

# Havering Place based Partnership

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Vision, principles and emerging priority areas

February 2023

# Havering Place Partnership



# Integrated Care Systems

## Integrated care systems (ICSs)

Key planning and partnership bodies from July 2022

### NHS England

Performance manages and supports the NHS bodies working with and through the ICS

### Care Quality Commission

Independently reviews and rates the ICS

### Statutory ICS

#### Integrated care board (ICB)

**Membership:** independent chair; non-executive directors; members selected from nominations made by NHS trusts/foundation trusts, local authorities and general practice

**Role:** allocates NHS budget and commissions services; produces five-year system plan for health services

#### Integrated care partnership (ICP)

**Membership:** representatives from local authorities, ICB, Healthwatch and other partners

**Role:** planning to meet wider health, public health and social care needs; develops and leads integrated care strategy but does not commission services

Cross-body membership, influence and alignment

Influence

Influence

### Partnership and delivery structures

#### Geographical footprint

##### System

Usually covers a population of 1-2 million

##### Provider collaboratives

NHS trusts (including acute, specialist and mental health) and as appropriate voluntary, community and social enterprise (VCSE) organisations and the independent sector; can also operate at place level

##### Place

Usually covers a population of 250-500,000

##### Health and wellbeing boards

ICS, Healthwatch, local authorities, and wider membership as appropriate; can also operate at system level

##### Place-based partnerships

Can include ICB members, local authorities, VCSE organisations, NHS trusts (including acute, mental health and community services), Healthwatch and primary care

##### Neighbourhood

Usually covers a population of 30-50,000

##### Primary care networks

General practice, community pharmacy, dentistry, opticians

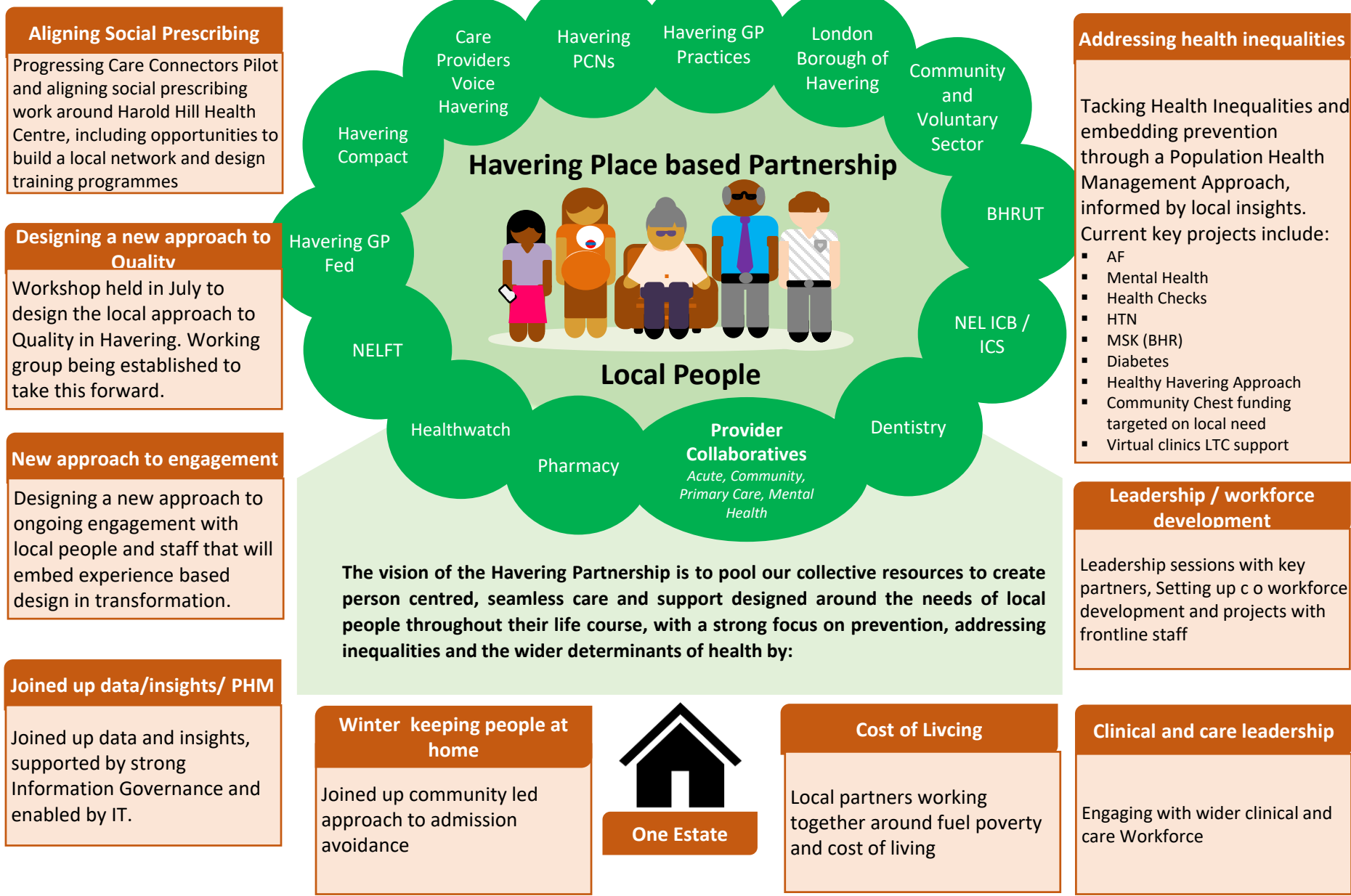
## PROPOSED governance arrangements post July 2022 PHASE 1



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

# Havering PbP – Priority Programmes on a page

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



## Key functions of a place based partnership

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

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

A series of principles for local health and care leaders

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

## Our collective vision for the Havering Partnership

The vision of the Havering Partnership is to pool our collective resources to create person centred, seamless care and support designed around the needs of local people throughout their life course, with a strong focus on prevention, addressing inequalities and the wider determinants of health by:

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



## How we want to work together to deliver this vision

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

1. **Patient/resident voice** – we need to ensure the patient/resident voice is central to our discussions and decision-making and that, in 12 months' time residents feel included and involved, and we have a clear picture of how people experience services and are engaged (let's measure this from the beginning!). As part of this we can get input from local councilors and organisations such as HealthWatch.
2. **Good governance and accountability** – we need to set up robust governance and accountability structures to enable us to deliver this vision. This will not be a 'quick win'.
3. **Adequate resourcing** – the PMO support needs to be increased and we need to fund Clinical and Care Leadership time to increase professional This also links into the ask of place around finance, quality, comms etc
4. **Good data and Insights** – we need good data to inform our decision-making and measure the impact of our work. As part of this we need to establish data sharing and systems access agreements.
5. **Shared accommodation** – practically, we should work swiftly to identify accommodation to support the colocation of services through shared accommodation wherever possible, as this offers huge benefits to staff and patients.
6. **A culture of collaboration and change supported at the most senior level** – we need to be setting the right culture across Havering where people are encouraged to collaborate rather than compete and where opportunities to create joint services and joint posts are sought out and supported.
7. **Practical arrangements** – we need clarity on the meeting schedule and membership of the Partnership and links to the wider system e.g. fire service/education etc.

## How we want to work together Clinical and Care Leadership

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

Population health management

Prevention

Anticipatory care

Understanding the population needs

- Data driven
- Listening to local people

Support and develop the community capacity and capability

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

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

Organise around the person and community:

- Strength based
- Asset based
- Person centred
- Holistic

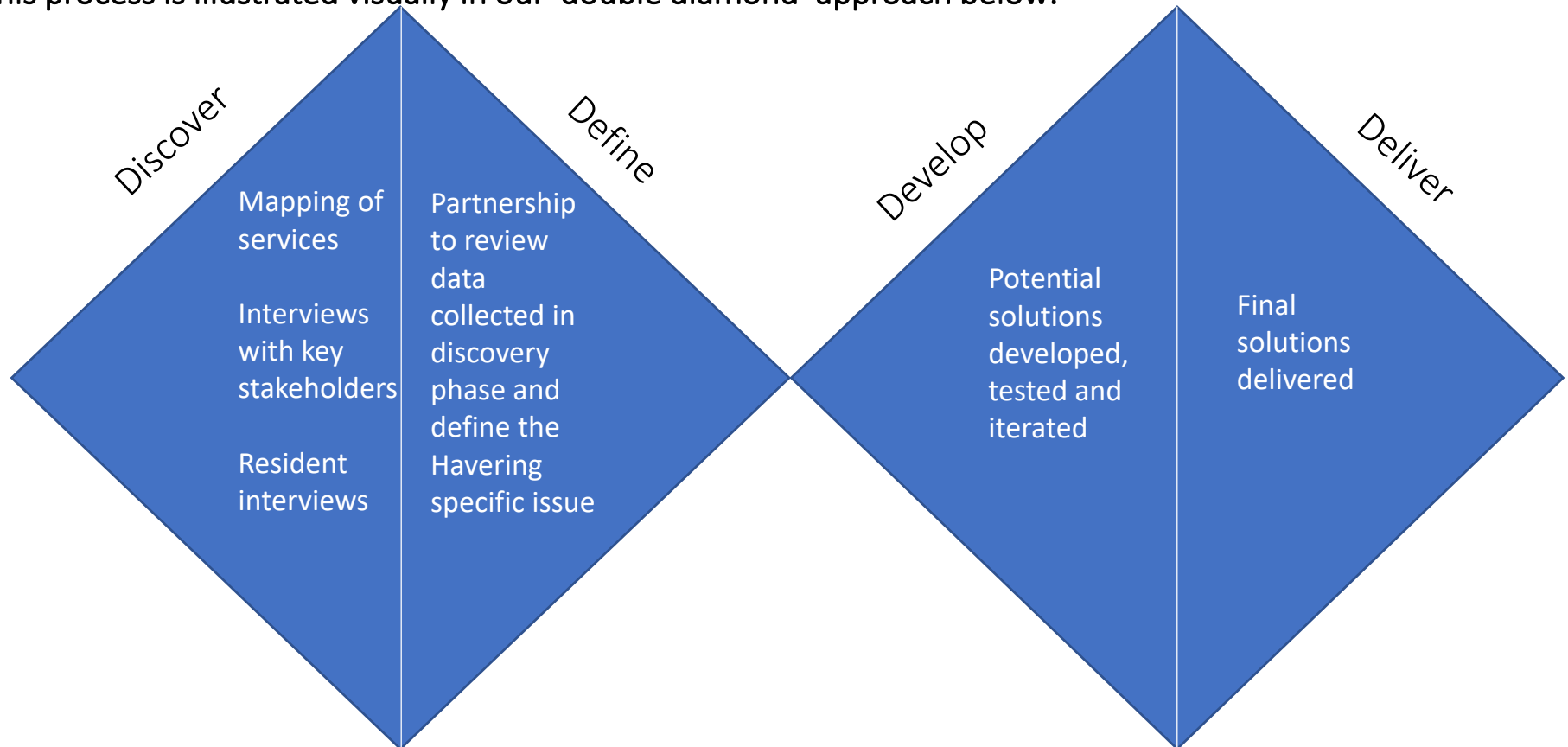
Integrated and collaborative approach to avoid duplication and make the best use of resources and breaks down organisational barriers to focus on the system

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

## Our approach to transformation

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

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



# Havering PbP Matrix Team – Core Leads

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