, much of which consists of converted residential buildings, as investment is made in more modern buildings.



Services will be delivered from facilities where practices can work together and access to on-site diagnostics (e.g. blood testing, ultra-sound and echo-cardiograms).

Back-office functions will be shared to support new models of care so that more funding can be available for clinical services.

1. Developing a system that incentivises efficient and effective use of capital assets
2. Delivering general practice in modern purpose-built/designed facilities
3. Consolidating unused and underutilised estates and developing a planned programme of disposal/transfer of properties to build an investment fund for local priorities
4. Aligning both the core NHS capital programme/funding/process and the new national transformation fund.

East London Health & Care Partnership

Primary Care Estate Vision

PRIMARY CARE NETWORK

Consolidated GP practices (estimated 1,000- 1,500m²)

examples include
Centre Manor Park

PRIMARY CARE PLUS

Consolidated GP Practices plus outpatient/integrated social care facilities
(estimated 1,500-2,500m²)

additional specialities
These could house additional 'office based' specialties e.g. dermatology, rheumatology, neurology, additional maternity services or integrated social care.

Primary and Community estate is needed to be fit to deliver the Five Year Forward View

The working definition of this is:

- Serves more than 10,000 patients
- Purpose build accommodation built within the last 40 years
- Larger than 1,000 m²
- More than five clinical rooms
- Capable of operating for seven day working

COMMUNITY ASSET/PRIMARY CARE NETWORK
(estimated 2,500m²+)

mixed use
Local authority services (e.g. library, drop-in-centre), leisure facilities and primary care network (or network plus). Examples include future builds at St Georges and Barking Riverside.

Any future investment will only be considered where it can be shown to:

- consist of flexible space able to support delivery of a range of services
- be accessible for all patients
- support integration of services and colocation

Estates will continue to have a critical role in delivering the improvements in patient care and efficiency savings set out in the Five Year Forward View.

Appendix III
Enablers – Primary Care Estates

East London Health & Care Partnership

The ELHCP Estates Strategy was published in October 2018 under development. The vision outlined in the estates strategic plan is:

"To develop good quality and cost-effective estates infrastructure which meets the complex needs of a growing diverse and relatively transient population. Our estates will need to be flexible, to support the delivery of new models of care over the next 5-20 years."

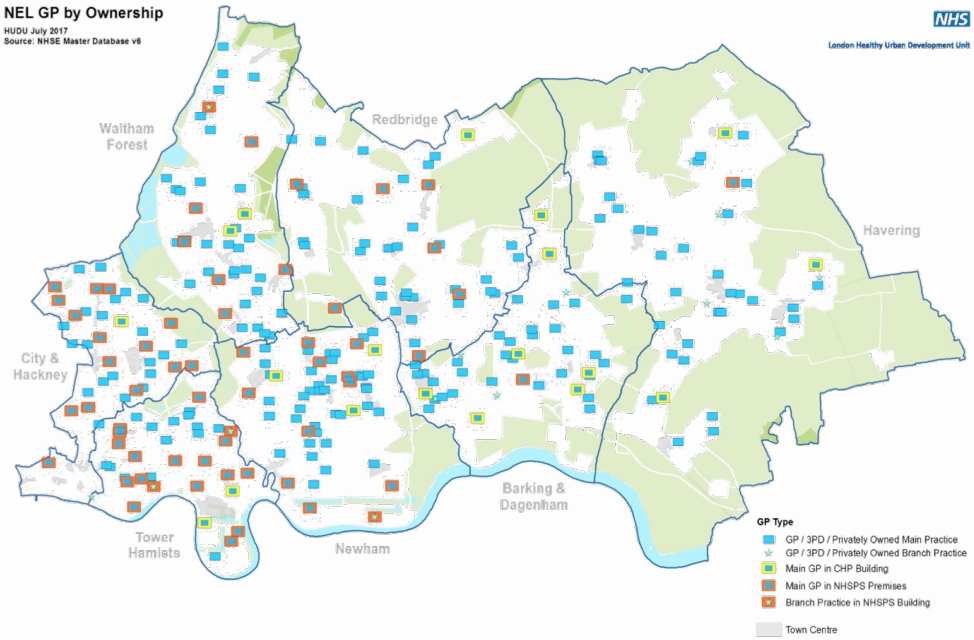
The foundation of the NEL primary care estates strategic plan is based on primary care working at scale, networks and federations treating populations of c70k, accessible 8am to 8pm, seven days a week.

Analysis of general practice ownership of assets reveals that:

- ✓ 60% are owned by GPs (3PD/Private)
- ✓ 31% are in NHS PS owned buildings
- ✓ 9% are in CHP buildings
- ✓ 60% of the GP premises are over 55yrs old, converted domestic premises and are unlikely to meet current standards for functional suitability and design
- ✓ Majority (69%) of the GP premises surveyed were small (< 5 clinical rooms) or medium sized (< 10 clinical rooms) this compares with the London-wide average of 74%.
- ✓ Baseline surveys reveal that the majority are generally either fully or over utilised during normal working hours. It can be assumed additional capacity can be created in these premises, if they were open during the evening and weekends

There is a significant difference in the level of estate utilisation for each health sector across the entire north east London.

Hospitals and primary care (GP owned) assets are nearly at maximum capacity and have very high utilisation of their premises (estimated at 90%), whereas 60% of community assets capacity is not utilised. We can utilise our current community assets much better as providers move towards new models of working.



We are working with the NHSPS and CHP on alternative leasing structures for better utilisation. By improving the utilisation in our strategic sites, we can reconfigure and release some estate to make revenue savings.

There is very limited opportunity to increase utilisation in the acute sector because the average utilisation is already very high.

It is imperative that ELHCP ensures maximum and most efficient use of existing primary care estates. This can have a major impact on our ability to deliver our vision. Close working between new models of care development and estates strategy is crucial to ensure most value for money from NEL existing estates.

We will work closely with the estates team through new models delivery group to deliver most efficient use of estate in primary care.

Appendix III
Enablers – Primary Care Digital

East London Health & Care Partnership
Primary Care Transformation Team
Helping the people of East London live healthy and independent lives

NHS Long Term Plan: The Digital Imperative

In ten years' time, we expect the existing model of care to look markedly different. The NHS will offer a 'digital first' option for most, allowing for longer and richer face-to-face consultations with clinicians where patients want or need it. Primary care and outpatient services will have changed to a model of tiered escalation depending on need. Senior clinicians will be supported by digital tools, freeing trainees' time to learn. When ill, people will be increasingly cared for in their own home, with the option for their physiology to be effortlessly monitored by wearable devices. People will be helped to stay well, to recognise important symptoms early, and to manage their own health, guided by digital tools.

Practical priorities will drive NHS digital transformation

- Create straightforward digital access to NHS services, and help patients and their carers manage their health.
- Ensure that clinicians can access and interact with patient records and care plans wherever they are.
- Use decision support and artificial intelligence (AI) to help clinicians in applying best practice, eliminate unwarranted variation across the whole pathway of care, and support patients in managing their health and condition.
- Use predictive techniques to support local health systems to plan care for populations.
- Use intuitive tools to capture data as a by-product of care in ways that empower clinicians and reduce the administrative burden.
- Protect patients' privacy and give them control over their medical record.
- Link clinical, genomic and other data to support the development of new treatments to improve the NHS, making data captured for care available for clinical research, and publish, as open data, aggregate metrics about NHS performance and services.
- Ensure NHS systems and NHS data are secure through implementation of security, monitoring systems and staff education.
- Mandate and rigorously enforce technology standards (as described in The Future of Healthcare) to ensure data is interoperable and accessible.
- Encourage a world leading health IT industry in England with a supportive environment for software developers and innovators.

Key digital primary care headlines from the LTP:

By 2020, five geographies, including London, will deliver a longitudinal health and care record platform linking NHS and local authority organisations, three additional areas will follow in 2021

In 2020/21, people will have access to their care plan and communications from their care professionals via the NHS App; the care plan will move to the individual's LHCR across the country over the next five years

In 2021/22, we will have systems that support population health management in every Integrated Care System across England

By 2023/24 every patient in England will be able to access a digital first primary care offer

During 2019 we will introduce controls to ensure new systems purchased by the NHS comply with agreed standards, including those set out in The Future of Healthcare

By summer 2021, we will have 100% compliance with mandated cyber security standards across all NHS organisations in the health and care system

Appendix III
Enablers – Primary Care Digital

East London Health & Care Partnership

As well as the practice redesign work facilitated by the Digital Accelerator and the requirements set out in the latest GP contract, the following key developments underpin the future ways of working in Primary Care:

- ✓ Expanding the use of the e-Referral Service to include other specialities in acute trusts and appropriate community and mental health services
- ✓ Expansion of the east London Patient Record (eLPR) into BHR and connecting to the rest of London via the 'One London' Local Health and Care Record Exemplar
- ✓ Comprehensive use of electronic ordering of pathology and radiology
- ✓ Redesign of Outpatients including the use of 'Advice and Guidance' and the eLPR
- ✓ The rollout of NHSMail and access to patient records including discharge summaries, and Co-ordinate My Care in nursing homes to support safe transfers of care and reduce admissions
- ✓ Expanded use of Co-ordinate My Care to support patients towards the end of their life

Where primary care is the cornerstone of our integrated care systems, digital improvements and innovation will be at the heart of primary care transformation in NEL.

'The London digital Transformation: Agreeing the approach and investment for integrated digital transformation in London's primary and urgent care system report' Nov 18, recommended the identification of local 'development ecosystems' to accelerate the integration of digital initiatives to support providers to enable patients to navigate the unscheduled care pathway more effectively using proposed maturity criteria as a guide (criteria on the right).

NEL commissioners have jointly agreed for Waltham Forest to be an accelerator site to concentrate investment and effort to maximise results before scaling across the STP.

A funding of £500k per STP is available to enable:

- Identify and design local integrated pathways
- Build a local team focusing on business change
- Collaborate using the Agile development methodology
- Driving supplier collaboration to build holistic solutions

This will enable to align the needs and opportunities of local systems with national priorities so that together we can maximise adoption of new technologies which empowers clinicians and people to improve the convenience and quality of care.

- We will ensure that any local team, designed to deliver the project, is fully integrated into new models of care and workforce groups to ensure efficient development and delivery on all fronts.
- We will ensure the necessary support for the accelerator site, both locally and nationally.
- We will ensure shared learning across the system and gather an evidence base for the impacts across the accelerator site.

Appendix III
Enablers – Wider System Programmes

Since the development of NEL STP, there are multiple integration and improvement programmes running across the 7 boroughs. These programmes are delivering a wide range of national and local priorities with patient centred comprehensive care as a consistent theme across all. Some programmes like integrated care are more intrinsically linked with primary are, whereas others such as estates development and clinical pathways reviews cover the whole system stakeholders.

Integrated care

The integration of health and social care is a crucial part of our person centred care vision in NEL. Progress in each borough is at different stages with various models being tested between commissioners and providers. For example, in BHR, a provider alliance is being encouraged to deliver population based comprehensive care with capitated budgets and appropriate risk reward share proposals under discussion. New development of Barking and riverside is being seized as an opportunity to develop 'primary care on a blank page' with proposals for a single health and care contract commissioned through a provider alliance.

Furthermore, new models of community care are being explored where the shift is towards a clustering of services for a geographically defined population across traditional health and social care, primary and community care boundaries.

This directly aligns with the development of primary care networks delivering primary and community services for 30-50k population, as mandated by NHS long term plan.

We need to be mindful of the overlaps and ensure seamless transition and integration of work across primary care transformation and integration programmes across NEL to utilise our resources effectively and efficiently.

Integrated Urgent Emergency Care

Improved access to primary care in and out of hours is one of the three asks outlined in NHS Shared Planning Guidance for urgent and emergency care systems by 2021. We need to ensure that we work closely with integrated UEC programmes across NEL to help deliver the outcomes required nationally.

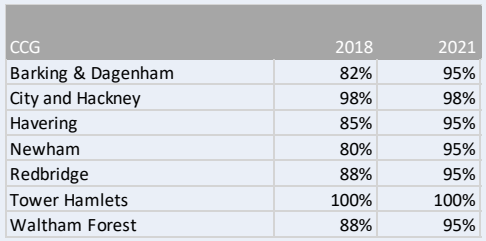
Communication

Effective and appropriate communication is key to ensure that we share best practice across NEL, celebrate our successes and provide support where needed.

We will work closely with the STP communication lead as well as London and Healthy London Partnerships communication leads and develop and communication and engagement strategy for the primary care transformation across NEL.

Appendix IV
Success Measures Table

East London Health & Care Partnership

Work stream	Aspirations by 2021	Success Measure
Quality & Efficiency	We will aim to achieve a CQC rating of good or outstanding for 95% of practices in each borough	
	We will aim to have at least one QI expert per network	By 2021, at least one named QI improvement expert per network, at least 46 across NE London.
	We will ensure workflow optimisation in each practice across NEL	Each practice across NEL (286 in total), would at least have one trained staff in handling clinical correspondence, freeing up GPs' time.
	We will develop a NEL wide QI methodology to ensure consistent quality across the STP	Publication of a live document outlining detailed step by step best practice examples for quality improvements from within NE London as well as national and global
	We will aim to implement best practice key principles for at least 5 care pathways across NEL within the available local resources to ensure consistent access and quality of services	Based on network population needs analysis, existing good practice across NEL (evidence base), at least 5 care pathways (for example COPD, diabetes) are reviewed, key principles developed, shared and, if possible, implemented across NEL
New Models	We will have mature providers in each borough delivering population based outcomes via networks	Providers across NEL working at-scale, providing efficiencies supporting the delivery of outcomes based contracts via networks
	Each network will have evidence of their response to their population demographics and needs	As stated
	Network Clinical Directors will be represented at appropriate system levels to reduce unwarranted inequalities	As stated

CCG	2018	2021
Barking & Dagenham	82%	95%
City and Hackney	98%	98%
Havering	85%	95%
Newham	80%	95%
Redbridge	88%	95%
Tower Hamlets	100%	100%
Waltham Forest	88%	95%

Appendix IV
Success Measures Table

East London Health & Care Partnership

Work stream	Aspiration by 2021	Success Measure
New Models	We will have standard policies and procedures for all at-scale providers, so that all staff are treated and supported equally	A standard set of HR policies, procedures and staff development programme is adopted by all at-scale providers across NEL
	In addition to online consultations, we will have at least one more digital tool in each practice	As stated
Workforce	We will implement a local salaried portfolio scheme for new and existing GPs across all boroughs	BHR already has a salaried portfolio scheme for new GPs. This is extended to existing GPs and other boroughs have developed and implemented a similar local salaried portfolio scheme.
	We will ensure continuous professional development opportunities for each professional category across NEL	Each professional clinical staff group (GPs, Nurses, Healthcare Assistants, Pharmacists etc.) have professional development opportunities across NEL.
	HEE and local CEPNs will develop an STP primary care workforce training hubs at locality level to support the development and realisation of educational programmes for primary and community care workforce at scale	7 workforce training hubs (one in each borough) are fully functional
	We will model our future primary care workforce requirement to ensure proactive recruitment.	Workforce modelling tool is used to outline future workforce requirements in each borough and plans are in place to address any gaps.
	We will develop innovative primary care employment models via workforce modelling tool.	As stated.

Appendix V
Task & Finish Group - Finance

East London Health & Care Partnership

Our total system financial challenge in a *'do nothing'* scenario would be **£578m** by 2021. Achieving ambitious 'business as usual' cost improvements as we have done in the past would still leave us with a funding gap of **£336m** by 2021. Through the STP, we have identified a range of opportunities and interventions to help reduce the gap significantly. This will be aided by Sustainability and Transformation Funding (STF) funding, specialised commissioning savings and potential support for excess Public Finance Initiative (PFI) costs. Significant work has started to evaluate the savings opportunities, particularly on specialised commissioning.

The financial challenge in NEL cannot be under estimated. However, commissioners and providers across NEL have been improving provider governance, care delivery quality, IT infrastructure and alignment of back office functions through national and local transformational funding.

To deliver our vision and meet the financial challenge, we not only have to keep the pace of change but also explore the avenues beyond our individual organisational limitations. This demands collaboration and transparency between commissioners and providers at an unprecedented level and we believe that through growing relationships and trust in NEL, we can meet this challenge.

Investment in primary care has varied across NEL. Most CCGs are struggling to invest upfront to support transformational change. There are differences in core contract income to practices *(often based on take up of enhanced services/QOF and numbers of PMS/APMS practices)* and the ability of CCGs to invest in local incentive schemes (LIS).

We will develop a financial resilience assessment framework for practices that are under stress (performance and/or financial) and agree principles for how and when practices drawings might be taken into account and will develop proposals for a transformation fund and principles for distribution of national transformational funds.

The table on the right shows a high level summary of practices' income in NEL. It also highlights the varied level of investment in LIS across the STP footprint. Over the last year, transformation funding has been used to increase provider maturity against London maturity matrix. The table below shows the funding allocations for each borough for 2018/19.

	B&D	C&H	HAV	NH	RED	TH	WF
No of Practices	36	42	44	51	42	35	42
RAW List Size (,000)	222.3	316.3	277.3	392.7	319.2	311.0	310.1
Weighted List Size (,000)	208.0	314.8	269.5	376.5	280.9	302.2	287.1
Average income by RAW patient (£)	104.4	105.0	96.9	109.3	84.9	107.1	97.5
Average income by weighted patient (£)	111.5	105.5	99.7	114.1	96.5	110.2	105.4
LIS Investment (total)[1,2]	**£1.7m**	**£10.7m**	**£2.3m**	**£1.1m**	**£2.1m**	**£7.3m**	**£0.5m**

Key Notes:
1.Based on 17/18 apart from LIS investment 18/19.
2.BHR CCGs LIS investment includes primary care provider development monies.
Apart from Tower Hamlets, figures on core income do not include full QOF payments (include aspiration not achievement).

Federation	Tranche 1 Population based allocation	Tranche 2 Needs Based Allocation
Barking & Dagenham	£113,661	£192,037
Redbridge	£162,808	£182,892
Havering	£141,616	£192,037
Waltham Forest	£158,615	£192,037
Newham	£203,370	£128,024
Tower Hamlets	£164,381	£109,735
City and Hackney	£162,049	£109,735
Total	£1,106,500	£1,106,500

We will review LIS outcomes across NEL to identify the approaches that are most effective and provide most value for money and will explore the potential for NEL wide LIS/s to achieve greatest impact across NEL footprint.

Appendix V

Task & Finish Group - Governance

The ELHCP primary care programme governance structure has recently been changed to create a more focussed board with oversight of the programme continuing to be clinically led with executive support and partners across the system. This will be supported by a senior management group with a focus on delivery.

Currently there are five primary care committees operating across NEL – one for BHR and one each for the other CCGs.

A committee covering Newham, Tower Hamlets and Waltham Forest has lapsed but borough based committees have continued. Issues raised about this:

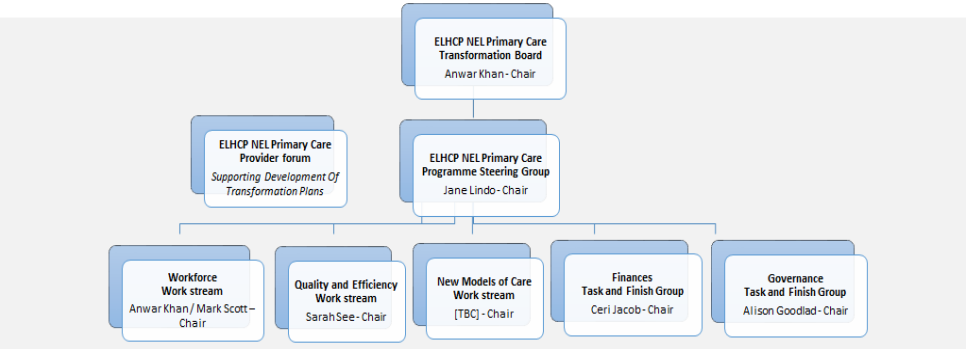
- There is a risk of inconsistent decision-making.
- There is a big administrative/bureaucratic burden.
- There are challenges managing conflicts of interest.

There is a need for greater collaboration on governance to support NEL and local wide working particularly to improve:

- Efficiency
- Consistency and transparency of decision-making
- Improve the management of conflicts of interest through non-conflicted clinical input
- Best use of lay member and clinical time
- Support collaborative working
- Promote information sharing and benchmarking.

Note: Local primary care strategy development and delivery still needs to be at local level and is the responsibility of CCG governing bodies.

NEL Primary Care Governance and Delivery Structure – *(Appendix 3)*



The NEL Primary care governance and delivery structure above gives a summary snapshot of the delivery accountability resting with respective individuals and organisations.

Collaborative and joint working among providers and commissioners will be crucial in delivering our vision of providing people with locality based person centred care.

It will be critical for us to hold each other to account and create a 'learn not blame' culture across the partners to help support design and delivery of our vision.

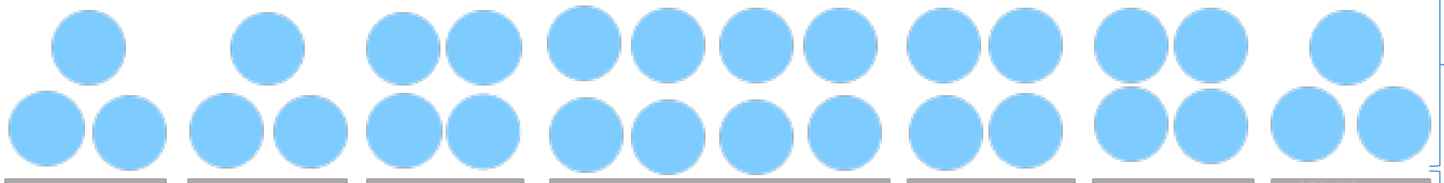
- ✓ We will explore the creation of NEL wide primary care committee to discharge delegated primary care responsibilities
- ✓ We will ensure links with other relevant strategies across the NEL, for example; Estates & IT.

Appendix VI
Integrated Health and Care in North East London

East London Health & Care Partnership

Systems levels connected through matrix governance across North East London

NEL Primary Care Strategy;
Primary Care Network Development
Primary Care Quality Improvement
Primary Care New models

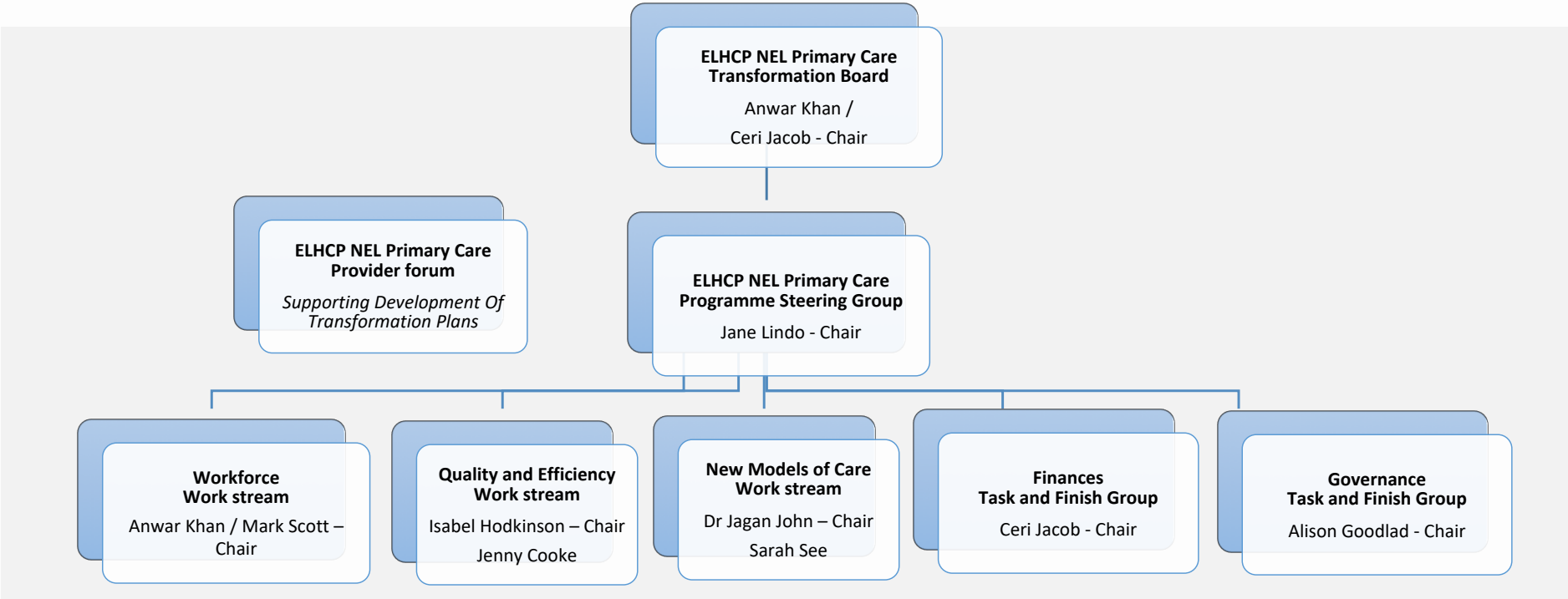


Networks/ Neighbour hoods/ Localities								Needs Analysis; Key delivery unit; Primary care networks
Borough/ Place	Barking & Dagenham	Havering	Redbridge	City and Hackney Transformation Board	Newham Wellbeing Partnership	Tower Hamlets Together	Waltham Forest Better Care Together	Delivery of Community Based Care, primary care at scale, out of hospital care; Integrated care partnerships; JSNA
Multi-borough	Barking, Havering and Redbridge Integrated Care Partnership			Inner North East London System Transformation Board				Collaborative working between providers; Strategic partnerships; Provision at scale
North east London	East London Health and Care Partnership/ North East London Commissioning Alliance							Setting overall clinical strategy (Senate); Linking with national and London

Integrated Care Programmes

Developing Integrated Care Systems

Appendix VII
Primary Care Transformation Governance



- Clinical Pharmacist
- GPNs retention plans
- GP Retention Schemes
- Training Reception Staff
- International GP Recruitment Programme
- GP Induction and Refresher Scheme
- Primary Care wider workforce development

- General Practice Resilience Programme
- Practice Transformation Support (£3 per head)
- Time for Care
  - Active Signposting
  - New Consultation Types
  - Reduce DNAs
  - Develop the Team
  - Productive Work Flows
  - Personal Productivity
  - Partnership Working
  - Social Prescribing
  - Support Self-Care
  - Develop QI Expertise

- GP Access
- Online Consultations
- New models of care development - blank page approach
- Provider maturity
- Network development

- Improvement schemes review for effectiveness and VFM and NEL wide services identification
- Development of financial resilience assessment framework for practices that are under stress (performance and/or financial) including levels of drawings
- Case for development of a NEL Primary Care Transformation Fund

- Develop a streamlined and consistent approach to governance for delegated primary care commissioning functions and the development of improvement schemes
- Rebranded NEL PCC team

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Havering Local Account 2017/19
Board Lead:	Barbara Nicholls – Director of Adult Social Care
Report Author and contact details:	**Caroline May -** Head of Business Management 01708 433671

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

- ☒ Theme 1: Primary prevention to promote and protect the health of the community and reduce health inequalities
- ☒ Theme 2: Working together to identify those at risk and intervene early to improve outcomes and reduce demand on more expensive services later on
- ☒ Theme 3: Provide the right health and social care/advice in the right place at the right time
- ☒ Theme 4: Quality of services and user experience

SUMMARY

The government requires each local authority to publish annually a "Local Account" of its adult social care activity. This Havering Local Account summarises adult social care and support achievements for the two year period 2017/18 and 2018/19, as well as ambitions for the future.

Local accounts form an important part of the Towards Excellence in Adult Social Care (TAASC) which is a national programme of sector improvement led by the Association of Adult Social Services Directors and the London Government Association. Local Accounts provide a key mechanism for demonstrating accountability for performance and outcomes. Local accounts can also be used as a tool for planning improvements, as a result of sharing information on performance with people who use services and engaging with them to get feedback on their experience.

The London Borough of Havering Adult Social Care Services Local Account 2017/19 is the fifth local account that will be published and it explains:

- What services we support and spend money on
- What we have achieved
- The changes and challenges we face

- Our ambitions and plans for further improvement

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

This year we have presented the information using infographics as far as possible.

RECOMMENDATIONS

That the Health and Wellbeing Board note the Local Account 2017/19 prior to publication.

REPORT SUMMARY

The key messages of the Local Account 2017/19 include:

Adult Social Care in Numbers

Depravation of Liberty Safeguards numbers are up to 1,607 in 2018/19, from 1,150 in 2017/18 and 1,083 in 2016/17 (48% increase over the three year period).

Those in receipt of Self Directed Support were down slightly in 2018/19 to 1,843 from 1,875 in 2017/18 (1,735 in 2016/17).

Reablement was provided to fewer people in 2018/19, 1,067 from 1,353 in 2017/18 and 1,143 in 2016/17. Of those who left reablement, only 10.2% required a long term service in 2018/19 (down from 21.7% in 2016/17 and 14.7% in 2017/18).

There was an increase in older people who were admitted to nursing care homes, up to 279 in 2018/19, from 240 in the previous year (321 in 2016/17).

Older people receiving community support fell to 2,597 in 2018/19 from 2,681 in the previous year (2,907 in 2016/17).

Most of the support provided is to those in the 85 plus age range (2,781 people, 40% of the overall total in 2018/19 and 3,042 people, 42% of the total in 2017/18).

In 2017/18, on average 1,100 people received homecare services each week, and 1,000 people in 2018/19.

In 2018/17 122 carers received a direct payment, rising to 152 in 2018/19.

In terms of services provided, most people receive equipment to support them living at home.

Budget

The council spent £57,682,192 on Adult Services in 2017/18, and £60,159,303 in 2018/19.

What we did well

Our Front Door, which is usually the first contact with us, underwent a redesign. We developed this with skilled staff so that we are better able to provide advice and guidance, and refer to the correct team, on a timely basis. This improved initial handling of contacts, giving a smoother experience for the customer. To this end, we introduced a new way of working called Better Living, which involves a series of conversations.

The feedback from residents using our services was generally positive. According to the 2017/18 annual Adult Social Care Survey, 91% agreed that Havering's care and support services help them to have a better quality of life.
In 2017/18 71% of people who used our services said that they felt safe, compared with 69% in the three previous years. This increased to 89% in 2018/19.

Fewer people were admitted into residential settings – with 519 per 100,000 people aged 65 or over permanently admitted to a nursing or care home in 2017/18, compared with 700 in 2016/17. This moved to 601 per 100,000 in 18/19.

In 2017/18, we implemented the Active Homecare Framework, a purchasing system which enables providers to operate in Havering so long as they meet quality criteria. We developed a method for understanding the outcomes for residents of the homecare that they have received. Results for 18/19 indicated that 85% of users rated the service as good or very good.

The numbers of older people needing long term support in the community fell from 2,907 in 2016/17 to 2,681 in 2017/18, and fell again to 2597 in 18/19.

In 2017/18, 78% of people with a learning disability in Havering were living in their own home or with their family, and 78.5% in 18/19.

In 2017/18, 85% of people in contact with secondary mental health services (for people with serious or complex psychiatric disorders) were living independently, and 86.4% in 18/19.

We have introduced a pre-paid purchase card, used by people to manage their personal budget. This means balances can be checked online, and the Council is clearer on how money is being spent, with less paperwork to process.

77% of people who use our services said in 2017/18 that they have control over their daily lives, compared with 71% in the previous three years, and 74.8% in 18/19.

We were commended by ADASS Peer Review in October 2017 for being stable and well-supported with strong and effective leadership, good councillor oversight, self-awareness and staff who are open to learning and change.

We have the Havering Social Care Academy for all social care staff working with children, adults, their families, carers and the wider community. The Academy provides staff with access to training, a research hub, and opportunities for career progression. Our aim is to improve stability and retention and improve the quality of services for residents, and to recruit more in-house staff. We reduced our use of agency staff from 45% to 20% of our workforce.

We developed a better understanding of the social care provider market and workforce arrangements, allowing us to encourage greater stability in the wider workforce. The local authority has developed a Provider Training Programme and supported significant growth in the Personal Assistant (PA) market. Increasing numbers of PAs have been able to access quality assured training in Havering, and we have established a register of accredited PAs for residents to choose from.

Our Reablement Service helps people get back on track after a stay in hospital, working with them for up to six weeks to be as self-sufficient as possible with the right support in place. 88% of older people were still at home 91 days after discharge from hospital into rehabilitation or reablement services in 2017/18, and 88.7% in 18/19. The proportion of residents finishing reablement and still needing a long term service fell from 22% in 2016/17 to just 11.3% for 17/18 and 16.6% for 18/19. We re-commissioned this service in 2018/19 to integrate with the Intensive Rehabilitation service commissioned by health. The rationale was to reduce duplication and enable staff to work in partnership. As the contract was ending in April 2019 we completed a procurement exercise in late 2018 which resulted in Essex Cares Limited (ECL) becoming the new provider. The service model in terms of integration is the same and we will work with ECL over the coming year to align services to the rest of the intermediate care pathway. This resulted in improved outcomes; 10.2% of clients left reablement with a long term service in 2018/19 compared to 14.7% in 2017/18.

The Havering Dementia Action Alliance (HDAA) signed up 15 organisations to the HDAA and trained 257 dementia friends. The HDAA built strong links with the hospital, Queen's Theatre, and various carers groups, following the launch of their Dementia Strategy and has reinstated the dementia cafés at Queen's and King Georges Hospitals which enables carers to talk and gather information. The Council have been working with care home providers to understand costs which make up a residential care placement. Provider forums have been designed to open up dialogue on this subject. This has led to better informed decisions through improved understanding of the pressures in the market. Havering is the first London borough to sign up for dementia friendly personal budgets.

We have successfully introduced CarePulse. This is a system to obtain consistent information about care home capacity. Healthy London Partnership helped bring care homes, the Council and Health together to agree a shared approach to collecting information about the market. This has meant that staff time has been saved, and more up to date and accurate information is available.
There has been a focus on expanding the number of Personal Assistants (PA) working in Havering to support residents with personal budgets.

Where we need to do better

In 2017/18 we received 108 complaints. Of these: 51 were upheld, 52 were not upheld and 5 were withdrawn. While this compares well with the 121 complaints received the year before, those complaints upheld raised a number of concerns.

As in previous years, there remains a key complaint theme around financial assessment and charging, particularly linked to the level and quality of services, mostly community-based services. The other key complaint issue to emerge in 2017/18 was around delivery of equipment.

In 2018/19, complaints decreased slightly to 91. Of these, 12 were upheld, 15 partially upheld, 38 not being upheld and 12 withdrawn.

The highest number of complaints was about external home care. The main reason for complaints still remains linked to financial issues and disputes on charges. There was also an increase in family members not being happy with the social worker's decision.

Areas identified for improvement during the year were around completeness of assessments, information to providers on the treatment of direct payments used for respite, and financial information. Some of these may be picked up through the new Adult Social Care system Liquid Logic when implemented.

Learning from complaints is crucial, to ensure the service can make improvements to how vulnerable residents and their families are supported. They continue to play an important role in highlighting areas of improvement and we will respond as appropriate.

We need to work harder at explaining the benefits to individuals of deciding how money is spent on their own care and support arrangements, if more people are to choose direct payments.

We need to conduct further needs analysis of people with learning disabilities in employment, to consider our approach when commissioning support, ensuring greater personalisation and better employment opportunities.

We have been working with our neighbouring boroughs as well as Barking, Havering and Redbridge Clinical Commissioning Group to build frameworks to jointly commission, as well as to share local knowledge and understanding of the wider geographical area.

We recognise we need to:

- broaden the 'customer journey' so that our first conversation with residents isn't confined to social care but ranges across the Council and Partners;
- continue to work with children's services on ensuring pressures are identified and managed, improving the transition between our services;
- seek opportunities to work better with local GP's and Primary Care on setting priorities,
- work closely with the voluntary sector, to focus on prevention, help improve support, reduce isolation and better support carers.

IMPLICATIONS AND RISKS

Financial implications and risks:
Although the report outlines the spend on Adult Social Care, there are no direct financial implications arising from this report which is for information only.

Legal implications and risks:
There are no direct legal implications arising from producing the Local Account, which is a key mechanism for demonstrating accountability for performance and outcomes, and for sharing information.

Human Resources implications and risks:
There are no direct implications arising from this report, which is for information only.

Equalities implications and risks:
The Public Sector Equality Duty (PSED) under section 149 of the Equality Act 2010 requires the Council, when exercising its functions, to have due regard to:

(i) The need to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
(ii) The need to advance equality of opportunity between persons who share protected characteristics and those who do not, and;
(iii) Foster good relations between those who have protected characteristics and those who do not.

Note: 'Protected characteristics' are age, sex, race, disability, sexual orientation, marriage and civil partnerships, religion or belief, pregnancy and maternity and gender reassignment.

The Council is committed to all of the above in the provision, procurement and commissioning of its services, and the employment of its workforce. In addition, the Council is also committed to improving the quality of life and wellbeing for all Havering residents in respect of socio-economics and health determinants.

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

BACKGROUND PAPERS

None

Social Care for Adults in Havering

Local account 2017–18 & 2018–19

Havering
LONDON BOROUGH

Social Care for Adults in Havering

Introduction

Welcome to our fifth annual update on Adult Social Care (ASC) services in Havering, the Local Account. The purpose of our Local Account is to let Havering residents know about local care and support services for adults, and how we are performing, as well as to provide information on priorities for the coming years.

The Council's vision is all about embracing the best of what Havering has to offer. It is made up of four cross-cutting priorities: communities, places, opportunities and connections.

In Adult Social Care (ASC) we continue to contribute to the Council's ambitions to work with residents to improve the places in which they live; to invest in the local economy and generate opportunities for people; strengthening connections across the borough and with London and Essex. Our priority will be continuing to support families and communities to look after themselves and each other, with a particular emphasis on our most vulnerable residents.

ASC is responsible for ensuring the most vulnerable adults in our community, and their carers, are provided with support to meet their assessed essential needs. Safeguarding is top priority, with a personal approach adopted with each case. We ensure residents are provided with practical support to help them live their lives and maintain independence, dignity and control, with individual wellbeing at the heart of every decision.

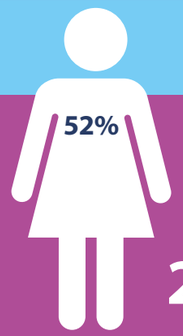
Everyone's situation is unique and we work with people across our communities: older adults, adults who have physical disabilities, those with sensory impairment, mental health needs and learning disabilities, as well as carers in the community.

For those that do not meet our eligibility criteria, there is a wide range of information, advice and guidance; and we continue to work with our partners to help people remain well and active for as long as they are able.

We hope you find this local account to be informative and useful.

Barbara Nicholls
Director of Adult Social Care and Health

Havering People



Havering's estimated Population is

253,371

131,681 Female

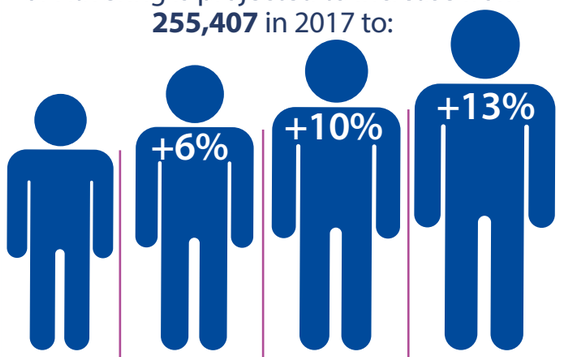
121,690 Male

(ONS Mid-year estimates 2016)

The life expectancy at birth for people living in Havering is **80.2 years for males** and **84.1 years for females**

Life expectancy from age 65 is – Females 21.6 years – Males 18.9 years.

According to the Greater London Authority (GLA) local authority population projections the population of Havering is projected to increase from **255,407** in 2017 to:



255,407 in **2017**

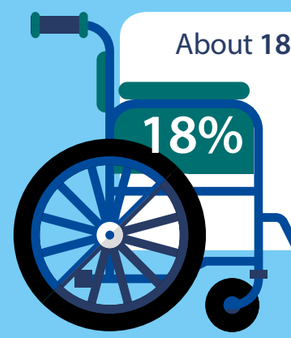
270,232 in **2022** – a 6% increase from 2017

281,590 in **2027** – a 10% increase from 2017

287,369 in **2032** – a 13% increase from 2017

32% of the population aged 65 or older live in one-person households. Almost half (**48%**) of all one-person households are occupied by people aged 65 or older.

This is the highest proportion in London.



About **18%** of working age people living in Havering disclosed that they have a disability or long term illness.

Havering has the oldest population in London with a median age of approximately 40 years.

Havering is ranked **166th** overall out of 326 local authorities in England for deprivation. There are pockets of depravation in the borough.

83% of Havering residents recorded as White British in the 2011 census, higher than both London and England.

Adult Social Care in Numbers

	2016/17	2017/18	2018/19
Deprivation of Liberty Safeguards (DoLS)	1,083	1,150	1,607
People who chose to meet their agreed health & social care needs by receiving Self Directed Support	1,735	1,875	1,843
People using the reablement service	1,143	1,353	1,067
Clients who have left reablement with a long term service	21.7%	14.7%	10.2%
Older people admitted to nursing / care homes (65+ average age 85)	321	240	279
Admission rate to nursing/care homes per 100,000 populations (65+ average age 85)	700	519	601.1
Older people receiving long term support in the community	2,907	2,681	2,597

Although total numbers have reduced for those receiving long term care and support in the community, we are seeing people needing more hours of care each week. However, we have been successful in admitting less people into residential care whilst enabling people to continue to live in their own homes, wherever possible and safe to do so. Other areas of care and support have seen an increase.

As can be seen DoLS is increasing year on year.

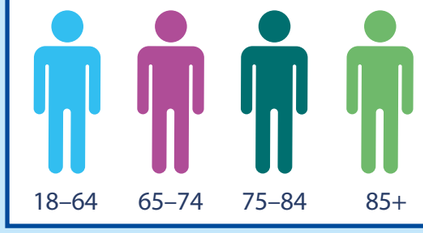
Social Care for Adults in Havering

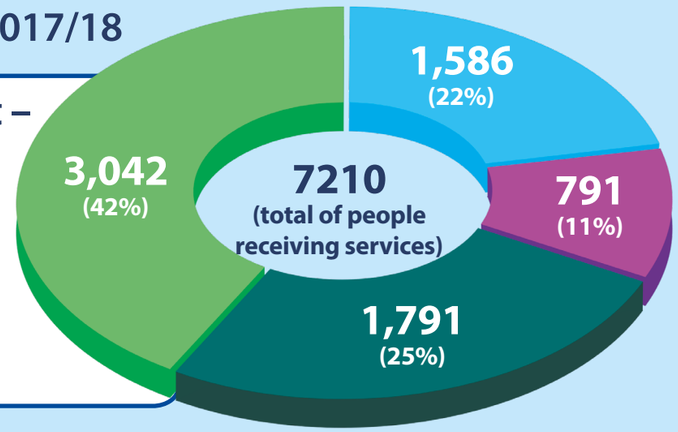
Social care at a glance

People come into contact with ASC in Havering for a variety of reasons. Chief among them are following admission to hospital, the onset of dementia, having suffered a fall, isolation and loneliness or an increasing complexity of needs that people can develop as they get older. There are also the complex needs that arise from people suffering mental illness, substance misuse problems, domestic violence and the increasing number of people affected by homelessness.

Support by age group 2017/18

Breakdown of Support – by age



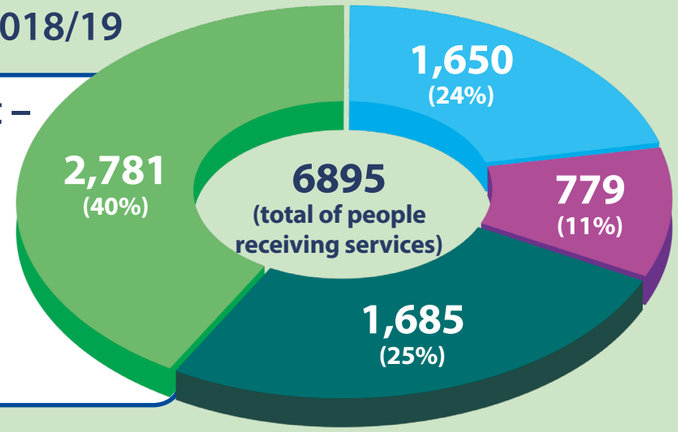


7,210 people received one or more of our services in 2017/18. Of these:

3,042 (42%) were aged 85 or over.
4,833 (67%) were aged over 75 years old,
5,624 (78%) were aged 65 or over.
1,353 people were referred to our Reablement Service.

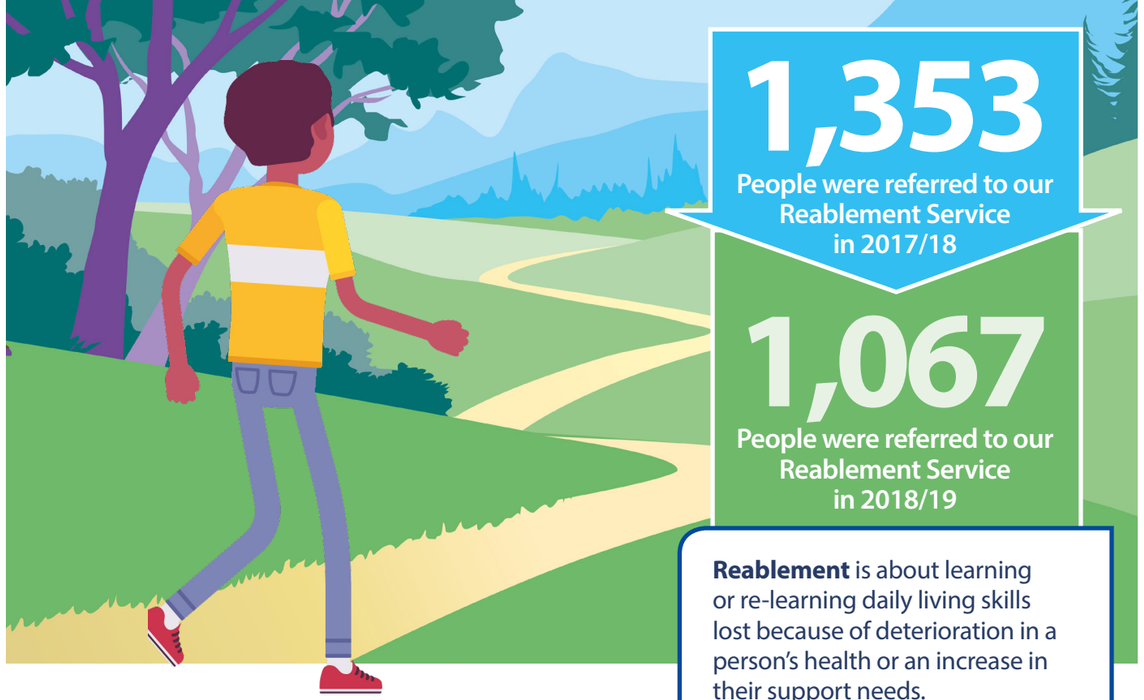
Support by age group 2018/19

Breakdown of Support – by age



6,895 people received one or more of our services in 2018/19. Of these:

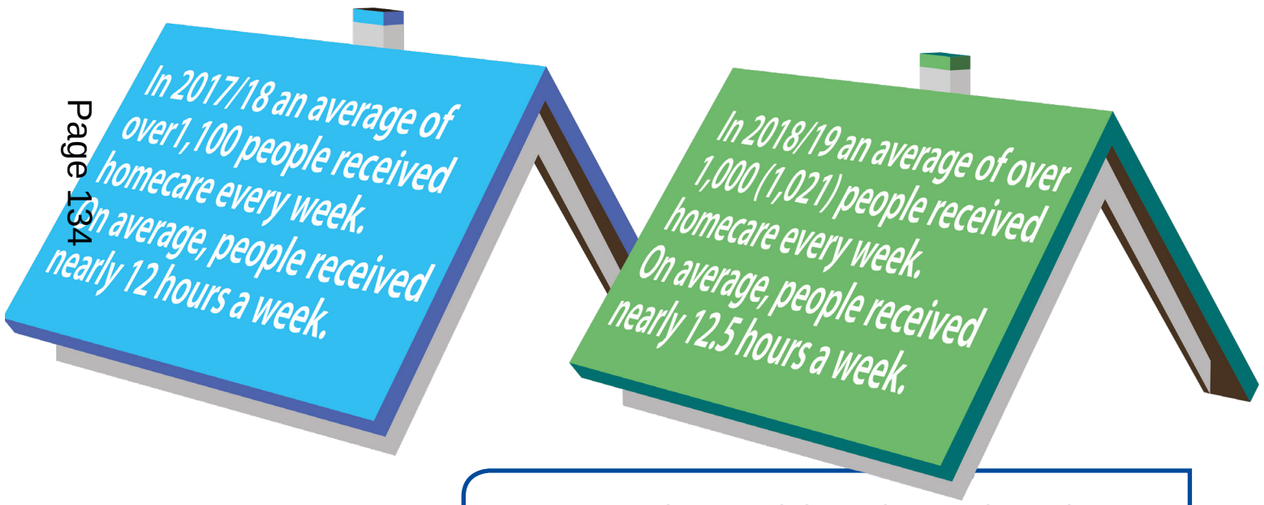
2,781 (40%) were aged 85 or over.
4,466 (65%) were aged over 75 years old.
5,245 (76%) were aged 65 or over.
992 people were referred to our Reablement Service.



1,353
People were referred to our Reablement Service in 2017/18

1,067
People were referred to our Reablement Service in 2018/19

Reablement is about learning or re-learning daily living skills lost because of deterioration in a person's health or an increase in their support needs.



Homecare is where people live in their own homes but get support with household tasks, personal care or other things that help them maintain their independence and quality of life.

In 2017/18 **1,875** people met their health and social care needs through Self Directed Support.

In 2018/19 **1,843** people met their health and social care needs through Self Directed Support.

Self Directed Support gives individuals informed choice about how social care is provided with a focus on working together to achieve individual outcomes.

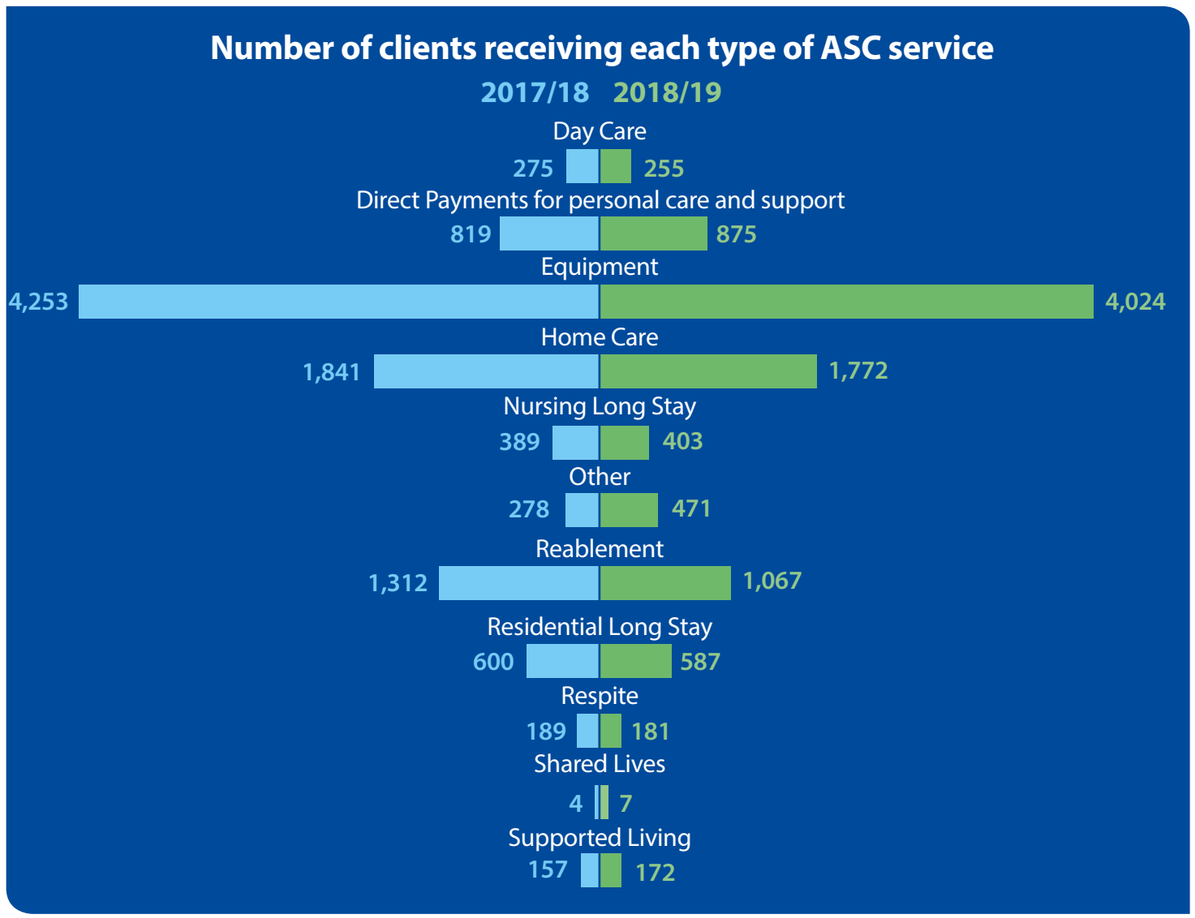
In 2017/18 **122** carers received a Direct Payment.

In 2018/19 **152** carers received a Direct Payment.

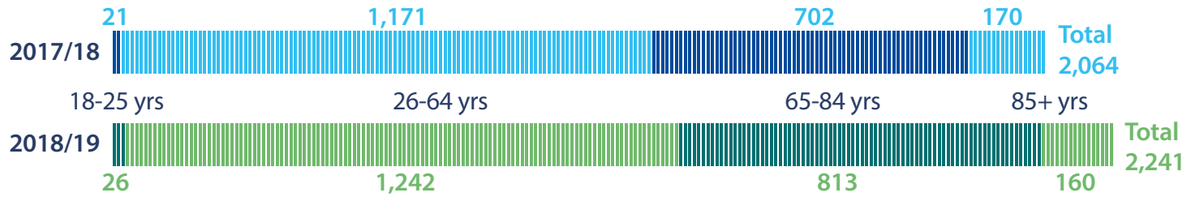
£ Direct Payments are payments made to individuals who have care and support needs or to carers who are eligible for support. The money received can be spent on things that help meet the needs as agreed in their support plan. Anyone who is assessed as needing care services has the right to request a direct payment instead of having services provided by the Council.

A carer is someone who provides unpaid care for a family member or friend whose disability, illness, mental health or substance abuse problem is such that they need their support.

Number of clients receiving each type of ASC service



Carers supported by Age Group Count of Age



Social Care for Adults in Havering

The Budget

As our population grows and ages, so too does the demand for social care services. We are seeing people needing more hours of care due to increasing complexity of needs leading to increases in the Community Team costs. Safeguarding is another area where costs have increased.

As we continue to experience budget pressures we need to target our resources in the best way possible. We achieved a balanced budget position in 2017/18 and 2018/19. A Peer Review in October 2017 conducted by Association of Directors of Social Services (ADASS) commended Havering Adult Social Care for its strong financial governance.

Demand has been managed through the positive impact of prevention measures, such as reablement and having the right conversations with people early on. We know that it is only by thinking and working differently, that we can continue to ensure the demand for services doesn't overtake the money available to deliver them.

Prevention is about interventions that help people to maintain or improve their health and/ or quality of life and their independence in the community.

Commissioning
is the planning and resourcing of services to achieve the best possible outcomes for the community and for individuals who require care and support.

Day opportunities
are where people who are socially isolated meet other people, have meals and take part in activities.

Assessment
is the gathering and assessing of information about an individual's needs to develop a plan.

Safeguarding
provides support to people with a learning disability, dementia, mental health or substance abuse problems who have care and support needs that may make them more vulnerable to abuse or neglect.

	Our spend in 2017/18	Our spend in 2018/19
	£57,682,192	£60,159,303
Broken down as follows:	2017/18	2018/19
Transforming Health & Social Care	£101,218	£119,602
Commissioned services including reablement	£4,024,336	£4,000,615
Older Peoples Support	£26,113,960	£27,501,239
Adult Safeguarding	£739,795	£953,698
Learning Disabilities	£21,523,698	£21,706,788
Mental Health	£2,919,838	£2,854,272
Health & Social Care Staffing	£2,259,347	£3,023,089

What we did well over this period

Our Front Door

Our Front Door, which is usually the first contact with us, underwent a redesign. We developed this with skilled staff so that we are better able to provide advice and guidance, and refer to the correct team, on a timely basis. This improved initial handling of contacts, giving a smoother experience for the customer

Better Living

To this end, we introduced a new way of working called Better Living, which involves a series of conversations:

- An initial conversation focused on listening, building on individual strengths, considering what resources are available via family, other networks and the community, with a view to promoting independence.
- The second conversation is about offering short term support for people in crisis, potentially involving intensive support for a limited duration.
- The third conversation explores, where appropriate, the use of a fair personal budget.

Positive feedback

The feedback from residents using our services was generally positive. According to the 2017/18 annual Adult Social Care Survey, **91%** agreed that Havering's care and support services help them to have a better quality of life. In 2017/18 **71%** of people who used our services said that they felt safe, compared with **69%** in the three previous years. This increased to **89%** in 2018/19.

Fewer admitted to residential settings

Fewer people were admitted into residential settings – with 519 per 100,000 people aged 65 or over permanently admitted to a nursing or care home in 2017/18, compared with 700 in 2016/17. This is moved to 601 per 100,000 in 18/19.

Investing in homecare

We have invested in the homecare market to stabilise care provision, to give capacity to provide services in Havering. We are committed to ensuring home care workers benefit from a reasonable funding regime.

Active Homecare Framework

In 2017/18, we implemented the Active Homecare Framework, a dynamic purchasing system which enables providers to operate in Havering so long as they meet quality criteria. We developed a method for understanding the outcomes for residents of the homecare that they have received. A set of measures and questions have been developed in partnership with people who use out service, their family and the Council. The Council's Quality Outcomes team regularly contact a random sample of people to gather feedback on homecare services. Results for 2018/19 indicated that **85% of users rated the service as good or very good.**

The numbers of older people needing long term support in the community fell from 2,907 in 2016/17 to 2,681 in 2017/18, and fell again to 2,597 in 2018/19.

In 2017/18, **78%** of people with a learning disability in Havering were living in their own home or with their family, and **78.5%** in 2018/19.

In 2017/18, **85%** of people in contact with secondary mental health services (for people with serious or complex psychiatric disorders) were living independently, and **86.4%** in 2018/19.

More choice and control

We introduced a pre-paid purchase card, used by individuals to manage their personal budget. This means people can check their balance online, the Council are clearer on how money is being spent and there is less paperwork to process.

77% of people who use our services said in 2017/18 that they have control over their daily lives, compared with **71%** in the previous three years, and **74.8%** in 2018/19.

Personalisation in Havering means putting the individual at the centre of the process of working out what their needs are, choosing the support they need and having control over their life.

Havering is the first London borough to sign up for dementia-friendly personal budgets.

Havering Dementia Action Alliance is working to ensure those affected by dementia are supported and accepted and able to live in their community. The Mercury Shopping Centre is piloting a 'Silent Tuesday' to improve the shopping experience of people with learning disabilities, autism and dementia and to reduce distractions that may deter people coming to the centre. The Queen's Theatre in Hornchurch are showing Dementia friendly performances called Down Memory Lane.

"I would like to take this opportunity to once again thank you for the kind consideration and help you gave to me and my family when arranging the placement of my mother. This was a very traumatic time for us and your patience, especially with me, was much appreciated. I would also like to thank you for the kindness, courtesy and patience you showed to my mother."

We were commended by ADASS Peer Review in October 2017 for being stable and well-supported with strong and effective leadership, good councillor oversight, self-awareness and staff who are open to learning and change.

We have the **Havering Social Care Academy** for all social care staff working with children, adults, their families, carers and the wider community. The Academy provides staff with access to training, a research hub, and opportunities for career progression. Our aim is to improve stability and retention, the quality of services for residents and to recruit more in-house staff. **We have significantly reduced our agency staff from 45% to 20% of our workforce.**

We developed a better understanding of the social care provider market and workforce arrangements, allowing us to encourage greater stability in the wider workforce. The local authority has developed a Provider Training Programme and supported significant growth in the Personal Assistant (PA) market. Increasing numbers of PAs have been able to access quality assured training in Havering, and we have established a register of accredited PAs for residents to choose from.

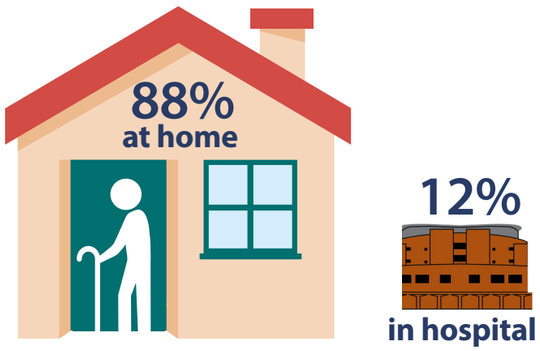
What we did well over this period (continued)

"I am writing to say a huge Thank You for all your help and support in moving [my mother] to Ashgate House. it is obvious to see she is far happier and healthier than she has been in a long time. Thanks to your efforts she now has quality of life and the appropriate level of care for her needs for the first time in years she has actually put on some weight! Since moving [her] mental health has also improved… it feels like a weight has been lifted knowing [she] is being cared for properly. It has allowed us to provide support and spend quality time with our mum, who is terminally ill, without worrying about the level of care and for that we will always be very grateful to you."

Getting patients home and able

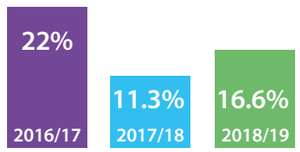
While challenges remain, the ADASS Peer Review described Havering's Joint Assessment and Discharge Team – based at King George and Queens hospitals and the first contact for many who use our services – as working well and finding creative solutions, not least in maintaining low delayed discharges from hospital. The Review described our record as 'impressive' and also praised our discharge-to-assess approach, which (also known as the home-first model) means a reduced level of assessment in hospital, and ensuring no decision about long term care is made until they return home.

Our Reablement Service helps people get back on track after a stay in hospital, working with them for up to six weeks to be as self-sufficient as possible with the right support in place.



88% of older people were still at home **91** days after discharge from hospital into rehabilitation or reablement services in 2017/18.

The proportion of residents finishing reablement and still needing a long term service fell from **22%** in 2016/17 to just **11.3%** in 2017/18 and **16.6%** in 2018/19.



Reablement service

We re-commissioned the reablement service to integrate with the Intensive Rehabilitation service commissioned by the health. The rationale was to reduce duplication and enable staff to work in partnership. As the contract was ending in April 2019 we completed a procurement exercise in late 2018 which resulted in Essex Cares Limited (ECL) becoming the new provider. The service model in terms of integration is the same and we will work with ECL over the coming year to align services to the rest of the intermediate care pathway. This resulted in improved outcomes; **10.2%** of clients left reablement with a long term service in 2018/19 compared to **14.7%** in 2017/18.

HDAA

The Havering Dementia Action Alliance (HDAA) signed up 15 organisations to the HDAA and trained 257 dementia friends. The HDAA built strong links with the hospital, Queen's Theatre, and various carers groups following the launch of their Dementia Strategy; and has reinstated the dementia cafés at Queen's and King Georges Hospitals which enables carers to talk and gather information.

Working with care home providers

The Council have been working with care home providers to understand costs which make up a residential care placement. Provider forums have been designed to open up dialogue on this subject. This has led to better informed decisions through improved understanding of the pressures in the market.

CarePulse

We have successfully introduced CarePulse. This is a system to obtain consistent information about care home capacity. Healthy London Partnership helped bring care homes, the Council and Health together to agree a shared approach to collecting information about the market. This has meant that staff time has been saved, and more up to date and accurate information is available.

Personal Assistants to support residents

There has been a focus on expanding the number of Personal Assistants (PA) working in Havering to support residents with personal budgets.

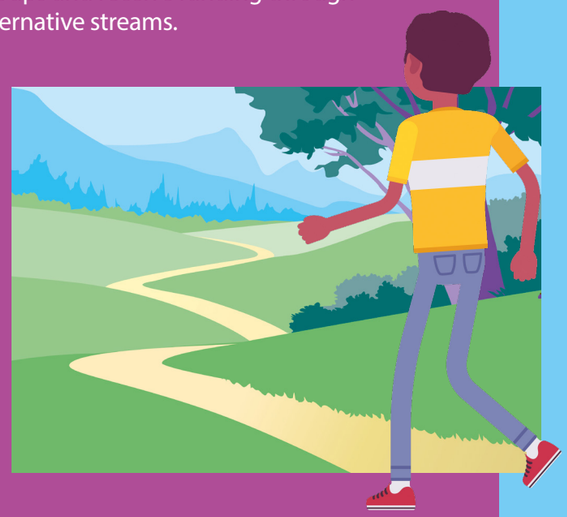
Prevention

Prevention is about ensuring residents have access to a range of support that helps them maintain their independence and prevents or delays the need for ongoing support.

The new voluntary sector service offer focuses on prevention; supporting Havering residents to live independent lives without recourse to more formal statutory support. The offer has been recently recommissioned and the voluntary sector services are split into three key outcomes:

- Promote social inclusion for those isolated and/ or prevent people from becoming socially excluded
- Develop community resilience and personal wellbeing through peer support networks
- Carers supported in their caring role and to maintain a life of their own

The commissioned voluntary sector services went live on 1st February 2018 and there is an expectation that over the life of the contract providers will aim to develop self-sustaining groups and receive funding through alternative streams.



Where we need to do better

In 2017/18 we received 108 complaints. Of these: 51 were upheld, 52 were not upheld and 5 were withdrawn. While this compares well with the 121 complaints received the year before, those complaints upheld raised a number of concerns:

As in previous years, there remains a key complaint theme around financial assessment and charging, particularly linked to the level and quality of services, mostly community-based services. The other key complaint issue to emerge in 2017/18 was around delivery of equipment.

In 2018/19 complaints decreased slightly to 91. Of these, 12 were upheld, 15 partially upheld, 38 not being upheld and 12 withdrawn.

The highest number of complaints was about external home care. The main reason for complaints still remains linked to financial issues and disputes on charges. There was also an increase in family members not being happy with the social worker's decision.

Areas identified for improvement during the year were around completeness of assessments, information to providers on the treatment of direct payments used for respite, and financial information. Some of these may be picked up through the new Adult Social Care system Liquid Logic when implemented.

Learning from complaints is crucial, to ensure the service can make improvements to how vulnerable residents and their families are supported. They continue to play an important role in highlighting areas of improvement and we will respond as appropriate.

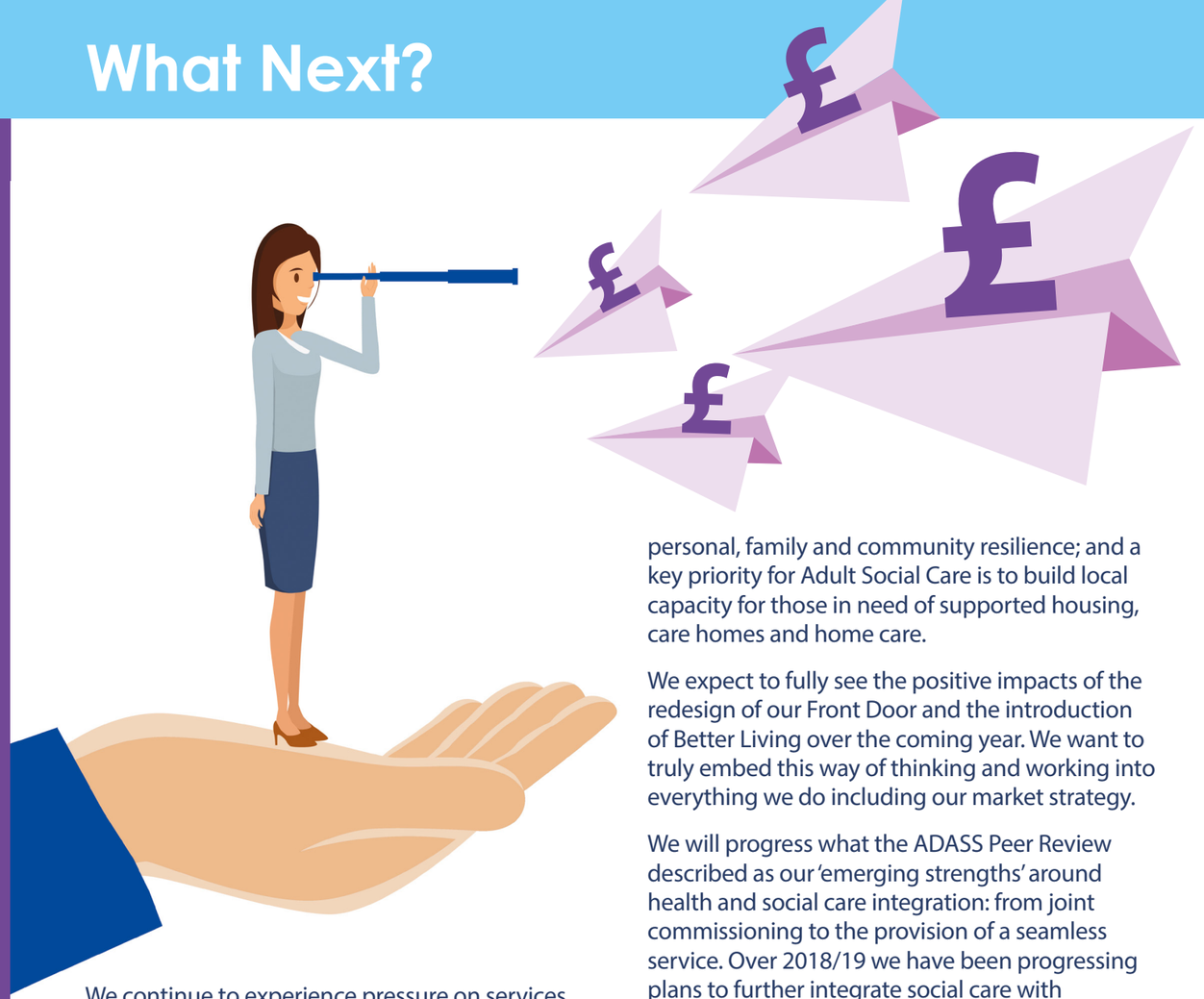
We need to work harder at explaining the benefits to individuals of deciding how money is spent on their own care and support arrangements, if more people are to choose direct payments.

We need to conduct further needs analysis for people with learning disabilities in employment, to consider our approach when commissioning support, ensuring greater personalisation and better employment opportunities.

We have been working with our neighbouring boroughs as well as Barking, Havering and Redbridge Clinical Commissioning Group to build frameworks to jointly commission, as well as to share local knowledge and understanding of the wider geographical area.

We recognise we need to:

- broaden the 'customer journey' so that our first conversation with residents isn't confined to social care but ranges across the Council and Partners;
- continue to work with children's services on ensuring pressures are identified and managed, improving the transition between our services;
- seek opportunities to work better with local GP's and Primary Care on setting priorities,
- work closely with the voluntary sector, to focus on prevention, help improve support, reduce isolation and better support carers.



We continue to experience pressure on services from a growing and ageing population, from the increasingly complex needs of those coming to us for support, and from the drive for greater support in the community for those leaving hospital. We will need to keep on top of these changes in demographics and in needs when planning and commissioning our services in the context of much reduced government funding.

We are meeting these challenges by working better and more effectively. This includes implementing a new case recording system to improve productivity and the flow of client information; working across organisations that make up the local health and care economy, and supporting and shaping the care market to ensure we have the capacity and the people in place to meet residents' care needs.

Adult Social Care with other departments in the council and community health services continues to work on new models of care and support e.g. locality-based teams in local communities. We continue to work with our voluntary sector partners, focussing on joined-up services that build personal, family and community resilience; and a key priority for Adult Social Care is to build local capacity for those in need of supported housing, care homes and home care.

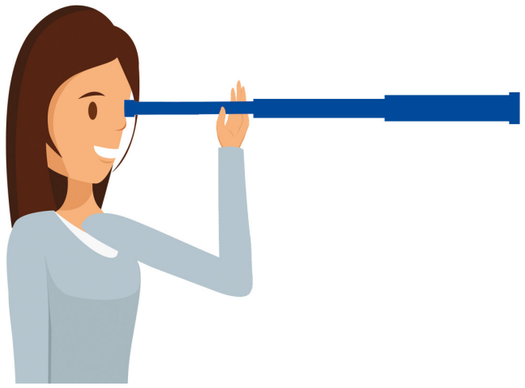
We expect to fully see the positive impacts of the redesign of our Front Door and the introduction of Better Living over the coming year. We want to truly embed this way of thinking and working into everything we do including our market strategy.

We will progress what the ADASS Peer Review described as our 'emerging strengths' around health and social care integration: from joint commissioning to the provision of a seamless service. Over 2018/19 we have been progressing plans to further integrate social care with community health services, in order to support people in their own homes, reduce unnecessary hospital admissions and accelerate hospital discharge into a safe community setting.

We continue to work to ensure there is a choice of personalised care available in the borough by actively working with providers and PAs on training, recruitment and retention, and by facilitating group forums, to stabilise the social care market.

Adult Social Care is now piloting Individual Service Funds for homecare. This is where the care budget is held by the care provider so they work with the individual to develop a personalised care and support package to meet the needs of the individual. This provides the opportunity to flex support from day to day.

Over the coming year the Adult Social Care will be reviewing the Direct Payments process with a view to improving access and making it quicker and easier for all involved. Although Havering's direct payment take-up rates are improving, we want



more people to receive support in this way, and to have more say over where the money allocated for their care and support is spent.

For personalisation we will be improving our processes and increasing options in the market to give people more choice and control.

We will continue to work with our provider market to ensure high quality and value for money services for vulnerable people, including those with autism.

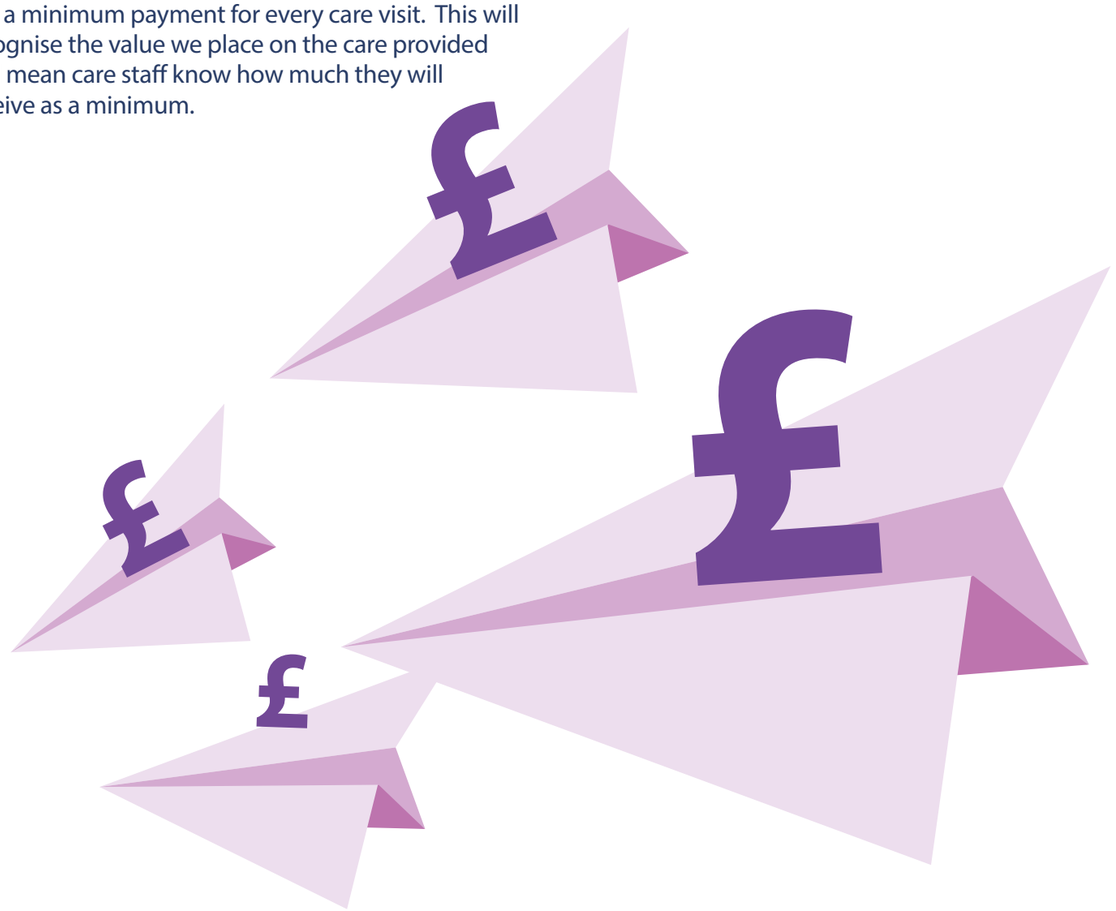
For homecare we will be shifting from time and task to focus on outcomes and quality. We want to support and develop the workforce. One way to achieve this will be to get to the position where we pay a minimum payment for every care visit. This will recognise the value we place on the care provided and mean care staff know how much they will receive as a minimum.

We will be piloting a trusted assessor model for residential care to reduce time lost in care home managers visiting the hospital to assess new residents.

A new Dementia Engagement Group will be set up to include carers, healthcare professionals, and admiral nurses to discuss smarter ways of working.

We will be working with our voluntary sector preventative services to develop a method of capturing the outcomes from the service.

We have started a programme to develop a number of local supported housing schemes across children's and adult social care. The first scheme for young people leaving care is expected to open late summer 2019 with a new build supported housing scheme for adults with disabilities expected in the summer of 2021, along with a scheme for children with disabilities and another scheme for young people leaving care. The schemes will enable the Council to manage costs more effectively and work more closely with providers to deliver high quality outcomes for vulnerable children, young people and adults.



Social Care for Adults in Havering

What do you think?

Whether you live in Havering and use social care yourself or care for somebody who does, or just want to have your say on local services, we would love to hear from you. To share your views on what you've read or if you would like to work with us to improve support for residents, please send your message to **ASCBusinesssupporthub@havering.gov.uk**

If you would like to know more about Adult Social Care in Havering visit: https://www.havering.gov.uk/info/20015/adult_social_care

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