NHS
North East London
Integrated Care Board

Havering ICB sub-committee

Agenda – 8 November 2023 – 4.05 – 5.00pm Via MS Teams

1.0 **1.1** **1.2** **1.3**	**Welcome** Declarations of Interest Minutes from the 12 July 2023 mtg Action log	4.05 (5 mins)	Chair	 Attached Attached Attached *pages 1 - 13*	 Note Approve Discuss/ Note
2.0	**Questions from the public**	4.10 (15 mins)	Chair/Lead	Verbal	Discuss/ Note
3.0	**Havering PbP Strategy and NEL System development plan**	4.25 (15 mins)	Luke Burton	Attached *Pages 14 - 40*	Approve
4.0	**Finance update**	4.40 (15 mins)	Sunil Thakker / Kathy Freeman	Attached *pages 41 - 49*	Note
5.0	**AOB**	4.55	Chair		
Date of next ICB sub-committee: 10 January 2024					

- Declared Interests as at 20/10/2023

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Andrew Blake-Herbert	Chief Executive; London Borough of Havering	Havering ICB Sub-committee Havering Partnership Board ICB Board ICS Executive Committee	Financial Interest	London Borough of Havering	Employed as Chief Executive	2021-05-01		Declarations to be made at the beginning of meetings
Barbara Nicholls	Strategic Director of People, Havering Council	Havering ICB Sub-committee Havering Partnership Board	Non-Financial Professional Interest	Association of Directors of Adult Social Services (ADASS)	Professional membership	2016-01-01		Declarations to be made at the beginning of meetings
Brid Johnson	Member of sub-committee (representative of NELFT)	Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board Havering ICB Sub-committee Havering Partnership Board Redbridge ICB Sub-committee Redbridge Partnership Board Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indirect Interest	Mid and South Essex ICB	My Partner is a Non-Executive Director at MSE ICB	2022-08-25		
Chetan Vyas	Director of Quality	Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board City & Hackney ICB Sub-committee City & Hackney Partnership Board Havering ICB Sub-committee Havering Partnership Board ICB Quality, Safety & Improvement Committee Newham Health and Care Partnership Newham ICB Sub-committee Redbridge ICB Sub-committee Redbridge Partnership Board Tower Hamlets ICB Sub-committee Tower Hamlets Together Board Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indirect Interest	North East London CCG	Spouse is an employee of the CCG	2014-04-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Some GP practices across NEL	Family members are registered patients - all practices not known nor are their registration dates	2014-04-01		Declarations to be made at the beginning of meetings

			Indirect Interest	Redbridge Gujarati Welfare Association - registered charity in London Borough of Redbridge	Family member is a Committee member.	2014-04-01		Declarations to be made at the beginning of meetings
Emily Plane	Head of Strategic Planning - Havering Place based Partnership	Havering ICB Sub-committee Havering Partnership Board	Non-Financial Professional Interest	Petersfield Surgery	I am a registered patient of Petersfield Surgery in Havering.	2022-11-02		
Ian Buckmaster	Member of Committee	Havering ICB Sub-committee	Non-Financial Professional Interest	Healthwatch Havering	I am a director of Helathwatch Havering, which receives some funding from NHS NEL.	2023-04-01		
Julia Summers	Head of Finance	Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board Havering ICB Sub-committee Havering Partnership Board Redbridge ICB Sub-committee Redbridge Partnership Board	Indirect Interest	Camden and Islington Mental Heath Trust	Husband is a director of the Trust.	2016-02-08		
Narinderjit Kullar	Clinical Director, Havering Place Based Partnership	Clinical Advisory Group Formulary & Pathways Group (FPG) Havering ICB Sub-committee Havering Partnership Board	Financial Interest	St Edwards Medical Centre	GP Partner at practice	2017-11-01		
			Non-Financial Personal Interest	BHRUT	Wife works within the trust (Quality and Safety)	2017-11-01		
			Non-Financial Personal Interest	Healthbridge GP Federation	Wife's Brother-in-Law is interim CEO of Redbridge GP Federation	2023-05-01		
			Non-Financial Professional Interest	Faculty of Clinical Informatics, Hexitime and Shuri Network	Ongoing membership with FCI, Hexitime and Shuri Successful application to the Shuri Network in obtaining a bursary for one year's membership for the Faculty of Clinical Informatics (2019/20). This is to encourage and facilitate BAME women to apply for membership. No money was	2020-12-01		No action required as no conflicts declared.

					received by myself. I now pay for my own membership with the FCI and I am committed to promoting difference and diversity in digital health. From March 2021, I joined Hexitime which is community to support members to offer their skills. As part of this, I can offer my skills for someone to shadow me under the the Shuri Network Digital Shadowing Programme and vice versa. Only time is exchanged, there is no monetary gain.			
			Non-Financial Professional Interest	Prescribing Services	Attended a educational conference	2022-11-30	2022-12-01	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Health Education England	I have volunteered to be a Health Ambassador for HEE. Health Ambassadors are health and social care staff and volunteers in clinical and non-clinical roles who have the opportunity to attend careers fairs and employability events to promote and encourage people to join the NHS workforce. They will offer advice on the opportunities out there and information about their professions (your personal journey into your role). Currently,	2022-01-03		No action required as no conflicts declared.

					the aim is to provide face to face and virtual talks to disadvantaged young people from schools and sixth form colleges in London.			
			Non-Financial Professional Interest	NHS North East London	Sessional role (4hrs per week) as Clinical Lead, Community Pharmacy Clinical Project Sponsor for the Digital First team, NHS North East London.	2022-03-01		No action required as no conflicts declared.
Vicki Kong	QIPP Programme Pharmacist	Havering ICB Sub-committee Havering Partnership Board	Non-Financial Professional Interest	NHS North East London	Havering Clinical Lead for Population Health Management	2023-03-20		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Q community	Member of Q community. Brings people together to support continual learning and quality improvement initiatives. I have previously (unsuccessfully) applied for funding under the Q exchange programme for a medicines optimisation digital resource and community platform.	2020-07-31		
			Non-Financial Professional Interest	Convensis	Attendance of the Oncology conference as one of the members of the panel discussing cancer screening and early intervention	2023-06-29	2023-06-29	No action required as no conflicts declared.
			Non-Financial Personal Interest	Upminster & Cranham Residents' association	Volunteer deliver the monthly local bulletin to residents in one road in	2023-05-29		No action required as no conflicts declared.

		Upminster and collect the annual subscription fee of £2 from each household that subscribes on that road.			
Non-Financial Professional Interest	Convensis	The declaration for the travel is showing however. I was a panel member for a discussion on Population Health Management conference. I was paid for rail travel to Manchester standard off-peak return.	2023-06-08	2023-06-08	
Indirect Interest	NHS North East London	My family is registered with Cranham Village Surgery since 2015. My mother is registered with Gubbins Lane surgery for many years.	2015-06-01		

- Nil Interests Declared as of 20/10/2023

Name	Position/Relationship with ICB	Committees	Declared Interest
Ann Hepworth	Member of an ICB committee	Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board Community Health Collaborative sub-committee Havering ICB Sub-committee Havering Partnership Board Redbridge Partnership Board	Indicated No Conflicts To Declare.
Selina Douglas	Executive Director of Partnerships	Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board Community Health Collaborative sub-committee Havering ICB Sub-committee Havering Partnership Board Mental Health, Learning Disability & Autism Collaborative sub-committee Redbridge ICB Sub-committee Redbridge Partnership Board Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Charlotte Pomery	Chief Participation and Place Officer	Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board City & Hackney ICB Sub-committee City & Hackney Partnership Board Community Health Collaborative sub-committee Havering ICB Sub-committee	Indicated No Conflicts To Declare.

		Havering Partnership Board ICB Audit and Risk Committee ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICP Committee ICS Executive Committee Newham Health and Care Partnership Newham ICB Sub-committee Redbridge ICB Sub-committee Redbridge Partnership Board Tower Hamlets ICB Sub-committee Tower Hamlets Together Board Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	
Mark Ansell	member of a committee	Clinical Advisory Group Havering ICB Sub-committee Havering Partnership Board	Indicated No Conflicts To Declare.
Jwala Gupta	Havering North PCN Clinical Director	Havering ICB Sub-committee Havering Partnership Board	Indicated No Conflicts To Declare.
Susanne Rauprich	member of a committee	Havering ICB Sub-committee Havering Partnership Board	Indicated No Conflicts To Declare.
REBECCA MAZRREKU	HPBP - Community Connections Lead	Havering ICB Sub-committee Havering Partnership Board	Indicated No Conflicts To Declare.

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Minutes of the Havering ICB sub-committee

13 September 2023

Members:	
Andrew Blake-Herbert (ABH) Chair ICB sub-comm)	CEO, London Borough of Havering
Dr Narinderjit Kullar (NK)	Havering Clinical Director
Cllr Gillian Ford (GF)	Councillor, London Borough of Havering
Luke Burton (LB)	Borough director, NHS North East London
Mark Ansell (MA)	Director of Public Health, London Borough of Havering
Barbara Nicholls (BN)	Director of Adult Social Care, London Borough of Havering
Annette Kinsella (AK)	Head of Integrated Services, London Borough of Havering
Steve Rubery (SRu)	CEO, PELC
Ann Hepworth (AH)	Director of Strategy and Partnerships, BHRUT
Sunil Thakker (ST)	Director of Finance, NHS North East London
In Attendance:	
Anna McDonald (Amc)	Senior Governance manager, NHS North East London
Debbie Harris (DH)	Governance officer, NHS North East London
Matt Henry (MHe)	Senior Shared PMO Programme Lead (Urgent & Emergency Care and Older Peoples), NHS North East London
Kirsty Boettcher (KB)	Deputy Director of Delivery - Unplanned Care, NHS North East London
Rhiannon Haag (RH)	Flexible Clinical Lead, NELFT
Emily Plane (EP)	Head of Strategy and System Development, NHS North East London
Paul Archer (PA)	Designated Nurse for Safeguarding and LAC, NHS North East London
Susanne Rauprich (SRa)	Chief executive of Citizens Advice
Michael Armstrong (MA)	Havering Care Association
Vicki Kong (VK)	Clinical and Care Lead – Population Health Management
Shelley Hart (SH)	Clinical and Care Lead – Community Connections
Rebecca Mazrreku (RM)	Clinical and Care Lead – Community Connections
Shezana Malik (SM)	Deputy Director Havering Community Services (Interim)
Dr Maurice Sanomi	Clinical Lead, Mental Health
Shefali Gaur (SG)	Marketing Officer, London Borough of Havering
Geoffrey Farmer (GF)	Havering Resident
Apologies:	
Dr Sarita Symon (SSy)	Havering PCN Clinical director
Dr Jwala Gupta (JGu) Co-Chair	Havering PCN Clinical director
Elaine Greenaway (EA)	Senior Public Health Strategist, London Borough of Havering
Pete McDonnell (PMc)	Community Services Manager (Adults), NHS North East London
Catharine Oates (CO)	Practice manager, Maylands
Dr N Rao (NR)	Havering PCN Clinical director
Chetan Vyas (CV)	Director of Quality, NHS North East London
Anne-Marie Keliris (AMK)	Head of Governance, NHS North East London

Jerry Haley (JH)	Head of Communities, Policy & Performance, LBH
Shibber Ahmed (SA)	PMO Programme Support Officer (Urgent Care/Older People), NHS North East London
Mark Topps (MT)	Regional Business Manager – West Essex and Havering, Regulated Services
Dalveer Johal (DJ)	Pharmacy Services Manager, NEL LPC (for Shilpa Shah)
Dr Mylvaganam Mano (MM)	Havering PCN Clinical director
Shezana Malik (SM)	Deputy Director Havering Community Services (Interim)
Dr J O'Moore (JOM)	Havering PCN Clinical director
Dr Asif Iman (AI)	Havering PCN Clinical director
Dr Gurmeet Singh (GS)	Havering PCN Clinical director
Dr Yasmin Heerah (YH)	Havering PCN Clinical director
Sandy Foskett (SF)	Senior Commissioner, LBH
Irvine Muronzi (IM)	Integrated Care Director Havering (Interim), NELFT
Laura Neilson (LN)	Commissioning and programme manager, LBH
Charlotte Pomery (CP)	Chief Participation and Place Officer, NHS North East London
Priti Gaberria (PG)	Commissioning and programme manager, LBH
Mani Khan (MK)	Transformation Lead, Havering Health
Tara Geere (TG)	Director of Children's services, LBH
Anne-Marie Dean (AMD)	Chair, Havering Healthwatch
Patrick Odling-Smee (POS)	Director of Housing, London Borough of Havering
John Timbs (JT)	Havering Care Association
Helen Page (HP)	CEO, Havering Health
Paul Rose (PR)	Chair, Havering Compact
Julia Summers (JS)	Head of Finance, NHS North East London (standing in for ST)
Brid Johnson (BJ)	Interim Executive Integrated Care Director (London) (NELFT)
Tha Han (TH)	Public Health Consultant, London Borough of Havering
James Hunt (JH)	Head of Housing Strategy, London Borough of Havering

Item No.	Item title
1.0	**Welcome, introductions and apologies**
	The Chair, Andrew Blake-Herbert, welcomed members to the meeting. Apologies were noted. All members joined the meeting virtually.
1.1	**Declaration of conflicts of interest**
	The Chair asked members to ensure they complete their Declarations of Interest form. No other declarations were declared.
1.2	**Minutes from the previous**
	Minutes from the previous meeting were agreed.
1.3	**Action log of the last meeting**
	The action log was updated accordingly
2.0	**Questions from the Public**
	The Chair advised that the ICB sub-committee had received eight questions in total but due to time constraints were only taking two questions in the meeting, with responses being fed back to all members of the public outside of the meeting who had submitted a question. **Question 1:** How will the NHS cope with the increase of residents joining the area following the area as a result of the enormous home building project along the Thames Gateway?

	Will there be additional health care centres and extended hospital beds made available. It has taken me over 3 months to get a follow up appointment with my GP and people are very worried. **Response:** The population of Havering is expected to continue to grow over the coming years, partially driven by new housing developments and regeneration. Developers are required to provide funding to support the development of the infrastructure required to support local people, so large developments will lead to potential enhanced capacity or new health centres, such as the St Georges development in Hornchurch. Timely access to appointments is a complex issue; the Covid Pandemic had a significant impact on primary care / General Practice capacity, as well as creating an increase in need, for both physical and mental health services. Havering practices are offering 30,000 more appointments to patients than pre-Pandemic levels. Additional Primary Care appointments are being made available; as of October 2022, all primary care networks (PCNs) across England are now required to offer patients a new 'enhanced access' model of care, which will see GP practices open for routine appointments from 6.30pm and 8pm Mondays to Fridays and between 9am and 5pm on Saturdays. Many local people could be better, and more quickly treated by other healthcare professionals, meaning that more GP appointments are freed up for those with more complex medical issues. So, we're working with our local Primary Care Networks to increase access to appointments with Nurses, Physios, Mental Health practitioners and others in primary care. In relation to hospital beds, there are a number of transformation programmes underway to make better use of the capacity that we have; we know that many local people, particularly those who are older, can spend longer than they need to in a hospital bed. We're working to support them safely at home, where they want to be, as soon as they're well enough, and to provide more care and support in the community, to reduce the number of avoidable hospital admissions. This will improve flow through the hospital, and increase the number of available beds at any one time. **Question 2:** What is being done to provide accommodation for people no longer requiring hospital care but currently having nowhere adequate to live ("bed-blockers"). It seems that something akin to convalescent homes, to use an old expression, are needed. **Response:** If the person has care needs, a 'discharge to assess' process has been established which would place the person into a care home while the person is fully assessed (rather than assessing them in hospital setting). There are also Intermediate care beds where a person could be admitted for rehabilitation and then discharge home, or discharge home with the 'Intensive Rehab service' coming in to support them. The discharge to assess element of this pathway ensures that those who are 'medically stable' are able to be transferred out of hospital as soon as possible.

	The Local Authority also provides reablement services for people with physical or mental health needs following a stay in hospital, to help them accommodate their illness by learning or re-learning the skills necessary for daily living. This is done in their home environment for up to six weeks following discharge. If the person does not have ongoing care needs, they will be assessed and supported by the housing team to find suitable accommodation if they do not currently have this; a hospital in-reach officer will pick up all the cases from Queens Hospital who are ready for discharge and either homeless or threatened with homelessness. This role is governed by housing legislation. If a client meets the threshold for temporary accommodation then this is arranged. Some cases are significantly more complex than others and action is taken to ensure that the accommodation is safe and suitable. Sometimes this can result in a slightly delayed discharge. People in this situation are also given advice and information on looking for their own accommodation (where this is appropriate) and they can also access the "Find Your Own" scheme (financial support with rent in advance/deposit). The Chair thanked residents for their questions.
3.0	**Health Inequalities - bids for sign off**
	Dr N Kullar (NK) introduced members to the Health Inequalities (HI) bids that have been discussed at a previous meeting. The bids were now being presented for formal endorsement and sign off by the ICB sub-committee. Highlights included: • A total of nine bids, five of which are from the main HI monies, and a number put aside for the Babies, Children & Young People (BCYP) workstream. • £100k was available for the main HI monies and for the BYCP four bids have been approved. • The ask of the Board is to endorse and sign off the HI bids. *Comments from the Board:* • How will we monitor and measure the success of the projects to be supported by the HI bids along with the outcomes of delivery? The Board were advised that, prior to looking at the bids for this financial year, an evaluation was undertaken and we are working hard with partners to provide feedback on these projects, which ones may need additional support and which ones (if any) didn't perform. It was also noted that a quarterly Health and Quality report is submitted to the Central team at North east London which goes through the schemes – Matt Henry offered to share the Q4 report with members. It is envisaged that, going forward, the monitoring will take place at 'Place' level meaning a report can go to the Place based Partnership Board. **Action:** Matt Henry to share Q4 Quality report with members. The Board endorsed and signed off the HI bids.
4.0	**Finance update**
	Sunil Thakker (ST) provided members on a month 4 finance position. Highlights included: • The month 4 year-to-date ICS position is a variance to plan of £58.4m. • In line with the operating plan and NHSE protocol the system is reporting a breakeven position at year-end.

	• The year-to-date variance to plan means that a formal finance recovery plan (FRP) has been developed and shared with regulators. This suggests that there is a potential system gap at year-end of £54.9m. • The drivers of the month 4 position include pressures relating to inflation, payroll, the impact of industrial action and run rate pressures such as ICB prescribing and mental health expenditure. Additionally, the is under delivery of efficiency schemes. • There is a high level of risk associated with delivery of the financial plan that will continue to be reported against throughout the financial year. • The Havering specific section of the report gives detail on spend that can be identified to place, including the better care fund and funds carried forward via a section 256 agreement or the BCF. • London Borough of Havering (LBH) has forecast an overspend against budget at year-end of £21.5m (based on month 3 information). • Financial information at place will continue to be developed throughout 23/24. *Comments from the Board:* • It was noted that London Borough of Havering (LBH) were also in a difficult finance position. There is a need for us to work as a system to use our collective resource to deliver the best possible outcomes. • With the Prime Minister talking about priorities, bed blocking for Winter versus on going pressures to deliver savings – how do these add up as we go into Winter? The Board noted that Winter Planning is going ahead with all partners both in Health and Social Care. Winter funding will be received in due course with monies being assigned specifically to these programmes on our portfolio. A double lock arrangement will be deployed meaning investments will need to be signed off by a Chief Officer in the ICB and Provider setting. • Is the Care Providers £391k Falls monies going to be taken as savings and if so? 1. Is it smart to take money out of the system that could potentially reduce cost the other end? ST and MA agreed to discuss this further off line. 2. As to our approach to the savings should there be some consultation rather than just advising of the end result? The Board were advised that there will be a consultation and engagement. The Board noted the update.
5.0	**AOB**
	1. Emily Plane (EP) noted that our communications to local people have improved engagement in terms of the Partnership. 2. ST reflected on previous programmes/initiatives that have been socialised in this setting that the Mutual Accountability Framework (MFA) needs to morph into a slightly different space. The Framework ultimately sets our way of working. The Chair agreed and suggested he feed this back up through the ICS Board.

Havering ICB sub-committee - Actions Log

	OPEN ACTIONS					
Action ref:	**Date of meeting**	**Action required**	**Lead**	**When**	**Notes**	**Status**
ACT002	12.07.23	**Better Care Fund (BCF) 2023-25** PMc to bring the BCF governance back to the October ICB sub-committee	KB	Dec		In progress
ACT003	12.07.23	**AOB** Luke Burton (LB) and Helen Page (HP) to picked up system induction with leads	LB/HP	Aug		On going

Havering Integrated Care Board Sub Committee

Wednesday 8th November 2023

Title of report	Havering Place based Partnership Interim Health and Care Strategy
Author	Emily Plane Head of Strategic Planning, Havering Place based Partnership
Presented by	Luke Burton Havering Place based Partnership Borough Director
Contact for further information	e.plane@nhs.net
Executive summary	The Havering interim strategy attached to this report articulates the key priorities for the Havering Place based Partnership in 2023/24. NHS North East London is in the process of a restructure, which includes the establishment of a new team at place for Havering, structured around the life course approach set out within this strategy. Once the new team is in place, partners intend to integrate commissioning of health and care in Havering as much as possible to ensure that services are seamless, are commissioned around the needs of local people including the wider determinants of health, and deliver value for money. This will be overseen in terms of impact by the Havering Health and Wellbeing Board who will ensure that the Local Health and Wellbeing strategy and the needs set out within the Havering Joint Strategic Needs Assessment are embedded in the Partnership work as part of a Population Health Management approach. The Havering Place based Partnership will drive forward the changes needed and oversee their roll out.
Action / recommendation	Havering ICB Sub Committee members are asked to **note, review** and **endorse** the Havering Place based Partnership Interim Health and Care Strategy, particularly the initial priorities for the Integrated Team at Place. Members are asked to receive further updates on progress once the Integrated Team is in place, including monitoring of impact, and development of the five year strategy, aligned to the refreshed Joint Strategic Needs Assessment.
Previous reporting	Havering Place based Partnership Board Havering Health and Wellbeing Board Key partners of the Havering Place based Partnership
Next steps/ onward reporting	Havering Cabinet NHS North East London Population Health Committee
Conflicts of interest	None identified at this stage

Strategic fit	• To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The priorities articulated within the strategy will be key to delivering the aspirations set out within the JSNA and delivering improved outcomes for local people. This includes a key priority around reviewing opportunities for joint commissioning between health and the local authority to ensure sustainability of services going forward.
Impact on finance, performance and quality	See below risk. Partners will work within the financial envelopes delegated to place.
Risks	The current financial constraints on both NHS North East London and the London Borough of Havering mean that partners find themselves in a situation where we are being asked to do more than ever, for less. Substantial running cost reductions are required both within the London Borough of Havering and NHS North East London – and without doing things differently and in a more joined up way, there is a risk that the Havering Partnership will not be able to deliver improved outcomes for local people, or improved value for money. It is absolutely imperative that partners collectively work together to prioritise our resources to our areas of greatest need, that we work together to deliver value for money in our contracts and processes, and that we collectively work together to improve outcomes for local people with the limited resources that we have.

1.0 Background

1.1 The Havering Place based Partnership, formally established in July 2022 following the creation of the NHS North East London Integrated Care Board, brings together the NHS, local government and providers of health and social care services, including the voluntary, community and social enterprise (VCSE) sector, Care sector, residents and communities. The primary purpose of the Partnership is to review and respond to the needs of local people, and improve the delivery of care and support to them to meet these needs in a way that is meaningful to them. Collaboration, a focus on prevention, and ongoing engagement with local people are the key elements of the partnership.

1.2 The Partnership has a formal Sub Committee with delegated authority from the NHS North East London Integrated Care Board for certain key decisions on local budgets and local to Havering decisions on health and care. This formal sub committee and wider partnership will primarily focus on the key factors that influence health and care of local people, including key wider determinants of health such as lifestyle factors and housing. The Partnership and Sub Committee will work alongside the Havering

Health and Wellbeing Board, both being driven by the key needs of local people as set out in the JSNA which is currently undertaking a refresh.

1.3 The Health and Wellbeing Board will have a slightly wider scope than the partnership Board, focusing, alongside the JSNA and Health and Wellbeing Strategy, on the wider elements of the council. A proposal is in development which sets out this relationship in more detail and will be presented to the Board by Mark Ansell, Director of Public Health for Havering.

1.4 Havering partners are working to develop a strong and ongoing relationship with local people and staff, so that they can shape our priorities and plans, ensuring that we are able to improve services in a way that will truly improve lives across the borough. We are strongly focussed on integrating services across health, care and the Community and Voluntary Sector, and supporting local people with the wider things that impact health and wellbeing, such as housing, social isolation and employment.

1.5 The partnership is in the early stages of development, but already has strong buy in from partners, and is committed to better meet the needs of local people, and in particular to reduce health inequalities.

1.6 We are developing local 'neighbourhood' teams of health and care staff, who will much more closely with the community and voluntary sector and primary care networks – GP practices working together in their areas – to improve the way that care is delivered to local people. Through this approach local people will receive more seamless care, tailored to their needs.

2.0 Havering Place based Partnership Interim Health and Care Strategy

2.1 The Havering interim strategy attached to this report articulates the key priorities for the Havering Place based Partnership in 2023/24. NHS North East London is in the process of a restructure, which includes the establishment of a new team at place for Havering, structured around the life course approach set out within this strategy. Once the new team is in place, partners intend to integrate commissioning of health and care in Havering as much as possible to ensure that services are seamless, are commissioned around the needs of local people including the wider determinants of health, and deliver value for money. This will be overseen in terms of impact by the Havering Health and Wellbeing Board who will ensure that the Local Health and Wellbeing strategy and the needs set out within the Havering Joint Strategic Needs Assessment are embedded in the Partnership work as part of a Population Health Management approach. The Havering Place based Partnership will drive forward the changes needed and oversee their roll out.

2.2 Partners across Havering have held a series of workshops focused around babies children and young people, and frail older people and urgent care, which have fed into the development of this strategy. A number of other key strategies are in development including a healthy weight strategy for the borough, and strategy for those who provide informal and unpaid care amongst others, which have also fed into the development of this interim strategy for the partnership.

2.3 Culture will be a key enabler for the delivery of both the interim, and five year strategy. This is both culture within our communities, and building community resilience, and building a positive working environment within Havering where all staff feel engaged, and empowered to effect positive change and improvement.

2.4 This strategy also aligns with and compliments the NHS North East London priorities as set out in their Interim Strategy, as well as the cross cutting themes including: Tackling Health Inequalities; a greater focus on Prevention; Holistic and Personalised Care; Co-production with local people; Creating a High Trust Environment that supports integration and collaboration; and Operating as a Learning System driven by research and innovation. The four main priorities for improving outcomes and tackling health inequalities, which align to the priorities set out within this interim Havering strategy include: Babies, Children & Young People; Long Term Conditions; Mental Health; Local employment and workforce.

2.5 Included in the attached interim strategy is:

- The Havering Place based Partnership vision, and life course approach
- The initial priorities of the Place based Partnership and joint Integrated Team for 2023/24, and their initial aspirations once the team is in post
- A draft terms of reference for the proposed group to be established to oversee delivery of this strategy, which will report progress to the Place based Partnership and Havering Health and Wellbeing Board
- A draft project plan for the proposed development of the full Havering Place based Partnership strategy from April 2024 – March 2031. This will be developed once the full integrated team is in place, and Board members will be kept updated on progress.

3.0 Timeline for review and endorsement/ sign off:

- Executive Leadership workshop to feed into the development of the strategy **Monday 18th September 2023**
- Havering Place based Partnership Leadership meeting

  Monday 16th October 2023
- Draft strategy to the Health and Wellbeing Board for endorsement **Wednesday 25th October 2023**
- Havering Senior Leadership Team meeting

  Wednesday 1st November
- Havering Place based Partnership Board

  Wednesday 8th November 2023
- Havering Cabinet meeting

  TBC – November 2023

4.0 Next steps:

- Review any feedback or amendments that need to be made to the final interim strategy.
- Progress endorsement of the Interim strategy as per the timeline set out above
- Once the Leads are in post within the Integrated Team at Place in Havering, they will;

- work to implement the priorities set out within this interim strategy
- work with the Havering Heads of Strategy and PMO to develop the priorities for the five year Havering strategy, as set out within the timeline within the strategy at **Attachment 1**

- Data leads to work to develop an integrated dashboard to monitor the aspirations set out within this strategy

5.0 Risks and mitigations

5.1 The current financial constraints on both NHS North East London and the London Borough of Havering mean that partners find themselves in a situation where we are being asked to do more than ever, for less. Substantial running cost reductions are required both within the London Borough of Havering and NHS North East London – and without doing things differently and in a more joined up way, there is a risk that the Havering Partnership will not be able to deliver improved outcomes for local people, or improved value for money. It is absolutely imperative that partners collectively work together to prioritise our resources to our areas of greatest need, that we work together to deliver value for money in our contracts and processes, and that we collectively work together to improve outcomes for local people with the limited resources that we have.

6.0 Conclusion / Recommendations

6.1 Havering ICB Sub Committee members are asked to **note, review** and **endorse** the Havering Place based Partnership Interim Health and Care Strategy, particularly the initial priorities for the Integrated Team at Place.

6.2 Members are asked to receive further updates on progress once the Integrated Team is in place, including monitoring of impact, and development of the five year strategy, aligned to the refreshed Joint Strategic Needs Assessment.

7.0 Attachments

7.1 **Appendix 1:** Havering Place based Partnership interim Strategy, April 2023 – March 2024

Emily Plane
Head of Strategic Planning, Havering Place based Partnership
November 2023

Havering Place based Partnership interim Strategy

April 2023 – March 2024

Version 2 – October 2023 – FINAL DRAFT

Foreword

Marie Gabriel, Chair, NHS North East London, and Non-Executive Director for the Havering Place based Partnership

NHS North East London and our wider Integrated Care Partnership is committed to ensuring that we work in productive partnership with our local people and communities. The services and support that we commission and deliver are focused on meeting their needs and aspirations first and foremost, and must be easy for those living and working in our boroughs to navigate. As Non-Executive Director for the Havering Place based Partnership I am pleased to see the way that the experiences of local people are directly being used to drive improvements to services, both on the ground, at service level, and in the strategies that are setting the direction of travel over the coming years.

The contributions of local people are powerful drives for change, and, combined with local data and insights, including the Joint Strategic Needs Assessment, have fed into the development of this interim strategy to create a clear set of initial priorities that will be built on in the coming years as the partnership evolves.

Dr Narinderjit Kullar, Clinical Director - Havering Place based Partnership, and a local GP

As a Doctor who has worked in Havering for a number of years, I am passionate about using my role as Clinical Director for the Havering Place based Partnership to not only improve outcomes for all people living with in the Borough but to also make Havering an exciting and empowering place to work for staff across all of our sectors. Engendering the right culture will be a key enabler for the delivery of this interim, and soon to follow, five year strategy; this is with reference to culture both within our communities to build community resilience, and through development of a positive working environment within all Havering Organisations whereby staff feel engaged and empowered to effect the changes and improvements required. As a partnership we are keen to work differently, supporting local people around the wider determinants of health to improve their wellbeing and by ensuring services are tailored to meet their needs throughout their life course with a key focus on prevention, health creation and early intervention in tackling illness.

Councillor Gillian Ford, Chair, Havering Place based Partnership Board, and Lead Member for Health

The current financial constraints on both NHS North East London and the London Borough of Havering mean that partners find themselves in a situation where we are being asked to do more than ever, for less. Substantial running cost reductions are required both within the London Borough of Havering and NHS North East London – and without doing things differently and in a more joined up way, there is a risk that the Havering Partnership will not be able to deliver improved outcomes for local people, or improved value for money. It is absolutely imperative that partners collectively work together to prioritise our resources to our areas of greatest need, that we work together to deliver value for money in our contracts and processes, and that we collectively work together to improve outcomes for local people with the limited resources that we have. This strategy sets out our immediate areas of focus, and our roadmap for developing our longer term strategy that will enable partners to meet the needs of local people, and deliver better value for money, making the best use of the resources that we have.

Havering Place based Partnership Interim Health and Care Strategy – Introduction

The Havering Place based Partnership, formally established in July 2022 following the creation of the NHS North East London Integrated Care Board, brings together the NHS, local government and providers of health and social care services, including the voluntary, community and social enterprise (VCSE) sector, Care sector, residents and communities. It's primary purpose is to review the needs of local people, and improve the delivery of care and support to them to meet these needs in a way that is meaningful to them. Collaboration, a focus on prevention, and ongoing engagement with local people are the key elements of the partnership.

Havering partners are working to develop a strong and ongoing relationship with local people and staff, so that they can shape our priorities and plans, ensuring that we are able to improve services in a way that will truly improve lives across the borough. We are strongly focussed on integrating services across health, care and the Community and Voluntary Sector, and supporting local people with the wider things that impact health and wellbeing, such as housing, social isolation and employment.

The partnership is in the early stages of development, but already has strong buy in from partners, and is committed to better meet the needs of local people, and in particular to reduce health inequalities.

We are developing local 'neighbourhood' teams of health and care staff, who will much more closely with the community and voluntary sector and primary care networks – GP practices working together in their areas – to improve the way that care is delivered to local people. Through this approach local people will receive more seamless care, tailored to their needs.

This interim strategy articulates the key priorities for the Havering Place based Partnership in 2023/24. NHS North East London is in the process of a restructure, which includes the establishment of a new team at place for Havering, structured around the life course approach set out within this strategy. Once the new team is in place, partners intend to integrate commissioning of health and care in Havering as much as possible to ensure that services are seamless, are commissioned around the needs of local people including the wider determinants of health, and deliver value for money. This will be overseen by the Havering Health and Wellbeing Board who will ensure that the Local Health and Wellbeing strategy and the needs set out within the Havering Joint Strategic Needs Assessment are embedded in the Partnership work as part of a Population Health Management approach.

Partners across Havering have held a series of workshops focused around babies children and young people, and frail older people and urgent care, which have fed into the development of this strategy. A number of strategies are in development including a healthy weight strategy for the borough, and strategy for those who provide informal and unpaid care, which have also fed into the development of this interim strategy for the partnership.

Culture will be a key enabler for the delivery of both the interim, and five year strategy. This is both culture within our communities, and building community resilience, and building a positive working environment within Havering where all staff feel engaged, and empowered to effect positive change and improvement.

As well as aligning to Havering Council's vision for the 'Havering that you want to be a part of', with a strong focus on people, place and resources, This strategy also aligns with and compliments the NHS North East London priorities as set out in their Interim Strategy, as well as the cross cutting themes including: Tackling Health Inequalities; a greater focus on Prevention; Holistic and Personalised Care; Co-production with local people; Creating a High Trust Environment that supports integration and collaboration; and Operating as a Learning System driven by research and innovation. The four main priorities for improving outcomes and tackling health inequalities, which align to the priorities set out within this interim Havering strategy include: Babies, Children & Young People; Long Term Conditions; Mental Health; Local employment and workforce.

Included in this strategy is:

- The Havering Place based Partnership vision, life course approach and initial key priorities
- Our initial priorities for 2023/24 and what we will deliver
- A draft terms of reference for the proposed group to be established to oversee delivery of this strategy
- A draft project plan for the proposed development of the full Havering Place based Partnership strategy from April 2024 – March 2031.

Havering Place based Partnership Interim Health and Care Strategy

April 2023 – March 2024

Our vision

A healthier Havering where *everyone* is supported to thrive

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. This compliments Havering Council's vision for the 'Havering that you want to be a part of', with a strong focus on people, place and resources.

We will do this by:

- Tackling inequalities and deprivation to reduce the impact that this has to access to services, and outcomes
- Improving **mental and emotional** support
- Tackling Havering's **biggest killers**
- Improving **earlier help, care and support**
- Working with people to build **resilient communities, supporting them to live independently**
- Improving **joined-up, whole-person care**

Our priorities

We want to improve outcomes for the whole population, right across the main life stages, from birth to death. Our strategy will therefore take a life course approach:

Start Well

Children and young people get the best start in life, are able to achieve the best opportunities and keep as healthy and well as possible throughout their lives

Live Well

People enjoy and are able to maintain a sense of wellbeing and good health, supported by resilient communities. They can access care and information when needed.

Age Well

People are able to live independently in their own homes with appropriate care and support to maintain and develop their social and community networks

Die Well

People are supported to ensure the last stages of their life happen in the best possible circumstances, receiving the right help at the right time from the right people

Key enabling priorities span the whole strategy, across all life stages:

Building community resilience	Workforce	Estates and digital infrastructure	Primary Care	Culture	Urgent & Emergency Care

What do we mean by Start Well, Live Well, Age Well and Die Well?

Start Well

- I feel safe and cared for
- I have green and open spaces I can visit or play in and am able to walk or cycle to and from places
- I feel like I can influence my own future and decisions that affect me
- I have a network of support, and can make friends through local groups
- I have a healthy and active lifestyle, helping me to maintain a healthy weight
- I live in a comfortable, safe home, free from mould and damp
- I can access timely support and diagnosis, in the community, when I need it
- I am learning what I can do to improve my own health and wellbeing

Live Well

- I can take care of my own health and wellbeing and am able to manage the challenges life may give me
- I lead a happy, fulfilling and purposeful life
- I feel supported by my family, friends and local community
- I have access to information and services when I need it, and know the right place to seek support, first time
- I have a healthy and active lifestyle, helping me to maintain a healthy weight

Age Well

- I can take care of my own health and wellbeing and am able to manage the challenges life may throw at me
- If I need support, it is provided in a way that helps me to maintain my independence for as long as possible
- I can access services and support when needed and my preferences are taken into account
- I have the information I need and I'm supported to understand and make choices
- I lead a happy, fulfilling and purposeful life
- I can continue to do what matters to me and be the person I want to be
- I am in control of my physical and mental health
- My family's/carer's needs are recognised and supported
- I feel a valued and respected member of my community
- Services are seamless and support me as a whole person

Die Well

- I will be asked for my end of life wishes and will be able to die, where practically possible, in my preferred place of care
- I know that when I die, this will happen in the best possible circumstances
- My family, friends and all those important to me will be supported throughout my end of life journey and if needed after my death.

Codesign with local people

The Havering Place based Partnership is committed to ongoing engagement and discussion with local people to ensure that health and care services in the borough are designed around their needs.

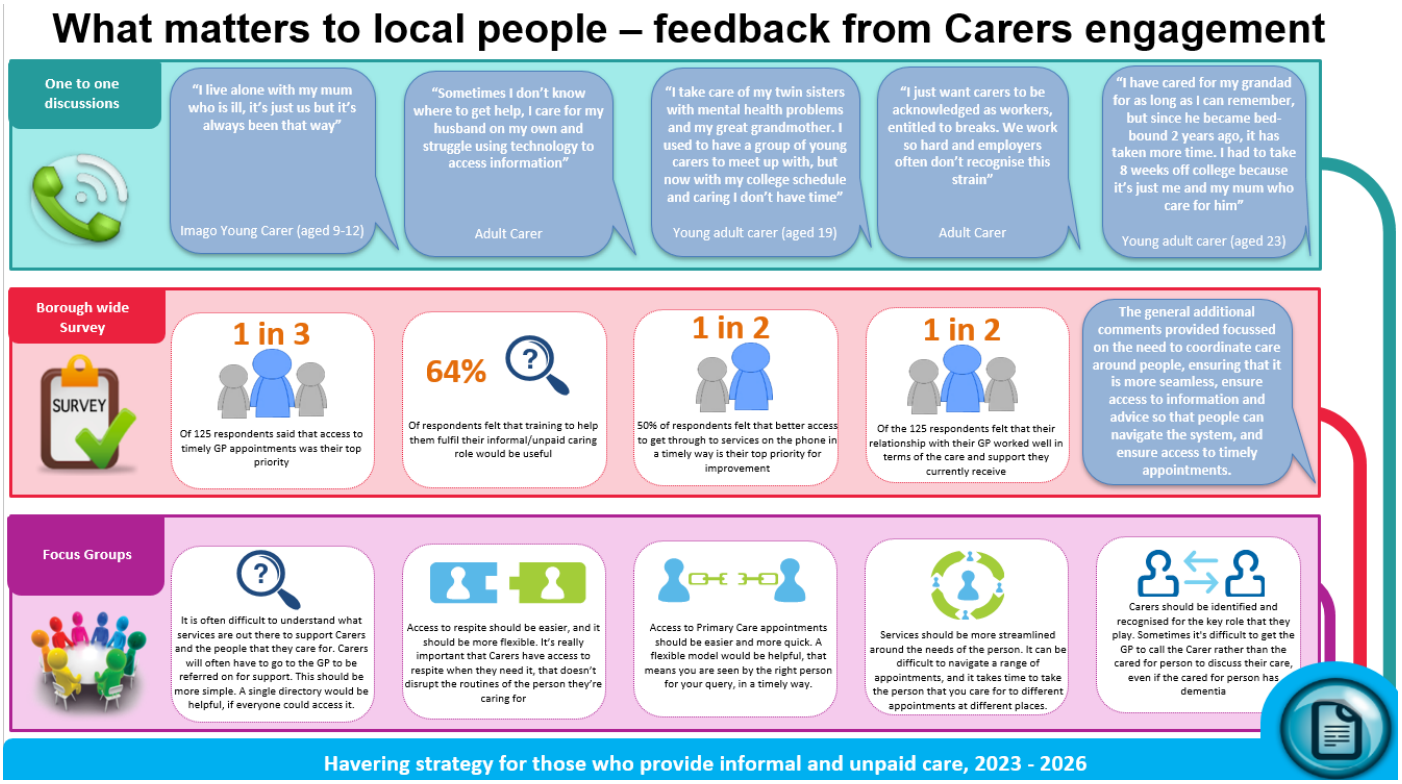
Since the inception of the Partnership (which built on a strong foundation of partnership between health, care and wider community and voluntary sector partners), the Havering team have been engaging with staff, partners and local people to understand what matters most to them.

We have engaged in a number of ways, through showcase events with staff across the borough to keep them updated and engaged on the work underway, survey's, engagement with local people through survey's focus groups and one to one discussion on key projects such as the development of the Strategy for those who provide informal and unpaid care. We have held local events and shared surveys to seek the views of local people on our priorities and programmes of work (as well as connecting them to a range of wider services and support), and are in the process of developing a number of case studies around the experiences of local people which we are embedding in our work to ensure that tangible improvements are made to service delivery.

Well known challenges are often voiced, such as timely access to appointments, and being able to get support from the right person or service, first time. However, one of the strongest points of feedback is that services and support feel fragmented – services often don't link up around the needs of the person, leaving staff working in the system to spend valuable time struggling to integrate care, within a framework of commissioned services that isn't set up yet to support a truly integrated way of working.

All of this feedback has been taken into account when developing this strategy and setting the priorities within it, and the Havering Place based Partnership will continue to engage and involve local people in our work going forward.

The infographic below summarises the feedback from the engagement work with local carers.



Case studies; improving services based on the real experiences of local people

The Havering Place based partnership is working with a number of local people to develop case studies illustrating their experiences and the breakdowns in care, which highlight in a very real and powerful way the improvements that we need to collectively make. These are a very powerful tool to highlight the changes that we need to make, and to drive positive change. We have developed a best practice approach, including the subjects of the case studies in the improvement work itself.

Havering Carers experience: Lynn's story

Lynn and her mother Joan share a really close bond, and are more like best friends. They're always there for each other, and see each other frequently.
Lynn's mother had started to slowly decline in the past couple of years, being less able to manage. Lynn noticed this and, as well as supporting her mother herself; acting as her advocate, booking appointments, arranging food shopping and other support, Lynn requested a Social Care assessment following which a care package was put in place (single handed, 4 times per day). A lot of the monitoring of her mother's diabetes and blood sugar levels falls to Lynn, including the decision of when to escalate; Lynn also notices that the diabetes medication is given by nurses on several occasions despite her mother's blood sugar levels at the time suggesting that it should not have been administered.

In 2022, Lynn's mother, who was at this point defined as 'housebound' developed a rash across her body, which left her in extreme discomfort. From then on, Lynn's mother's condition began to decline, despite Lynn's struggles to get her seen by the right people to support her. The following page maps their journey from this point.

Havering Carers experience: Lynn's story

There are many instances within Joan and Lynn's journey where care could have been improved, particularly:

- There was a lack of care coordination /person centred care around Joan's journey, with Lynn trying to fill this function; there were many occasions where Lynn was not listened to, and she really had to push to have her mother seen
- There were many cases where, to get the referral or support she knew that her mother needed, Lynn had to go back to the GP for an appointment, to get the onward referral
- Joan's rash was never properly investigated / addressed, and she was in significant discomfort because of this throughout the last few months of her life
- Lynn was never identified as a carer / no one who saw Lynn ever checked that she was receiving the support to which she was entitled
- Joan's journey was convoluted, and without Lynn acting on her behalf and taking her to appointments, could have been significantly worse
- Lynn is now left with not only the impact of losing one of the people whom she loved most in the world, but also the impact of the experiences that she and her mother had to go through during the last months of her mother's life

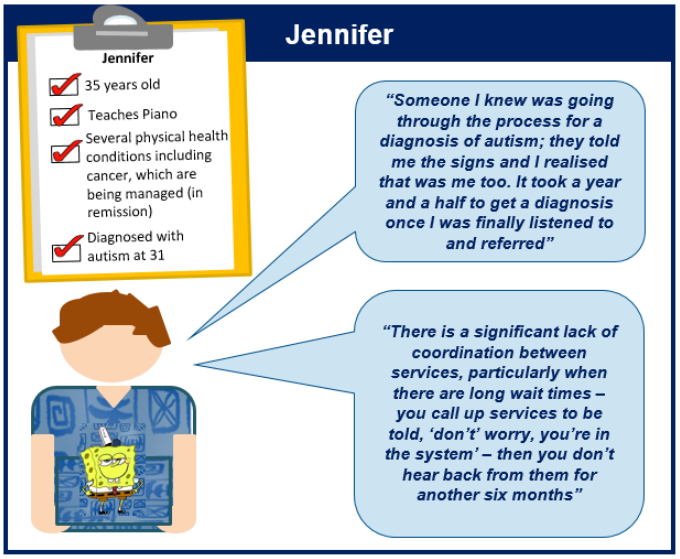
Jennifer's story – experiences of a person with Autism in Havering. All graphics are original artwork by Jennifer, and remain Jennifer's intellectual property.

Jennifer's story

Jennifer is really creative. She teaches Piano for her job, and loves to draw and create new designs. She has written a book, 'A Tarnished Stone' which is available on Amazon.

Jennifer has several health conditions which she is stoic and matter of fact about. She works hard to navigate the complex health and care system to manage these.

Jennifer also has Autism, and was diagnosed as an adult – Jennifer had to fight hard for her diagnosis, and is keen to ensure that her experiences help to improve things for other local people who are going through similar. Jennifer realised following her diagnosis that she had been masking her autism ever since she was a child.



List of conditions

Jennifer has a number of conditions that she is managing including:

- ADHD
- Autism
- Psoriasis
- Alopecia
- Asthma
- Epilepsy
- Mental health challenges including Trauma and PTSD
- In remission (check up in December) for Papillary Clear Cell renal Carcinoma
- Polycystic Ovaries
- Sacroiliac joint dysfunction

Jennifer's story

North East London Health & Care Partnership

My Autism and ADHD Diagnosis

- My friend was going through their assessments for diagnosis for Autism; they read the signs to me, and I just thought 'that's' me'
- I went to my GP to start the process for assessment; but the doctor was quite dismissive. They couldn't understand why I wanted a referral for assessment at my age. This made me not want to go back to this GP.
- It took a year and a half to finally get the diagnosis following the initially assessment
- Had to have a diagnosis via a computer due to Covid
- There was also a mix up to get the diagnosis, in that I hadn't been sent a link, so I had to call around trying to let the person know that I was trying to join the meeting, I just hadn't been sent the link. My diagnosis session was 1.5 hours long, however, half an hour of this was lost due to the link not being sent to me
- I was also diagnosed with ADHD 2022; it was thanks to the psychologist that I got the ADHD diagnosis – originally didn't seek to get diagnosis but then couldn't stop thinking about it once it had been pointed out to me
- The ADHD diagnosis took about six months

Following My Diagnosis

- It was a lightbulb moment the first time I realised that I had autism – it helped me to understand more about why I act in certain ways
- Having the diagnosis helped, but I didn't get much help or support after this
- Following the diagnosis I received an email that pretty much said 'congratulations you're autistic, here's some books you can read and some email addresses. Goodbye'
- I also received a Letter for potential employers setting out the reasonable adjustments to make as this person is autistic
- But there was no real support
- It is comforting to know that if I need social care in the future, I'll be eligible for it
- There is definitely more that could be done to support people post their diagnosis, especially if they're an adult and have been through a lifetime of masking their autism and thinking that they're different

Jennifer's story

North East London Health & Care Partnership

Some of my positive experiences of the NHS
▪ I've had some really good experiences of care and I think it's important to share this so that the people who delivered them know the difference that they made to me ▪ I went to the vascular department at Queens for a check-up – I went in early and the nurse in there recognised that I have Autism and ADHD. She was really sympathetic, let me into the appointment early. The Doctor for this appointment was also really good – they explained everything to me so well that I actually enjoyed the appointment. I've never had such a fun test before. ▪ I've had a really nice Epilepsy nurse for the past 15 years who is there if I need her. I can have a discussion with her about management of my condition

Improvements that could be made
▪ I went to a recent meeting in Dagenham for those with Autism, about improving services for them. There were a lot of autistic people there, yet the whole event had been arranged without a single thought about what an appropriate environment for those with autism should be – if events are being held for those with Autism, about services for those with autism, the events should be designed with Autistic people in mind ▪ It would be helpful if it could be flagged on notes and medical records that a person has autism, and that it's not really appropriate for them to wait in a busy and loud waiting area. ▪ I have had cancer and have yearly check-ups for this – I was initially required to travel into London for this – three trains and a bus to have a full body scan, all with a full bladder. Have finally been able to transfer to a hospital closer to home for this. ▪ It's very stressful when you know you need to have an scan undertaken, and you have to call up services to try to find out why an appointment hasn't come through. ▪ Waiting rooms are often very bright and noisy – not comfortable places at all for those with autism. It often feels like an ordeal going to appointments ▪ When having multiple appointments on the same day, long gaps between appointments are also a real struggle for those with autism

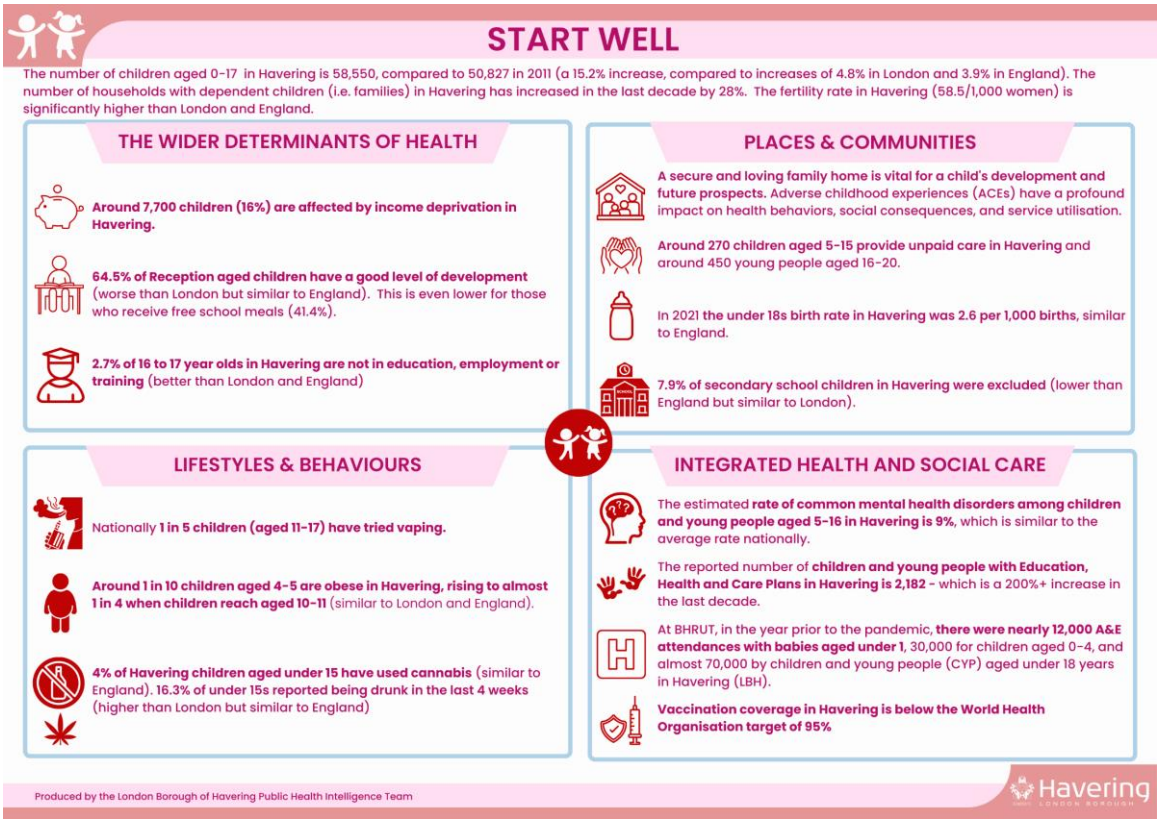
Things we can do to make a positive change in Havering

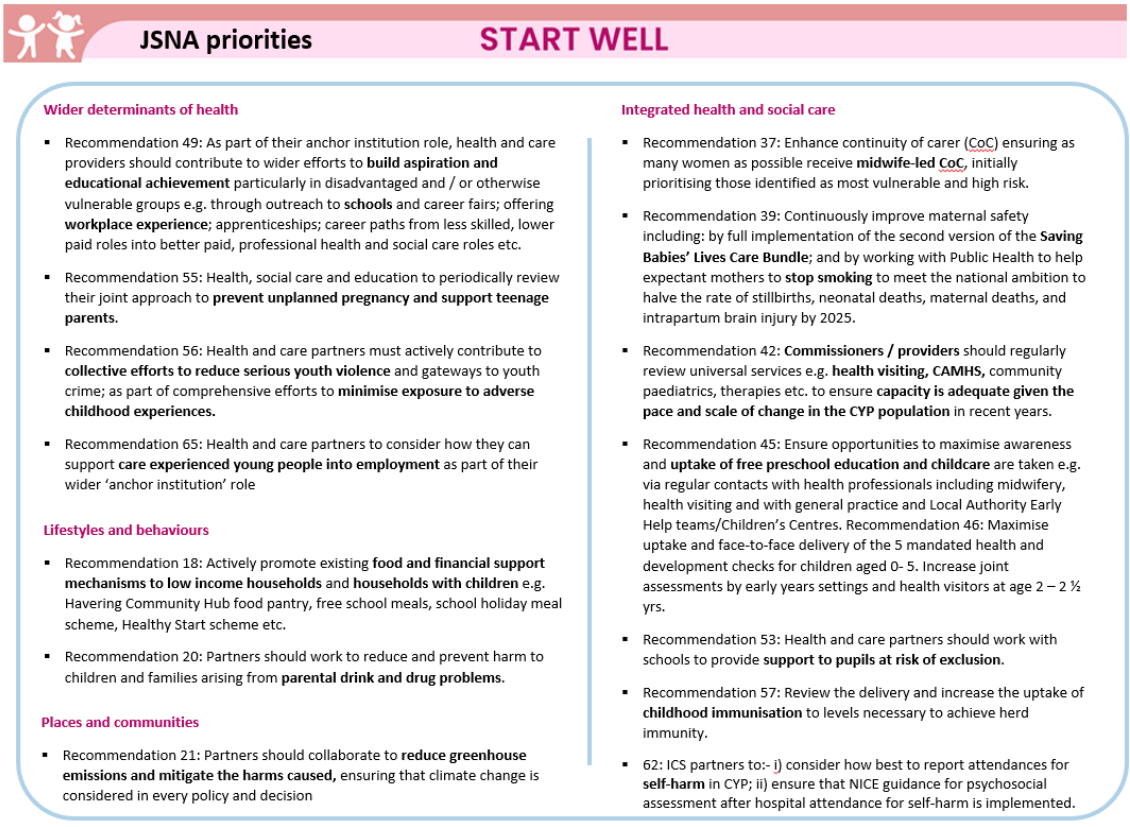
North East London Health & Care Partnership

Area	Proposed actions to improve services for those with Autism
Recognition of autism amongst front line staff	▪ Front line staff should be aware of autism and the needs of people with autism ▪ They should be able to adapt appointments and support to meet these needs, and certainly should be able to recognise the signs of autism and be supported to have conversations with people about getting a diagnosis ▪ If a person approaches a GP to request an assessment, they should be understanding and not dismissive of the person's request; a diagnosis in adulthood can really help a person with autism to understand more about themselves and understanding of themselves about why they may do certain things differently from other people ▪ Regarding the Sunflower Lanyards that Autistic people use for appointments – we need to ensure that more frontline staff recognise these. It should be noted that not all of those who are autistic like to use the sunflower lanyard – it would be better if there is a flag on system at the hospital /practice to bring to the attention of staff
Coordination of services	▪ Services should be more coordinated and where wait times are long, people shouldn't have to keep calling to try to find out what's happening with their appointment ▪ Information sent for appointments should be clear, and right the first time, to prevent delays in care and wasted appointments ▪ Outpatient appointments and particularly appointments for cancer services should be changed as little as possible
Support for those who are Autistic	▪ It would be helpful if it could be flagged on notes and medical records that a person has autism, and that it's not really appropriate for them to wait in a busy and loud waiting area. ▪ Recognition that perhaps the person may need a slightly longer appointment to be given the time to ask the questions that they want to about their condition should also be considered ▪ If NHS events are held for those who are autistic, their needs should be taken into account when picking the venue and location of the meeting. For example, no bright lights, a sensory room etc. ▪ Language in letters that go out to patients should be as clear and to the point as possible
Tailoring of services to meet the needs of those who are autistic	▪ Some services, such as mental health support should be tailored to meet the needs of those with Autism ▪ I needed Therapy for some significant things I've been through in my life – I was referred for CBT therapy but the service that works for other people didn't really meet my needs and I don't think it would meet the needs of others who are neurodiverse ▪ Appointments overrunning can be a real struggle for those with autism – appreciate this is often the case in the NHS but it leads to significant stress
Support following diagnosis of Autism	▪ For adults particularly this could be strengthened – there should be more support post diagnosis, and more links into support groups and others who are in a similar position

Key priorities identified in the JSNA

The following key recommendations are taken from the Havering Joint Strategic Needs Assessment (JSNA) and themed according to our life course approach. The JSNA is currently being refreshed, and the full Havering Place based Partnership strategy will build on the refreshed JSNA.





LIVE WELL

Havering's **population has increased by 10.5%** over the past decade, reaching 262,052 in 2021 and is **becoming younger with the median age decreasing** from 40 to 39, the opposite to the trend across London and England. **Life expectancy in Havering is similar to the national average** (79 for males, 83 for females), but recent improvements have stalled, and there was a decline during the pandemic.

THE WIDER DETERMINANTS OF HEALTH

27,000 adults resident in Havering are income deprived and there is significant variation across the borough, ranging from 1.6% in the least deprived neighborhood to 33.9% in the most deprived.

Havering has higher employment rates (79.8%) compared to London and England, but many residents commute out of the borough for better-paying jobs. 21.6% of residents in Havering are in jobs that are low paid (higher than London average 20.2%)

The average age of death for homeless individuals is just 47 years for men and even lower for women (43 years). **The number of new rough sleepers has been increasing in Havering, from 21 in 2018/19 to 59 in 2020/21.**

PLACES & COMMUNITIES

6% of deaths in Havering are attributed to air pollution, exceeding the national average (5.1%) but lower than the London average (6.4%).

Havering had both healthy and unhealthy high streets, with Rainham ranking 10th and Hornchurch ranking 145th out of 146 in a London league table (1 being the least healthy).

Only 14% of adults in Havering walked for travel three or more times per week. The borough has limited public transport infrastructure, **high car ownership (110 cars per 100 households), and low cycling rates (0.1% of adults cycling three times per week).**

LIFESTYLES & BEHAVIOURS

Over 20,500 adults (10.2%) in Havering are smokers, lower than London (11.5%) and England (13%).

Obesity in Havering is high, with more than 6 in 10 adults overweight or obese, surpassing the London average (56%), but similar to England (64%).

Around 1.1% of adults (approx. 2,200) were dependent on alcohol in 2019/20. Additionally, about 0.12% (233) were using opiates and/or crack cocaine. Around **one in five adults in Havering were drinking more than the recommended 14 units of alcohol per week.**

INTEGRATED HEALTH AND SOCIAL CARE

One in four adults experience mental illness and the total harm to health is comparable to that caused by cancers or cardiovascular disease.

Nationally cancers account for a quarter of all years of life lost. **1 in 2 people will be diagnosed with cancer in their lifetime.**

Life expectancy has increased, but most of the additional years come with health challenges, particularly due to long-term conditions, which significantly contribute to health inequalities based on ethnicity and deprivation.

Healthcare services have experienced a significant increase in waiting times both before and during the pandemic. This strain on capacity has become a persistent issue throughout the year, rather than being limited to the winter season.

Produced by the London Borough of Havering Public Health Intelligence Team

Havering LONDON BOROUGH

JSNA priorities LIVE WELL

Wider determinants of health

- Recommendation 5: 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 20: Partners should work to improve the offer to **people with drink and drug dependency and additional mental health problems**
- Recommendation 71: 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 76: Statutory services across BHR should be encouraged to offer people with health problems including mental health problems the opportunity to gain employment.

Lifestyles and behaviours

- Recommendation 18: Actively promote existing **food and financial support mechanisms** to low income households and households with children e.g. Havering Community Hub food pantry, free school meals, school holiday meal scheme, Healthy Start scheme etc.
- Recommendation 19: Ensure that there is a comprehensive **whole system approach to tackling obesity** with additional efforts aimed at supporting groups known to have higher prevalence of obesity.
- Recommendation 41: Improve access to **domestic violence support** to all women accessing maternity services through the introduction of an early support and referral scheme for identified victims
- Recommendation 67: **Raise public awareness of mental ill health, tackle associated stigma and strengthen personal resilience**, including by making use of 'Every Mind Matters' resources and self-help aids; giving particular consideration to groups who appear less likely to seek help such as **LGBTIQ+ and ethnic minority residents, and older people**.
- Recommendation 85: Continue efforts to raise **awareness of the causes and signs and symptoms of cancer** with the public and healthcare professionals.

Places and communities

- Recommendation 26: Councils to make use of the powers available to create a **healthier offer on our high streets**, prioritising disadvantaged areas with the unhealthiest offer, and taking into consideration the views of the local community.
- Recommendation 31: Building on **regeneration** plans in the borough; develop an effective approach to promote the benefits of living in Havering as part of collective effort to fill hard to recruit **health and social care vacancies**.
- Recommendation 35: Partners to consider and respond to the **needs of employees** who, post-pandemic, **routinely work from home to ensure their physical and mental health.**
- Recommendation 73: Mental health and substance misuse services to work with relevant Council services to effectively **outreach to and support the street homeless**

Integrated health and social care

- Recommendation 3: All partners within the developing integrated care system must give **prevention** and treatment equal priority if they are to succeed in improving health**, narrow inequalities** and provide high quality, affordable health and social care services.
- Recommendation 70: Continue to 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 75: **MH services** should **audit re-admissions to identify the underlying causes of re-admission** and whether improvements could be made as part of planned discharge, and ongoing treatment and support (including support from local authority housing teams).
- Recommendation 78: Improve the management of **physical health of patients with SMI**; ensure all get an annual health check and, through joining up initiatives across the system, improve effectiveness of support available to assist with lifestyle change, starting with smoking
- Recommendation 79: Ensure there are comprehensive **strategies/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 87: Implement the national **optimal cancer pathways**
- Recommendation 93: BHR should review the local approach to **maximising participation in the National Diabetes Prevention Programme** and develop an action plan for improved uptake and outcomes.
- Recommendation 94: BHR should review and amend where necessary the current approach to the delivery and monitoring of **diabetes care to ensure that all effective care** is consistently provided.

AGE WELL

Havering has a significant proportion of older residents aged 65+ (17.6%), second only to Bromley in London. **The 65+ population in Havering grew by 9.1% in the last decade.** By 2030, the number of people aged 85 and above is expected to increase by 2.4K (32%) to reach 9.9K.

THE WIDER DETERMINANTS OF HEALTH

- Around 3,500 older people aged 65+ (6%) in Havering live in the most deprived neighbourhoods in England.
- Fuel poverty affects 9% of the population and contributes to approximately 1 in 10 excess winter deaths.
- As older people often experience reduced income after retirement, it becomes crucial to prioritise high-quality and affordable housing to promote the health and wellbeing of the population.

PLACES & COMMUNITIES

- In Havering, there are approximately 17,634 individuals aged 65+ living alone.
- Most neighborhoods in the borough have a low Passenger Transport Accessibility Level (PTAL) score of 2 or below.
- 79% of internet non-users are over the age of 65.
- Overall the rates of crime in Havering remain relatively low.

LIFESTYLES & BEHAVIOURS

- Older people generally have lower smoking rates (**9.7% of 65-74 year olds smoke**), but is still significant. Those who smoke in old age often started at a younger age and could find it harder to quit.
- Over half of older people aged 65-84 do not eat at least 5 portions of fruit or vegetables a day.
- Over half of those aged over 85 and over a third of aged 75-84 are physically inactive.

INTEGRATED HEALTH AND SOCIAL CARE

- **Men in Havering have a lower healthy life expectancy** compared to the national average.
- Diagnosis rate in Havering (53%) for dementia is significantly below the national target of 66%
- Havering has fewer care home beds (8.0 per 100 people aged 75+) compared to the national average in England (9.4).
- In Havering, flu vaccine coverage for individuals aged 65 and above improved, meeting the national target of 75% for the first time in over a decade, although it remained below the national average.

Produced by the London Borough of Havering Public Health Intelligence Team

Havering LONDON BOROUGH

JSNA priorities AGE WELL

Wider determinants of health

- Recommendation 13: **Strengthen** community resilience through continued partnership with the VCS. This includes building upon and mapping existing **VCS capabilities**, identifying gaps in community support and providing opportunities for skills development.

Lifestyles and behaviours

- Recommendation 83: Undertake a deep dive/equity audit to **understand which populations are not taking up screening and support a programme of community engagement** working with those identified as less likely to participate in screening programmes to increase uptake.

Places and communities

- Recommendation 29: 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.

Integrated health and social care

- Recommendation 2: Plans regarding integrated health and social care services (pillar 4) should give the same priority to **conditions resulting in ill health and disability** as for conditions causing premature death
- Recommendation 102: Maintain efforts to further increase the completeness of **dementia diagnosis,** and improve access to the information and support for patients and their families
- Recommendation 107: Ensure that patients at risk of **frailty** are systematically identified, using **population health management approach**; effectively supported by the local partners to stay well; or receive urgent additional help in times of crisis.
- Recommendation 110: Further **improve the reablement offer** to maximise the proportion of patients who return home and stay home after admission to hospital.
- Recommendation 111: Develop plans to implement the **Enhanced Health in Care Homes (EHCH) model** to all care homes.

DIE WELL

There were 2,430 deaths in Havering in 2022 and an estimated 12,150 bereavements. Due to the ageing population, the number of deaths are projected to rise to 3,000 by 2043.

THE WIDER DETERMINANTS OF HEALTH

- **19% of people of working age and 11% of pensioners die in poverty in Havering**, compared to a UK average of 28% and 13% respectively
- Census data shows **46,111 of the Havering population is aged 65+** (17.6%), of which 6,974 are aged 85+ (2.7%). In London and England the proportion of the population aged 85+ is lower (1.6% and 2.4%).
- **Life expectancy in Havering is similar to the national average** (79 for males, 83 for females)
- **The mortality rate in Havering (1,094/100,000) is higher** than London (975/100,000) and England (1,042/100,000)

PLACES & COMMUNITIES

- Across the UK, **over 40% of adults who want formal bereavement support don't receive any**
- Nationally, **half of bereaved children said they didn't get the support they needed** from their schools and colleges
- **20,636 people in Havering care for a family member, friend of neighbour** because they have long-term physical or mental health conditions or illnesses, or problems related to old age

LIFESTYLES & BEHAVIOURS

- **12.7% of the Havering population are aged 65 or over and live at home alone** (compared to 9.1% in London and 12.8% in England)
- **1,061 potential years of life lost in Havering due to alcohol-related conditions for males and 339 for females**
- **There were 8.4 suicides per 100,000 people** from 2019 to 2021 in Havering (compared to 7.2 in London and 10.4 in England)

INTEGRATED HEALTH AND SOCIAL CARE

- **Few people would choose to die in hospital and yet almost half of all people in Havering do so**, significantly higher than national levels.
- Each year, an estimated **550 people in Havering do not receive the palliative and end of life care they need**
- **7.70% of deaths were preceded by 3+ emergency admissions in the last 3 months of life** in 2019 (England average = 7.1%)
- Across England, just **25% of carers report having had a carer's assessment or re-assessment in the last 12 months**

Produced by the London Borough of Havering Public Health Intelligence Team

Havering LONDON BOROUGH

JSNA priorities DIE WELL

Integrated health and social care

- Recommendation 112: Strengthen end-of-life care to increase the proportion of people who are **supported to die with dignity** in their usual place of residence.

Our immediate priorities

Partners have held a series of workshops, scrutinising data, the JSNA, and what local people have fed back to us around what means most to them and the areas that they feel need greatest improvement, to identify our top priorities for each life course area for 2023/24:

Start Well Immediate Priorities
Work with parents and families to build their resilience; meeting the needs of families at home without the need for more intensive interventions later along their journey
Increase identification of and support for children and young people who provide informal and unpaid care for family members
Build on and improve the mental health offer for schools, working with young people
Increase the number of children receiving timely Autism Spectrum Disorder (ASD) diagnosis and integrated family support
Reduce the wait time of children for Special Educational Needs therapy provision

Live Well Immediate Priorities
Increase uptake of screening and prevention programmes, particularly targeted to groups who experience greater health inequalities, and place a greater focus on those on the edges of care, embedding a preventative, improved wellbeing approach. Implement active waiting lists etc.
Work with partners through the Better Homes, Better Health to improve living conditions for local people that impact on health, including mouldy and damp homes
Implement the recommendations in the Havering Healthy weight strategy
Implement the action plan in the Havering strategy for those who provide informal and unpaid care, to increase the number of Carers who are identified as such, and receive the support, benefits and information to which they're entitled

Age Well Immediate Priorities
Develop a multidisciplinary team approach at place around Primary Care Networks, with established teams who are able to coordinate care around the needs of individuals to meet their needs in the community
Reduce the rate of emergency hospital admissions, including readmissions and reduce the rate of acute length of stay for frail older people, returning them home sooner
Reduce the rate of older people having discharge delays from hospital (delayed transfers of care)

Die Well Immediate Priorities
Increase the percentage of people who have, or are offered, a personal health budget towards end of life (fast-track)
Reduce the average number of patients per month who die in hospital whilst being delayed to be discharged
Reduce the percentage of older people who die within 7 days of an emergency hospital admission

Digital Immediate Priorities
Increase the number of organisations and clinicians that have access to full patient records
Increase the percentage of people accessing services digitally
Increase the use of single care plans
Roll out the Joy app and increase the number of people and staff accessing the marketplace element as a single database of services

Workforce Immediate Priorities
Work to reduce staff turnover rates in the first 12 months of employment
Work to create a culture that makes Havering an inviting place to work, reducing vacancy rates and reliance on agency staff
Support more local people into careers in health and care and VCSE in Havering

Estates Immediate Priorities
Work to increase efficiency of our bed base across the borough including Rehabilitation, intensive care and operating theatres
Reduce void costs on empty buildings, ensuring that we make the best use of the estate that we have
Increase the use of multi-organisational space to support multidisciplinary team working in Havering, and care delivered closer to home in our neighbourhoods

Primary Care Immediate Priorities
Improve timeliness of and access to primary care appointments (reducing wait time for an appointment)
Reduce variation between GP practices across Havering (more practices rated as good and outstanding)
Delivery of the aspirations set out within the Fuller review including multidisciplinary working at a neighbourhood level

Urgent and Emergency Care Immediate Priorities
Increase the percentage of patients whose needs are addressed through a single call to NHS 111 and reduce the percentage of patients advised to attend ED following a call to NHS 111
Meet new urgent and emergency care standards
Increase the percentage of emergency hospital admissions receiving same day emergency care

Culture Immediate Priorities
Induction and Organisational development programme to support the integration of the joint team, and embed joint ways of working
Wider piece of work with staff across the system, building on the Showcase event approach, engaging them in the work underway, and empowering them by creating an environment where they feel able to suggest and make positive changes and improvements
Work with Communications and Engagement team colleagues across our organisations to embed a more comprehensive way of engaging with local people and staff across the borough

Integrated Commissioning / Joint Team Immediate Priorities
Map and review existing contracts across Havering, reviewing opportunities for joint commissioning, and identifying any gaps, feeding this into the development of an Integrated Commissioning plan
Market Management – a demand and capacity review to be undertaken, considering alternative approaches and implement a pilot approach to new projects, embedding a culture of continuous learning and innovation, feeding into a comprehensive Markey Position statement
Immediate requirement to deliver improved value for money through commissioning of contracts

Our key ambitions and outcomes

The priorities above will enable Partners to deliver the below aspirations for each life course.

Data leads for both the NHS and Local Authority are working together to develop a dashboard which will help to monitor progress against the following aspirations. This required some datasets to be more joined up, and the Partnership is looking at innovative information sharing approaches to enable this.

Start Well Ambitions		
Immediate ambitions (1-3 years)	**Medium term (3-5 years)**	**Long term (5 - 10 years)**
Reduce the number of children and their families attending Emergency Departments for non-emergency care	Increase the number of Children and Young People receiving support for their emotional wellbeing through Primary Care	Increase the number of children and their families receiving best practice End of Life Care provision
Reduce the number of Children and Young People attending Emergency Departments in emotional or mental health crisis	Increase the number of children receiving timely Autism Spectrum Disorder (ASD) diagnosis and integrated family support	
Improve access to services and reduce wait times, particularly for Primary Care, non-elective care, and other services	Reduce the wait time of children for Special Educational Needs therapy provision	
Reduce spend on care for those with more complex needs by looking at innovative and local solutions for placements	Increase the use of Child Health Hubs to deliver integrated community care for children and their families	
Deliver greater value for money through joint commissioning of contracts where possible, which will also deliver more seamless, integrated services for local people	Reduce the percentage of children who are physically inactive and/or obese	
	Reduce the number of children and young people living in cold, damp or mouldy homes	

Live Well Ambitions		
Immediate ambitions (1-3 years)	**Medium term (3-5 years)**	**Long term (5 - 10 years)**
Improve access to services and reduce wait times, particularly for Primary Care, non-elective care, and other services	Increase diagnosis rates for type 2 diabetes and hypertension	Increase healthy life expectancy
Reduce the percentage of adults who are physically inactive and/or obese	Increase the percentage of adults with a learning disability living in settled accommodation	Reduce the gap in life expectancy between the most and least deprived areas of the borough
Reduce smoking prevalence in adults	Increase the percentage of cancers being diagnosed at an earlier stage	Reduce alcohol-related mortality
Increase the number of social prescribing referrals to support people to access wider wellbeing support	Reduce the number of people living in cold, damp or mouldy homes	Reduce the rate of suicides
Increase the number of people who provide informal and unpaid care who are registered with the Carers Hub and in receipt of information and support		Reduce early deaths from cardiovascular disease and respiratory disease
Increase use of digital enabled systems to support early detection for Atrial Fibrillation and Chronic Kidney Disease		Eliminate all inappropriate out of area mental health placements
Increase uptake of home testing including ACR and blood pressure		
Increase the number of people being		

referred to the national diabetes prevention programme		
Reduce wait times and increase support for those with lower level mental health issues to enable a preventative approach to mental health and wellbeing		

Age Well Ambitions		
Immediate ambitions (1-3 years)	**Medium term (3-5 years)**	**Long term (5 - 10 years)**
Increase the number of older people with a personalised care and support plan	Reduce the number of older people being referred for adult social care	Reduce permanent inappropriate admissions into residential care
Reduce the rate of emergency hospital admissions, including readmissions	Increase access for older people with a common mental illness to psychological therapies	Reduce the percentage of older people reporting that they feel lonely
Reduce the rate of acute length of stay for frail older people, returning them home sooner	Increase the number of volunteers supported to find a volunteering opportunity	
Reduce the rate of older people having discharge delays from hospital (delayed transfers of care)	Reduce the number of frail older people living in cold, damp or mouldy homes	
Increase the number of informal and unpaid Carers having a carer assessment and receiving appropriate support	Increase the number of older people who have their seasonal flu vaccination	

Die Well Ambitions		
Immediate ambitions (1-3 years)	**Medium term (3-5 years)**	**Long term (5 - 10 years)**
Increase the percentage of people who have, or are offered, a personal health budget towards end of life (fast-track)	Increase the percentage of people in the last 3 years of life who are registered on a local end of life register	Increase, in the recording of preferred place of death
Reduce the average number of patients per month who die in hospital whilst being delayed to be discharged	Increase access to Bereavement support in Havering	Increase the number of people who die in their preferred place of death
Reduce the percentage of older people who die within 7 days of an emergency hospital admission	Reduce the percentage of older people who die within 14 days of an emergency hospital admission	

Digital Ambitions		
Immediate ambitions (1-3 years)	**Medium term (3-5 years)**	**Long term (5 - 10 years)**
Increase the number of organisations and clinicians that have access to full patient records	Increase the number of people using care technology	Full population health management system in place with integrated datasets across health and care
Increase the percentage of people accessing services digitally	Increase the percentage of people electronically managing appointments	
Increase the use of single care plans	Establish a Population Health Management system that will increase targeted support for local people, supported by multidisciplinary / neighbourhood teams at place	
Roll out the Joy app and increase the number of people accessing the marketplace element as a single database of services		

Workforce Ambitions		
Immediate ambitions (1-3 years)	**Medium term (3-5 years)**	**Long term (5 - 10 years)**
Reduce vacancy rates	Reduce clinical staff turnover rates in the first 12 months of employment	Support more local people into careers in health and care and VCSE in Havering
Reduce reliance on agency and interim staff	Reduce non-clinical staff turnover rates in the first 12 months of employment	

Estates Ambitions		
Immediate ambitions (1-3 years)	**Medium term (3-5 years)**	**Long term (5 - 10 years)**
Increase appropriate use of and through flow of extra care housing	Reduce void costs on empty buildings, ensuring that we make the best use of the estate that we have	
Increase older people rehabilitation bed efficiency	Increase the use of multiorganisational space to support multidisciplinary team working in Havering, and care delivered closer to home in our neighbourhoods	
Increase general intensive care unit efficiency		
Increase operating theatre efficiency		

Primary Care Ambitions		
Immediate ambitions (1-3 years)	**Medium term (3-5 years)**	**Long term (5 - 10 years)**
Increase the number of primary care appointments per 1,000 patients	Improve timeliness of access to primary care appointments (reducing wait time for an appointment)	Fully matured Primary Care Networks delivering primary care at scale
Increase the uptake of digital access, such as video consultations and e-consultations	Reduce variation between GP practices across Havering (more practices rated as good and outstanding)	
Increase NHS111 slot conversion rates, each practice to release 1 appointment per 3,000 patients	Delivery of the aspirations set out within the Fuller review including multidisciplinary working at a neighbourhood level	
Increase the number of social prescribing referrals		

Urgent and Emergency Care Ambitions		
Immediate ambitions (1-3 years)	**Medium term (3-5 years)**	**Long term (5 - 10 years)**
Increase the percentage of patients whose needs are addressed through a single call to NHS 111		
Reduce the percentage of patients advised to attend ED following a call to NHS 111		
Meet new urgent and emergency care standards		
Increase the percentage of emergency hospital admissions receiving same day emergency care		

During 2023/24, we will work up quantified performance targets for a smaller set of key metrics which will

be monitored and reported on quarterly at the Havering Place based Partnership Board, feeding up into the Havering Health and Wellbeing Board. Other metrics will be monitored elsewhere. A dashboard will be developed highlighting how we are performing against our targets.

The following page sets out our plan over the course of 2023/24 to develop a five year strategy for the Havering Place based Partnership, co-developed with local people and staff.

Next steps to develop our Partnership 5 year strategy

One of the founding principles of our Havering Place based Partnership is that we will develop our priorities and strategy with local people and front line staff, ensuring that they can influence and get involved in improvements across the Borough. This is a strong feature of the proposal to develop our 5 year strategy. The full five year strategy will be consistent with the refreshed Havering Joint Health and Wellbeing Strategy which we will develop in parallel as a partnership.

Draft high level project plan

	Proposed activity	Lead	By
1	Monday 3rd July – Havering Executive Planning Session - Review key population health challenges within the JSNA around the life course approach - Identify the immediate top 3 priorities for each life course pillar, as well as longer term priorities based on the information within the JSNA	Luke Burton Emily Plane Working with leads from across the partnership	**Complete** – July 2023
2	Ongoing programme of showcase events with staff from across the Havering Place based Partnership, focused around our key priority areas and supporting engagement / raising awareness of the work underway	Emily Plane Judith Smy	Ongoing
3	The Havering Big Conversation Event – Romford Market – first in the series of events to discuss priorities of the Partnership with local people, and feed this back into our longer term strategy	Emily Plane	**Complete** - Wednesday 19th July 2023
	Rainham and Harold Hill events to engage with local people around preparation for winter, and discuss what matters most to them in terms of Health and Care	Sharon Adkins – Health Champion lead Kelly McBridge – Core Connector Programme lead Emily Plane	**Complete** – September 2023
4	Havering Place based Partnership team to be fully recruited, following consultation and subsequent interviews for vacant posts (subject to discussions around a more integrated place team)	Luke Burton Emily Plane Matt Henry	October – December 2023
5	Once all 'heads of' positions are filled, a workshop to be held with partners for each life course pillar, focussing on: - Review of key performance and challenges, including JSNA priorities - Stocktake of upcoming procurements across health and care / opportunities - Budget review, spend vs actual envelope, including any savings targets for the ICS that Place will be responsible for delivering - Stocktake of the work underway - Review of the current gaps - Gap analysis of current challenges vs projects / priorities underway - Develop full project plan, setting out priorities / deliverables over the next 1-2, and then 3-5 years - Develop proposed metrics to monitor progress - **As part of this work, run focus groups, 1-1 discussions and surveys with the populations affected, asking for their views and priorities**	Head of start well, live well and age well Supported by Head of Strategic Planning – Emily Plane Head of PMO – Matt Henry	October – December 2023
6	Outputs of workshops to be fed into draft 5 year plan	Emily Plane	December – January 2024
7	Engagement exercise with local people and front line staff on emerging priorities	Emily Plane	January 2024 – March 2024
8	All of the above to feed into final 5 year strategy	Emily Plane	April 2024
9	Throughout development, ongoing updates to be shared with the Havering Place based Partnership, and Wellbeing Board members	Luke Burton / Emily Plane	Ongoing
10	Develop templates for monitoring progress, and establish reporting process, including dashboards for each life course	Matt Henry	April 2024

11	Development of a dashboard to monitor the aspirations set out in this strategy, to feed into the Place based Partnership and Health and Wellbeing Board	Matt Henry	Ongoing
12	Ensure development alongside and alignment with the Havering Joint Commissioning Strategy and Joint Health and Wellbeing strategy	Public Health Team Joint Commissioning Team Havering PbP Team	Ongoing
13	Final 5 year strategy to be shared with Havering Place based Partnership and Health and Wellbeing Board for endorsement	Emily Plane	April 2024
14	Project group to monitor progress against delivery of the aspirations and metrics set out within the 5 year strategy. Reporting to be set up on an ongoing basis with the Havering Place based Partnership and Health and Wellbeing Board	Matt Henry Emily Plane	From May 2024

The metrics within this strategy, as well as the above project plan to develop the 5 year Havering Place based Partnership strategy, will be overseen by a Havering Strategy Working Group. This group will report into the Havering Place based Partnership Board, feeding up into the Havering Health and Wellbeing Board. Draft terms of reference for this group are set out on the following page.

Havering Place based Partnership Strategy Working Group

Draft Terms of Reference and proposed membership

Purpose:

The purpose of this group will be to:

- Monitor progress against the priorities set out in the 2023/24 strategy
- Unblock and escalate any issues from each workstream that may prevent delivery of the aspirations in the 2023/24 strategy
- Input into and oversee development of the Havering Partnership 5 year strategy
- Bring together asks of enabling programmes / identify further enablers that are required across the life course approach to enable delivery of our key priorities as a partnership

Frequency: Every two months, virtually

Onward reporting: Havering Place based Partnership Board, feeding up into the Havering Health and Wellbeing Board on a quarterly basis

Proposed Chair: Luke Burton

Proposed Membership:

Dr Narinderjit Kullar, Clinical Director, Havering Place Based Partnership

Head of Strategic Planning (Emily Plane)

Head of PMO (Matthew Henry)

Head of Start well (TBC)

Head of Live well (TBC)

Head of Age well and die well (TBC)

Anthony Wakhisi, Public Health Principal

Lucy Goodfellow, LBH

Laura Neilson, LBH

Priti Gaberria, LBH

Clinical and Care leads to be invited as required for updates on their respective priorities

Further leads to be invited as required

Havering ICB Sub-Committee

8 November 2023

Title of report	Havering Place Month 6 2023-24 Finance Overview
Author	Julia Summers, Head of Finance
Presented by	Sunil Thakker, Director of Finance
Contact for further information	Sunil.thakker@nhs.net juliasummers@nhs.net
Executive summary	**Key issues** • The month 6 year-to-date ICS position is a variance to plan of £83.1m. • In line with the operating plan and NHSE protocol the system is reporting a breakeven position at year-end. • The year-to-date variance to plan means that a formal finance recovery plan (FRP) has been developed and shared with regulators. This suggests that there is a potential system gap at year-end of £54.9m. • The FRP trajectory requires an improvement in the run rate position of the ICS to bring the current run rate of expenditure closer to plan. At month 6, factoring into account the impact of industrial action, the ICS is £4.9m away from its FRP trajectory. • The drivers of the month 6 position include pressures relating to inflation, payroll, the impact of industrial action and run rate pressures such as ICB prescribing and mental health expenditure. Additionally, there is under delivery of efficiency schemes. • There is a high level of risk associated with delivery of the financial plan if further mitigations aren't delivered. • Havering specific spend is in line with the information reported to committee previously. An update on ICB local devolved budgets will be given at the next committee. • Financial information at place will continue to be developed throughout 23/24. • **Recommendations** • Note the contents of the report
Action required	Note
Previous reporting	N/A
Next steps/ onward reporting	Regular updates to Havering Place based partnership

Conflicts of interest	No conflicts of interest
Strategic fit	Which of the ICS aims does this report align with? • To enhance productivity and value for money
Impact on local people, health inequalities and sustainability	Update on financial sustainability of the system
Impact on finance, performance and quality	Financial plans are set of the resources available. The report provides an update on financial performance.
Risks	The main risks flagged across the system are excess inflation, efficiency delivery, run rate and operational pressures, the impact of industrial action and a lost maternity CNST risk sitting with providers. Due to the level of risk associated with the delivery of the of the financial plan is currently rated 20 within the risk framework.

NHS
North East London

Month 6 2023-24 Finance Overview – NEL ICS

Meeting name: Havering ICB Sub Committee

Presenter: Sunil Thakker

Date: 8 November 2023

Executive Summary - Finance

Month 6 ICS Position - YTD £83.1m deficit variance against plan.

The ICS has reported a year to date deficit at month 6 of £88.4m. This gives an adverse variance to plan of £83.1m.

The main drivers are inflation, under delivery of the efficiency target, staffing (including agency usage), industrial action and other run rate pressures.

Month 6 I&E - YTD - ICS

		YTD	Forecast
Target	£m	(5.3)	0.0
Actual	£m	(88.4)	0.0
Variance Surplus / (Deficit)	**£m**	**(83.1)**	**0.0**

Financial Risks to the ICS Forecast outturn.

Gross risks across the system of £184m.

Main drivers – inflation, efficiency risk, run rate risks and income risks to providers.

The net risk is £54.9m. This assumes £129.1m of potential risk will be mitigated.

ICS Risk

		Gross Risk	Post Mitigations
System wide risks	£m	(184.0)	(54.9)
Operational improvements and recurrent mitigations	£m	0.0	0.0
Non Recurrent mitigations	£m	0.0	0.0
Total	**£m**	**(184.0)**	**(54.9)**

NEL ICB – YTD deficit variance of £17m against plan.

The ICB planned year-to-date surplus of £7.7m. The year-to-date reported position is a deficit of £9.3m which gives an adverse variance to plan of £17m. At month 6 the ICB has hit the financial recovery plan (FRP) trajectory.

The ICB run rate pressures, largely relate to prescribing and mental health and under delivery of efficiencies.

Month 6 I&E NEL ICB

		YTD	Forecast
Target	£m	7.7	15.4
Actual	£m	(9.3)	15.4
Variance Surplus / (Deficit)	**£m**	**(17.0)**	**0.0**

ICS Delivery of Efficiencies

Year-to-date efficiency plan across the system of £121.5m. Actual delivery of £94.1m, resulting in under delivery of £27.4m.

Efficiencies have been recategorized in the ICB to include those that are cash releasing. Non cash releasing efficiencies are included in the FRP stretch.

Under delivery is expected to continue year end with forecast slippage of £40.8m.

ICS Efficiencies

		YTD	Forecast
Target	£m	121.5	277.8
Actual	£m	94.1	237.0
Variance	**£m**	**(27.4)**	**(40.8)**

NEL ICS - Financial Summary Month 6

Surplus / (Deficit) - Adjusted Financial Position

	YTD Surplus / (Deficit)			Full Year Forecast Surplus / (Deficit)		
	Plan £m	Actual £m	Varianc £m	Plan £m	Forecast £m	Variance £m
North East London ICB	7.7	(9.3)	(17.0)	15.4	15.4	(0.0)
Providers	(13.0)	(79.1)	(66.1)	(15.3)	(15.3)	0.0
ICS Total	**(5.3)**	**(88.4)**	**(83.1)**	**0.0**	**0.0**	**0.0**

Month 6 Summary Position

- The year-to-date ICS position against the plan is a **deficit of £83.1m**. This is made up of a provider deficit of £66.1m and ICB deficit of £17m.
- In line with the operating plan and the national reporting protocol the forecast position at month 6 is **reported as a breakeven position**. This assumes that providers will deliver a planned deficit of £15.3m and the ICB will deliver an offsetting surplus.
- However, as reported in previous month the year-to-date position suggests there is a **risk of a year-end deficit**. This has resulted in a formal Financial Recovery Plan (FRP).
- The FRP assesses the impact of cost improvement schemes (CIPs) and other corrective actions. This leaves a **potential system gap at year-end of £54.9m**. Regulators have requested that further work is done to bring the position back in line with the plan (breakeven position at year-end).

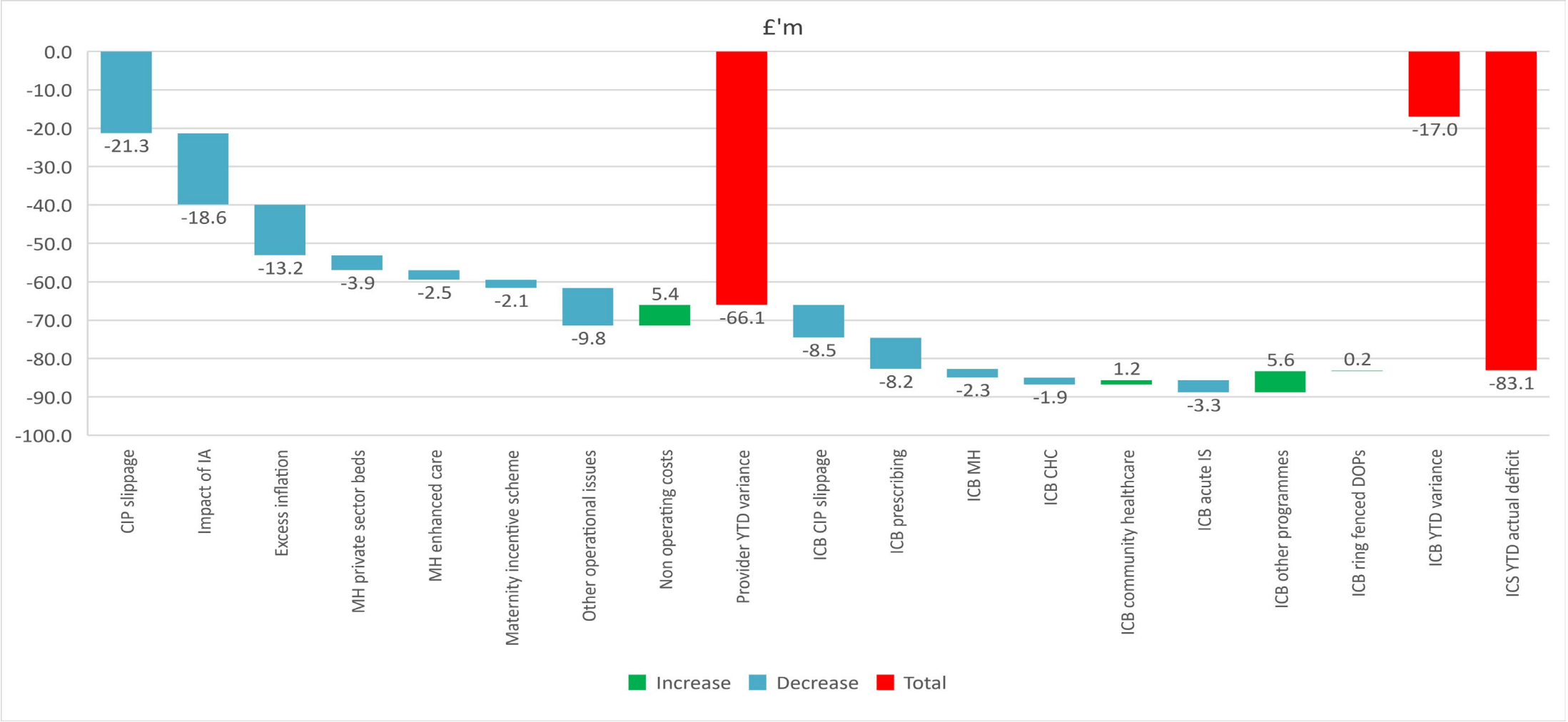
NEL ICS Financial Summary Month 6

Organisations	Year to date			Reported Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
BHRUT	(3.0)	(23.6)	(20.6)	(0.2)	(0.2)	0.0
Barts Health	(13.7)	(46.5)	(32.8)	(27.8)	(27.8)	0.0
East London NHSFT	0.8	(3.2)	(4.0)	5.4	5.4	0.0
Homerton	0.1	(8.3)	(8.4)	0.2	0.2	0.0
NELFT	2.9	2.6	(0.3)	7.0	7.0	0.0
Total NEL Providers	**(13.0)**	**(79.1)**	**(66.1)**	**(15.3)**	**(15.3)**	**0.0**
NEL ICB	7.7	(9.3)	(17.0)	15.4	15.4	(0.0)
NEL System Total	**(5.3)**	**(88.4)**	**(83.1)**	**0.0**	**0.0**	**0.0**

Month 6 Summary Position

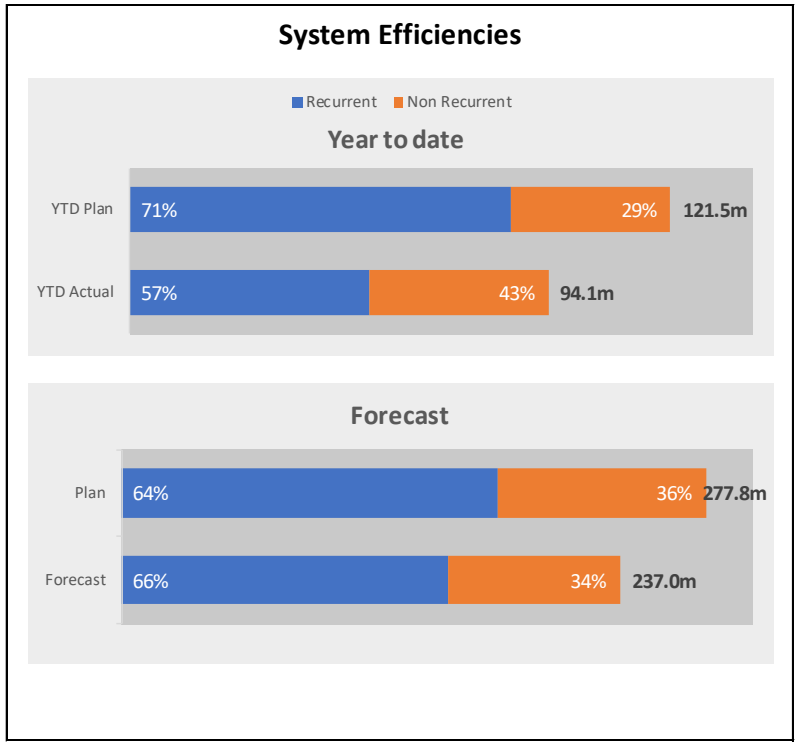
- One of the main drivers of the ICS position is a year-to-date under delivery against the efficiency target. The total year-to-date position on efficiencies is an under delivery of £27.4m, with expected year-end slippage of £40.8m.
- The ICB overspend is driven by under delivery of efficiencies and run rate pressures in prescribing, mental health and CHC. The run rate pressures are driven by a combination of volume growth and price increases. Within the forecast position the ICB has assumed that it will deliver £98.4m cost improvement schemes and additional FRP stretch measures. This is a stretching target with an increase in delivery expected in the remaining six months of the financial year. Delivery of savings from month 7 onwards is expected to be in excess of £12m per month.
- Provider efficiency slippage accounts for £17.7m of its reported overspend. System providers are also reporting pressures in relation to inflation, industrial action and staffing (including pay awards and agency usage).
- In terms of agency usage system providers are exceeding the agency cap set by NHSE for 23/24. The annual agency cap is set at £140.6m. Month 6 year-to-date spend on agency is £97.4m (69% of the cap). The extrapolated run rate suggests that provider outturn spend on agency could be in the region of £195m. However, providers are expecting to put corrective measures in place and have reported forecast agency spend of circa £158.5m (£18m above the cap).

NEL ICS - Summary of Month 6 YTD Variance



NEL ICS Efficiencies – Month 6 and Forecast

- The total year-to-date planned efficiency target for the NEL system is £121.5m and the forecast target is £277.8m.
- The year-to-date efficiencies delivered across the system is £94.1m, resulting in under delivery against the target of £27.4m.
- Delivery of efficiencies is a major risk to the system and there was a slow start to the delivery of efficiency schemes. The FRP has detailed a stretch to existing schemes which will improve the delivery run rate. It is, therefore, expected that there will be improvements in the identification and delivery of efficiencies over the remaining months of the financial year.
- At year-end the ICB is forecasting under delivery against the efficiency target of £18.1m, with providers expecting under delivery of £22.7m. The total year-end position is a forecast under delivery of £40.8m.
- The information on the right is based on information submitted to NHSE from ICB data sources and provider financial returns. The chart shows the proportion of recurrent and non-recurrent schemes both in terms of the plan and actual performance.



Efficiencies	Year to date			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Total Provider Effieciency	**92.0**	**74.2**	**(17.7)**	**195.2**	**172.5**	**(22.7)**
NEL ICB	29.5	19.8	(9.7)	82.6	64.5	(18.1)
Total System Efficiency	**121.5**	**94.1**	**(27.4)**	**277.8**	**237.0**	**(40.8)**

NEL ICS – Month 6 Performance and FRP Trajectory

Organisation	Year to date	FRP		Industrial Action (IA) Impact	
	M1-6 Actuals £m	FRP Expected M1-6 Actuals £m	Variance from FRP £m	M1-6 Adjusted Actuals (IA) £m	Adjusted Variance from FRP £m
BHRUT	(23.6)	(17.1)	(6.6)	(20.7)	(3.6)
Barts Health	(46.5)	(39.2)	(7.4)	(39.1)	0.1
East London NHSFT	(3.2)	(1.7)	(1.5)	(3.0)	(1.4)
Homerton	(8.3)	(6.2)	(2.0)	(7.0)	(0.8)
NELFT	2.6	2.9	(0.3)	2.7	(0.1)
Total NEL Providers	**(79.1)**	**(61.3)**	**(17.8)**	**(67.1)**	**(5.8)**
NEL ICB	(9.3)	(10.3)	0.9	(9.3)	0.9
NEL System Total	**(88.4)**	**(71.6)**	**(16.9)**	**(76.4)**	**(4.9)**

- The FRP trajectory requires an improvement on the monthly run rate position, with an expectation of an in-month breakeven position from month 7.
- In month 6 the system financial performance was £16.9m above the FRP trajectory.
- However, industrial action has impacted on the overall financial position. Removing the costs of industrial action from the month 6 year-to-date position results in adjusted year-to-date actual deficit of £76.4m. At month 6 the FRP trajectory expected year-to-date deficit of £71.6m. This means that the system is effectively £4.9m adrift from the FRP trajectory. The adjusted position is dependent on the costs of industrial action being covered by an additional funding source. This is yet to be confirmed.