Notice of Meeting

HEALTH SCRUTINY COMMITTEE

Tuesday, 3 September 2019 - 7:00 pm
Committee room 2, Town Hall, Barking

Members: Cllr Eileen Keller (Chair) Cllr Paul Robinson (Deputy Chair), Cllr Mohammed Khan, Cllr Donna Lumsden, Cllr Chris Rice and Cllr Emily Rodwell

By Invitation: Cllr Cameron Geddes and Cllr Maureen Worby

Date of publication: 22 August 2019

Chris Naylor
Chief Executive

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AGENDA

1. **Apologies for Absence**

2. **Declaration of Members' Interests**

   In accordance with the Council's Constitution, Members are asked to declare any interest they may have in any matter which is to be considered at this meeting.

3. **Minutes - To confirm as correct the minutes of the meeting held on 25 June 2019 (Pages 3 - 7)**

4. **Barking & Dagenham, Havering and Redbridge Integrated Care Partnership and Provider Alliance Updates (Pages 9 - 26)**

5. **Consultation on Proposed Continuing Healthcare Placement's Policy (Pages 27 - 46)**

6. Update on Barking Riverside (Pages 47 - 70)

7. New Primary Care Networks (Pages 71 - 88)

8. Joint Health Overview and Scrutiny Committee Update (Pages 89 - 91)

9. Work Programme (Pages 93 - 94)

10. Any other public items which the Chair decides are urgent

11. To consider whether it would be appropriate to pass a resolution to exclude the public and press from the remainder of the meeting due to the nature of the business to be transacted.

Private Business

The public and press have a legal right to attend Council meetings such as the Assembly, except where business is confidential or certain other sensitive information is to be discussed. The list below shows why items are in the private part of the agenda, with reference to the relevant legislation (the relevant paragraph of Part 1 of Schedule 12A of the Local Government Act 1972 as amended). ***There are no such items at the time of preparing this agenda.***

12. Any other confidential or exempt items which the Chair decides are urgent

Our Vision for Barking and Dagenham

ONE BOROUGH; ONE COMMUNITY; NO-ONE LEFT BEHIND

Our Priorities

A New Kind of Council

- Build a well-run organisation
- Ensure relentlessly reliable services
- Develop place-based partnerships

Empowering People

- Enable greater independence whilst protecting the most vulnerable
- Strengthen our services for all
- Intervene earlier

Inclusive Growth

- Develop our aspirational and affordable housing offer
- Shape great places and strong communities through regeneration
- Encourage enterprise and enable employment

Citizenship and Participation

- Harness culture and increase opportunity
- Encourage civic pride and social responsibility
- Strengthen partnerships, participation and a place-based approach

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MINUTES OF
HEALTH SCRUTINY COMMITTEE

Tuesday, 25 June 2019
(7:00 - 8:05 pm)

Present: Cllr Eileen Keller (Chair), Cllr Paul Robinson (Deputy Chair), Cllr Mohammed Khan and Cllr Chris Rice

Also Present: Cllr Jane Jones

Apologies: Cllr Donna Lumsden and Cllr Emily Rodwell

1. Declaration of Members' Interests

Councillor C Rice stated that he was a member of North East London Foundation (NELFT) Trust's governing body.

2. Minutes - 25 March 2019

The minutes of the meeting held on 25 March 2019 were agreed.

3. Barking, Havering and Redbridge University Hospitals NHS Trust - Financial Recovery Update

The Chief Finance Officer for the Barking, Havering and Redbridge University Hospitals Trust (BHRUT) delivered a presentation updating the Committee on its financial recovery.

Members noted from the presentation that:

- There was no material or structural reason why the Trust should be making losses;
- A large part of the deficit (around £30m) was driven by inadequate local health infrastructure;
- The Trust would save around £60m if it could become as efficient as the top 25% of trusts in the country, by focusing on improving quality and reducing waste which would be better for patients;
- Key 'deficit drivers' were the historic local health economy and the excess cost of employing temporary staff;
- The Trust was implementing 'The PRIDE Way' which was a quality improvement method, used by the Virginia Mason Hospital in Seattle, that focussed on improving quality and reducing waste;
- The Trust had big ambitions to become among the best integrated care systems and was working with its partners to achieve this; and
- The Trust would be refreshing its Clinical Strategy this year which would provide a renewed focus on achieving high quality and efficiency.

In response to questions, Dr Smith, Chief Medical Officer for BHRUT stated that:

- Whilst it was true that the Trust had a long history of high usage of temporary and agency staff, it was continually working to make progress on

this; for example, the Trust had changed its offer in relation to its emergency care consultant vacancies and developed an Academy of Emergency Medicine in relation to junior positions in the Emergency Department, both which had been very successful. It had taken a similar approach to recruitment to its surgical team which had helped to fill 23 of its hard to recruit to vacancies and was now replicating this for recruitment into some acute care specialities. The Trust had also developed other clinicians to take on advanced roles and produced a Nursing Workforce Strategy. Nevertheless, the high usage of temporary and agency staff was still a big challenge for the Trust and it would continue to work hard to find ways to manage this. The Trust was not alone in facing recruitment challenges - there were approximately 50 GP vacancies which was a huge strain on the system. All key local partners, including the Council, should be working together imaginatively to make working in this part of London more attractive;

- With regards to reducing waiting times, one of the main challenges was to reduce demand which was a health-system wide issue. The adoption of the PRIDE way had helped the Trust to look at the processes and pathways in great detail and eliminate waste, which included patient waiting times. Much of this work related to what the Trust termed 'reducing waste in system'; for example, it used to be the case that when a patient suffered a fracture, they would be required to come to the fracture clinic, sent away for tests, and then return to the clinic and referred for treatment – not all these visits were necessary, and amounted to 'waste in the system'. Furthermore, the Trust would need to look at reducing waste in relation to how it managed long term conditions and it was also in discussions with NELFT on better ways to work together for patients with mental health conditions, which was a significant issue. However, the reduction in 'waste in the system' could not be delivered by the Trust in isolation and would need the involvement of primary care and other key stakeholders to bring real transformation to the patient experience. This was not about turning patients away but looking at ways to streamline pathways and ensuring patients were receiving the most appropriate care at the right time, for example, one of the consultants in the fracture clinic believed waiting times could be reduced by half if he were to undertake more virtual consultations. Also, some work needed to be done to ensure its directory of specialties was very clear so patients were always referred to the right professional in the first instance.
- The Trust accepted that according to predictions about the growth of the population in North East London in the future, and the demand this would bring for its services, it faced a huge challenge. The local health system would have to undergo transformation to bring forth the financial benefits of integrated care. In theory each extra person would attract an allowance; however, the reality was more complicated than that. The Trust would be consulting on its Clinical Strategy later this year, which would need to take future population growth into account.

Members welcomed the measures taken by the Trust to reduce waiting times; however, stated that the caveat to this was that there would always be a group of vulnerable patients for whom new approaches may not be appropriate, such as those with learning difficulties, or elderly patients, who may not be able to participate in a virtual consultation without the correct support. Members asked the

Trust to ensure all departments within the Trust were aware of this and had the arrangements in place to provide the best care to these groups. Members also asked the Trust to ensure it services were user-friendly for patients who used ambulance to travel to and from their services, so that for example, they were not waiting for long periods of time after their appointment to be picked up and taken home. Dr Smith agreed that this was a very important point and assured the Committee that when reconfiguring services, the Trust always consulted its patient partners to ensure services would meet the needs of all patients, including the most vulnerable.

4. Barking, Havering and Redbridge University Hospitals NHS Trust - Health Education England Focus Group's Findings

Dr Smith delivered a presentation explaining the findings of Health Education England (HEE) in relation to the standards of staff training and medical education, and the actions taken by the Trust in response to HEE's report.

Members noted from the presentation that;

- BHRUT hosted a large number of doctors in training. As part of the monitoring service for feedback from trainees, HEE, along with the General Medical Council (GMC), undertook reviews on the quality of the trainee experience. In addition, HEE undertook a risk-based trainee focus group visit to the Trust on the 2 April 2019, which was planned following the release of the GMC National Training Survey 2018 results. During this visit, some concerns were raised in relation to the acute medical on-call rota, clinical supervision, the relationships between the higher medical trainees and the Emergency Medicine department;
- As a result of the visit, HEE issued nine mandatory improvement requirements to the Trust and this led to the GMC placing Acute Medicine into enhanced monitoring, due to the potential for patient harm (no harm had actually occurred); and
- Dr Smith and the Director of Medical Education took these concerns very seriously and were leading the improvement work plan. The Trust continued to work the HEE and GMC and had provided evidence of progress in line with the HEE Quality Visit Action Plan.

Dr Smith took members through the nine mandatory improvement actions the Trust was progressing in detail.

Whilst members were pleased that there were now more individuals that trainees could report issues to, they expressed concern that it had taken a HEE visit for the Trust to become aware that it had a problem. Members also expressed concern that the problems faced by doctors in training could be similar to those faced by other professionals in the Trust, such as nurses. The Trust's ICE assured members that it was confident that trainees in other professions did not face a similar experience as the management and accountability structure was clearer and the supervision requirements were more developed. The ICE accepted that the Trust needed to work very hard with regards to the culture around doctors in training to ensure all colleagues knew the value of working together. It had already started this work, using the PRIDE way's 'Respect for People' framework to establish high standards; however, it would take a number of years to achieve this.

Members expressed concern that some of the required actions identified by the HEE were basic, such as providing evidence that the consultant on-call was clearly identified and providing supervision and support to medical trainees. Dr Smith accepted that this was the case and added that sometimes organisations needed a mirror held up to them to see where poor practice was occurring. The Trust had a long journey ahead to get to the standards required and telling all staff to listen first would be her 'mantra' going forward.

Members asked how consultants were held accountable in terms of their management of staff. Dr Smith stated that over the last few months, it had worked hard to get recognition amongst consultants that there were significant issues in the management of trainees, which had to be overcome. Its next steps were to get to a point where it was tackling all incidents of poor behaviour by building capacity to do this. It had, for example, developed its clinical leadership, appointed clinical leads, and clarified structures and expectations.

Members commented that addressing HEE's concerns and going even further to provide an excellent training experience for trainees was crucial to the Trust's future, otherwise trainees would not return to work for the Trust once they qualified. The ICE assured the Committee that the Trust's Board was absolutely determined to address all the actions and build on them to create a positive culture in the long term. Dr Smith assured members that there were now clearly identified leads whom trainee doctors could talk and report to regarding any problems they were facing. In addition, all trainees had access to a 'Guardian of Safe Working', an internal consultant who was separate to the Trust's Board to whom they could raise concerns anonymously. The Trust had also carried out workshops to help with problem solving in the context of team working.

Members asked whether the Trust had arrangements in place to support trainee doctors who had ambitions to become future leaders, such as opportunities to shadow consultant leaders. Dr Smith stated that all trainees had to demonstrate elements of leadership training as part of their 'sign-off' and there were opportunities to shadow board directors. Senior trainees could apply for Chief Registrar posts, which had protected leadership and management time. The Trust also had a number of staff undertaking a Darzi Fellowship, (a one-year programme aimed at those at the start of their leadership journey, undertaking one main project for the Trust as their sponsor). However, the Trust could do more on this aspect, and she would take this back as a recommendation for the Trust to reflect further on.

The Chair thanked the Trust's representatives for attending the meeting and taking the time to answer its questions.

5. Joint Health Overview and Scrutiny Committee

The Chair asked members to note a report on the Joint Health and Overview Committee (JHOSC), which, as well as providing information on local joint health scrutiny arrangements between the borough and other boroughs, asked the Committee to confirm the appointment of three of its members to the JHOSC.

The Committee agreed to appoint Councillors E. Keller, P. Robinson and M. Khan to the JHOSC for the 2019-20 municipal year.

6. Work Programme

The Chair, having explained that the Work Programme was a flexible document, in order to be able to reflect changing local priorities, asked members to review the Committee's draft Work Programme and welcomed suggestions for other items for consideration by the Committee.

The Committee agreed the Work Programme.

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HEALTH SCRUTINY COMMITTEE

3 September 2019

Title: Barking & Dagenham, Havering and Redbridge Integrated Care Partnership and Provider Alliance Updates	
Report of the BHR Clinical Commissioning Groups and Barking, Havering & Redbridge University Hospitals Trust	
Open Report	**For Information**
Report Author: Eleanor Durie, Communications Manager, BHR CCGs Natasha Dafesh, Senior Communications Officer	**Contact Details:** Tel: 020 3688 1577 E-mail: eleanor.durie@nhs.net Tel: 01708 435 022 Ext: 2522 Email: natasha.dafesh@nhs.net

Summary

Alison Blair, Director of Transition for Barking and Dagenham, Havering and Redbridge (CCGs) will deliver the presentation at Appendix 1, which provides an update on the work of the BHR Integrated Care Partnership.

Matthew Cole, the Council's Director of Public Health, on behalf of Fiona Peskett, Director of Provider Alliance (Barking, Havering & Redbridge University Hospitals Trust) will present the update at Appendix 2, on the Provider Alliance.

Recommendations

The Health Scrutiny Committee is recommended to note the updates and ask questions of the presenters on the work of the Integrated Care Partnership and Provider Alliance to ensure service improvements and health outcomes for the Borough's residents are being delivered.

Reason

The Health Scrutiny Committee has the key responsibility of holding health partners and services accountable for the health outcomes of the Borough's residents.

Public Background Papers Used in the Preparation of the Report:

List of Appendices:

Appendix 1 – BHR Integrated Care Partnership Update
Appendix 2 – Provider Alliance Update

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Appendix 1

BHR Integrated Care Partnership
Better care, better lives, together

BHR Integrated Care Partnership update

Alison Blair, Director of Transition - Barking and Dagenham, Havering and Redbridge

Barking and Dagenham Health Scrutiny Committee

3 September 2019

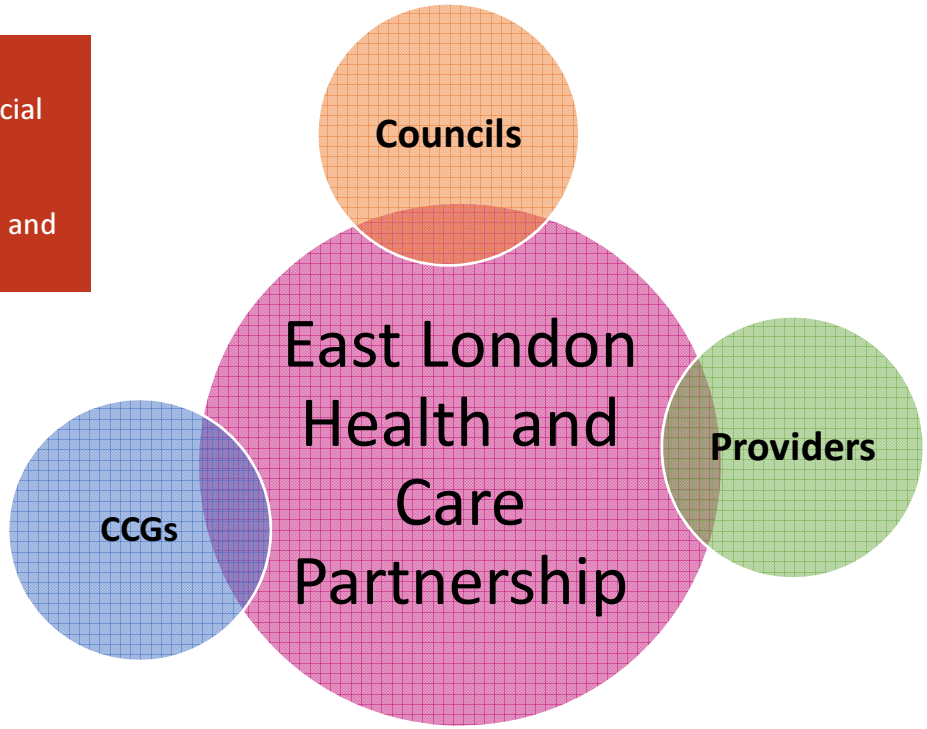





East London Health and Care Partnership (ELHCP)

East London Health & Care Partnership

Councils
Local councils commission social care services such as sexual health, drug and alcohol, and some mental health services, and residential care homes.



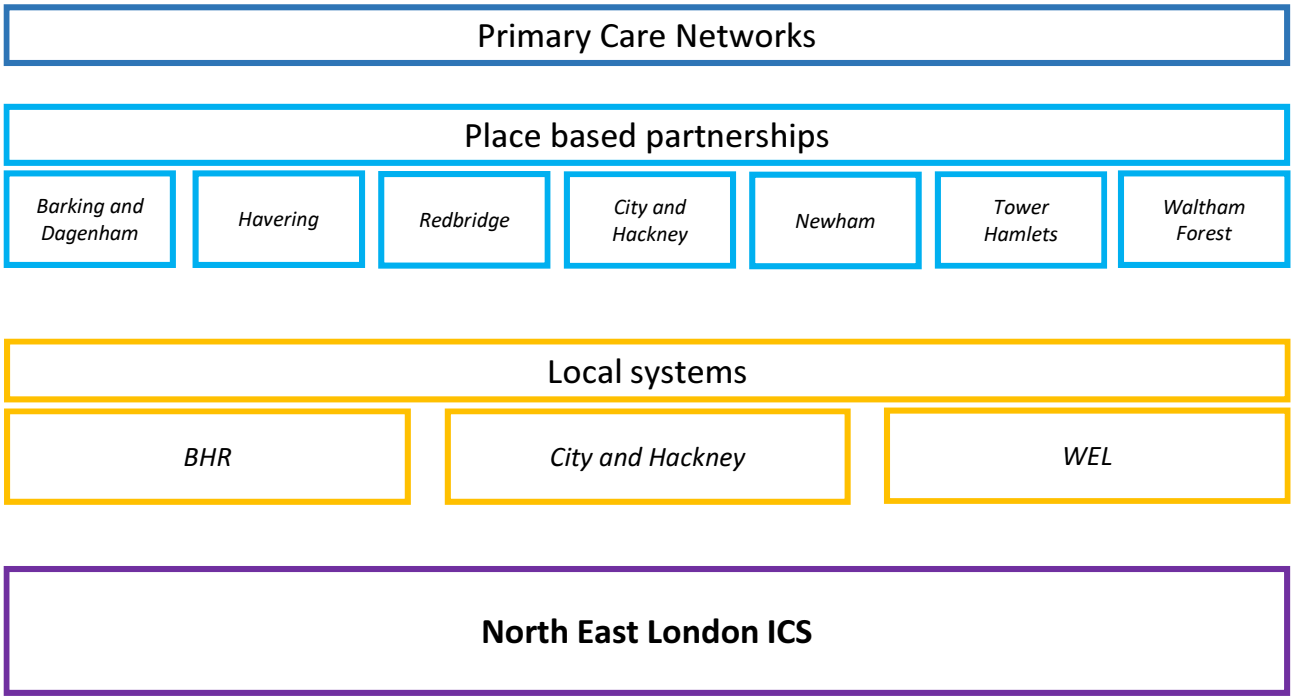
Providers
These organisations deliver health services such as GP practices, hospitals, mental health, and community services. Providing inpatient, outpatient, emergency and planned services, mental health and community services, in hospitals, clinics and people's homes.

NHS Clinical Commissioning Groups (CCGs)
Plan and buy health services for the residents in their borough: from cancer care to mental health; hospital operations to prescriptions.

Together these organisations plan and coordinate health and social care across north east London
=
East London Health and Care Partnership (ELHCP).

North East London Integrated Care System (ICS)

East London Health & Care Partnership



ICP VISION

Source: BHR Accountable Care Strategic Outline Case, November 2017

To accelerate improved health and wellbeing outcomes for the people of Barking and Dagenham, Havering and Redbridge and deliver sustainable provision of high quality health and wellbeing services.

Barking and Dagenham, Havering and Redbridge Integrated Care Partnership statement of purpose

Integrated culture

- The ICPB has agreed a set of values and principles (see below)
- The ICPB recognises there is a lot more work to be done to engage with staff and is exploring how to take this forward with comms leads from each respective ICP organisation.

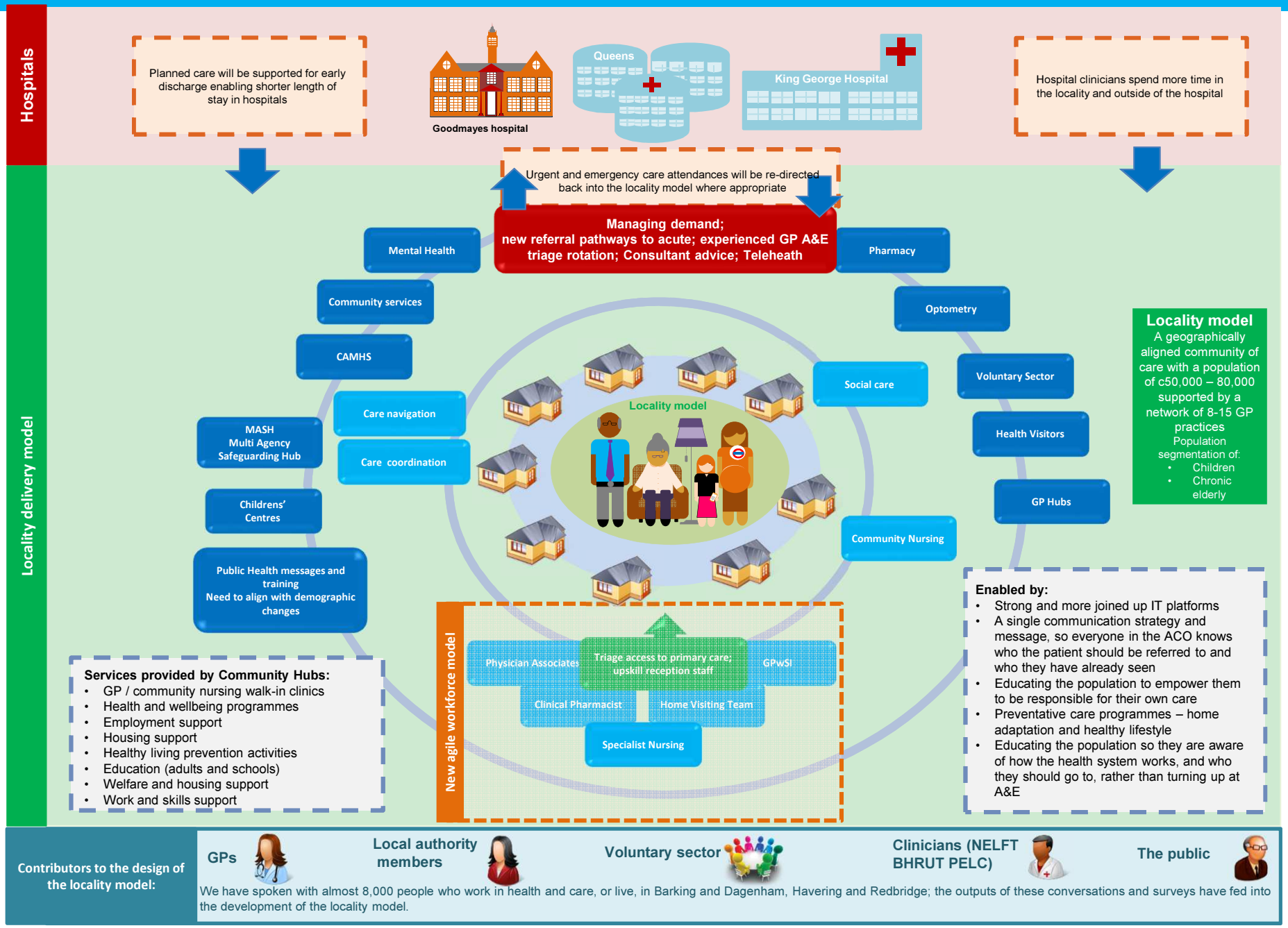
Values

- ✓ To sign up to our joint vision, putting the patient and public at the centre of our work
- ✓ To put quality and safety at the heart of everything we do
- ✓ To work together to deliver the vision, not undermine each other
- ✓ To lead, not blame
- ✓ To look for answers not give excuses

Principles

- ✓ We work in partnership and demonstrate respect for all professional perspectives
- ✓ We aim for agreement wherever possible and stick to it
- ✓ We aim for honest closure where we cannot agree
- ✓ We speak well of each other
- ✓ We involve each other as early as possible
- ✓ We try our hardest to work on a 'no surprises' basis
- ✓ When we collectively give authority to team members to act, we let them deliver

Delivery model



Transforming Health and Care in BHR

System challenges

Health and wellbeing challenges

Care and quality challenges

Funding and efficiency challenges

BHR CCGs; *High impact transformation areas targeted to address key challenges using principles of integrated care vision*

	Prevention	Primary care	Planned care	Unplanned care
	Moving care upstream to prevent deterioration, includes wider determinants of health. Focussed on prevention of disease and ill health	Develop primary care at scale including workforce and supporting delivery of more integrated care through GP Fed development	Care in right place, first time, reducing inappropriate activity, and improving effective decision making	Reducing inappropriate demand, admissions and ensuring appropriate length of stay (reducing delayed discharges)
Older people, frailty & end of life				
Children & Young People				
Long term conditions				
Mental health				
Medicines optimisation				
Maternity				
Cancer				

BHR Joint Commissioning Board; *Developing cross system strategic commissioning to deliver integrated care system vision*

- **Frailty**
- **To be scoped**
- **Diabetes & AF**

Key enablers including:

- Develop Joint Commissioning opportunities
- Population Health management
- New digital platform
- Robust workforce plan
- Robust comms and engagement
- Fit for purpose estates

Barking Riverside; place based care model

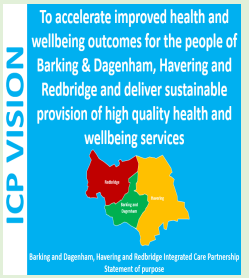
Corporate objectives

- Securing financial recovery
- Development of an accountable care system
- Delivery of our CCG and system-wide transformation programmes for planned, urgent and emergency, complex and mental health care
- Continued implementation of our agreed Primary Care Transformation Strategy
- High quality safe and compassionate care from all commissioned services. - delivering better outcomes

BHR Provider Alliance

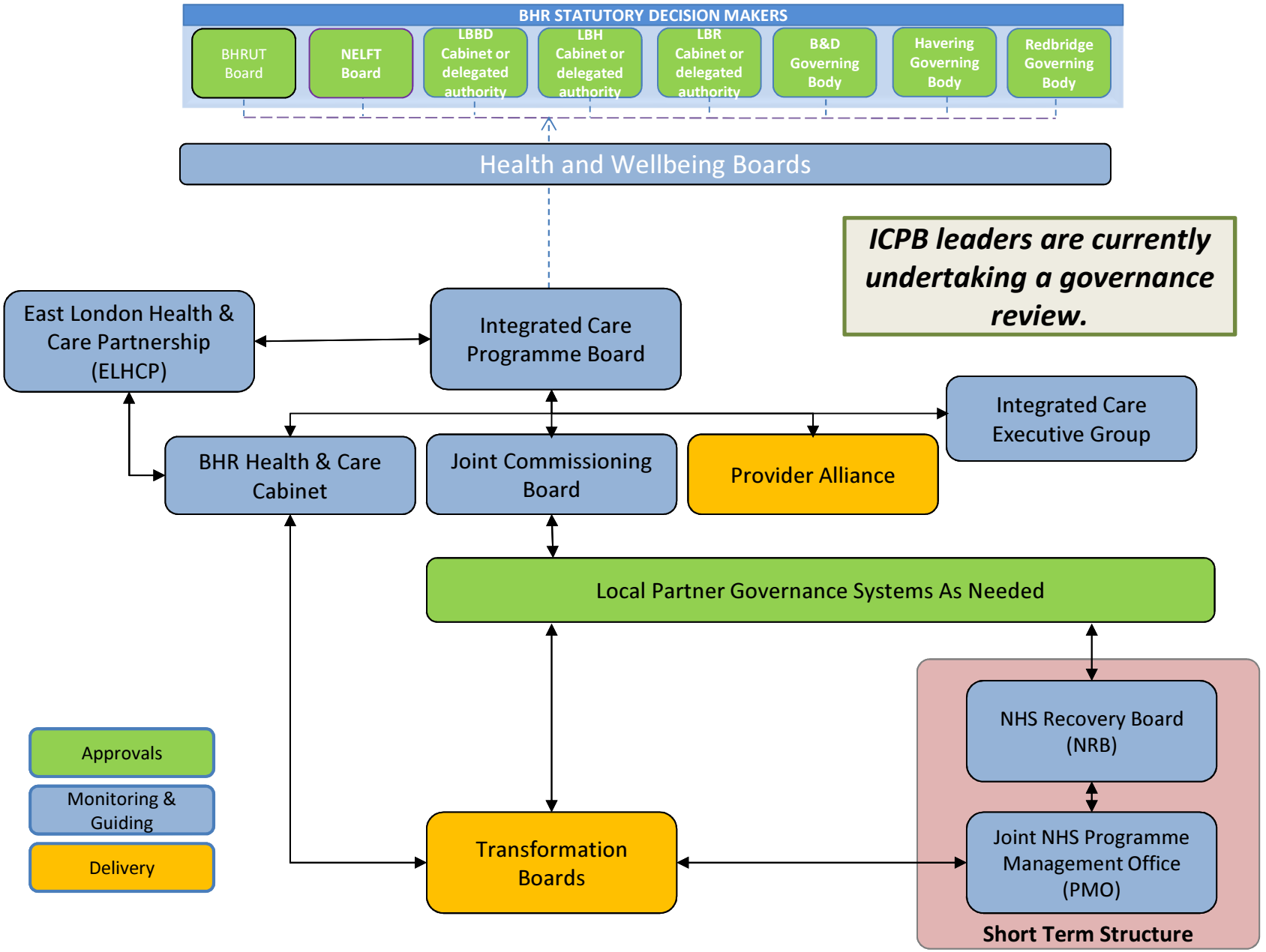
Development of Integrated Care System delivery model

Vision



New delivery model achieving improved health and wellbeing outcomes for local people

System Leadership – current integration governance -



Transformation Board achievements

East London Health & Care Partnership

Children and young people

- Full multi-agency agreement on the shared vision for CYP services and the requirement for cultural change.
- An agreed whole system view and a common understanding on the areas requiring prioritisation.
- Full agreement to ensure focus on service user experience and outcomes and an avoidance of operational distractions.

Older people and frailty

- Falls prevention: published BHR Falls Strategy and expansion of Age UK led strength and balance exercise groups across BHR.
- Home-is-best (admission avoidance): 2 week trial in July as part of BHRUT's a "Perfect Tweek Week" successfully diverted 19 patients from admission and established daily collaborative decision-making "huddle" between multiple-provider teams.
- Care homes: "Significant 7" training for nearing 1000 care-home staff to recognise early signs of health deterioration and alignment of a GP practice with named nursing home through an integrated nursing homes scheme.
- End of life care: roll-out of "Coordinate My Care" from April 2019, with the commencement of a local incentive scheme and targeted IT support.

Transformation Board achievements

East London Health & Care Partnership

Cancer

- Health Promotion Champions to engage with BME and other hard to reach groups (five champions per CCG).
- Implemented bowel screening coordinator to increase screening rates.
- Implemented faecal immunochemical testing to enable GPs to test patients who have blood present in stools, preventing the need for endoscopies.
- Became part of the SUMMIT study to increase early lung cancer detection.

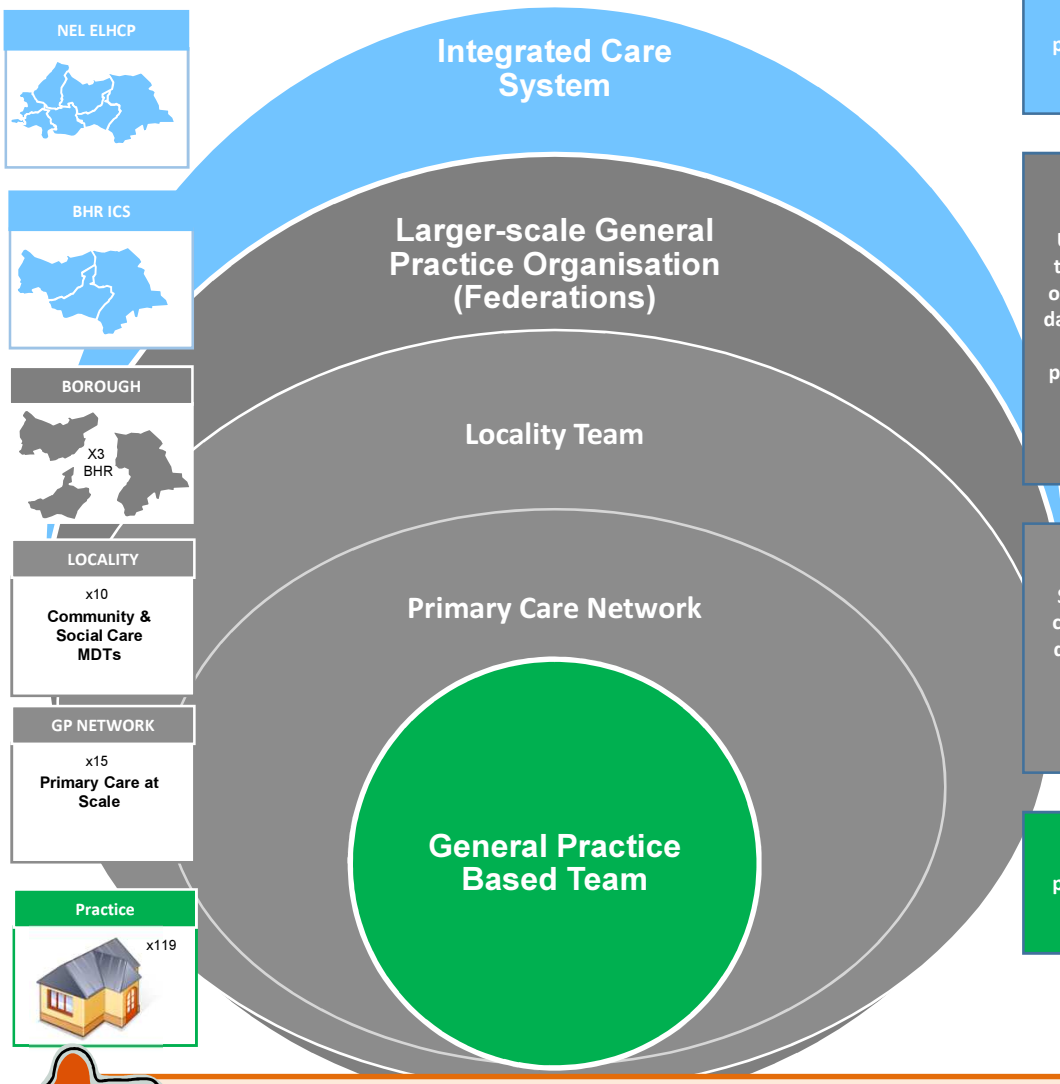
Long term conditions (LTC)

- 2019/20 LTC GP Local Incentive Scheme in place with continuing focus on diabetes treatment targets and targeted atrial fibrillation detection.
- Developed opportunistic atrial fibrillation detection scheme with BHRUT and community pharmacy partners – business case to be brought in early September.
- Agreed to pilot LTC multidisciplinary team (MDT) focussing on complex patients – pilot will test the hypothesis that MDT working can reduce non elective admissions for this patient group.

Mental health

- Developed and agreed a tool for measuring system impact.
- Undertook and completed a draft mapping of adult mental health system to inform the new model of care.
- Agreed a new service model for the delivery of Improving Access to Psychological Therapies.

Integrated Care System in Context



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

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

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

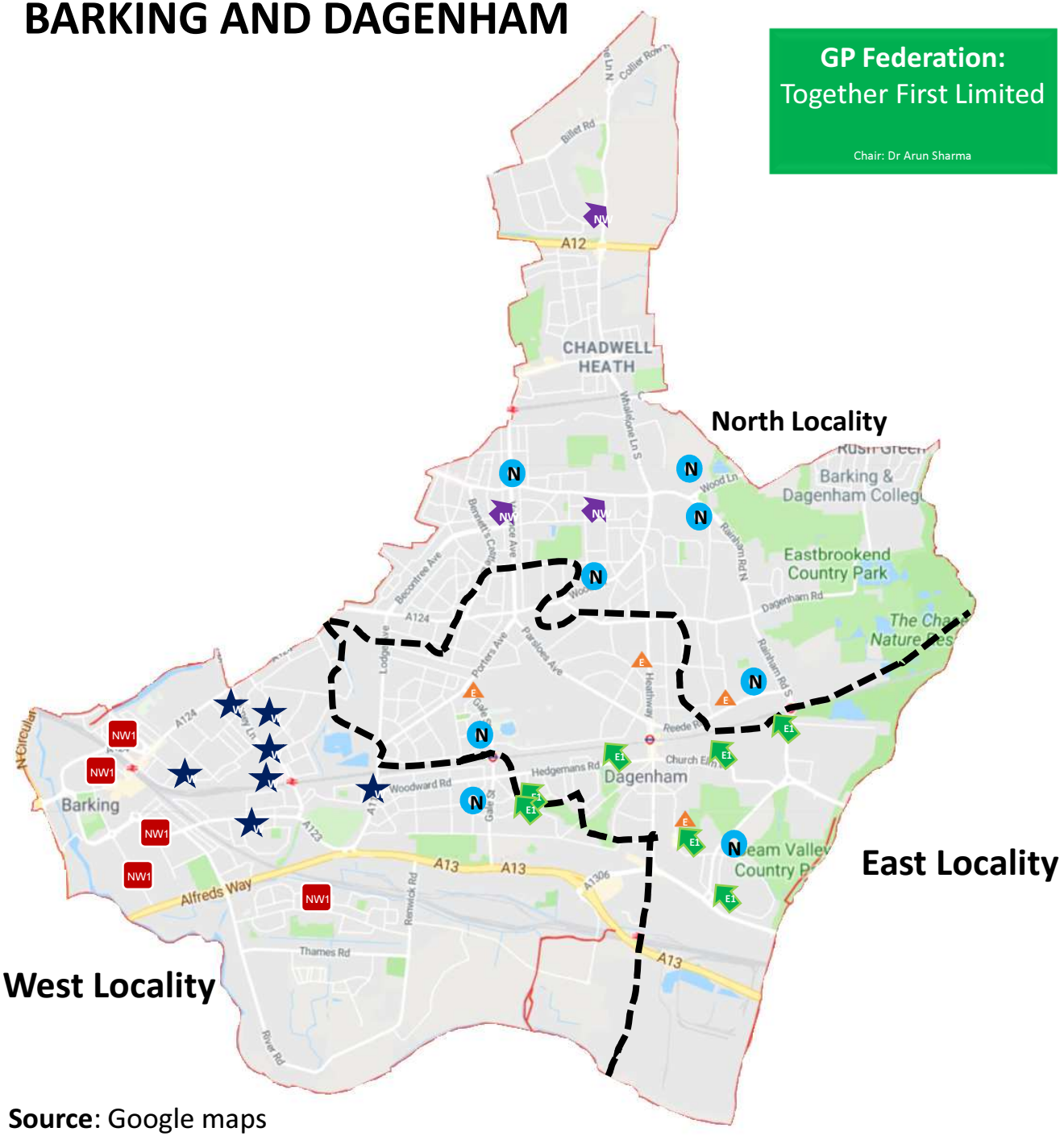
General practice as the foundation of a wider Integrated Care System, working in partnership with other health and care providers to collaboratively manage and provide integrated services to a defined population within a shared budget.

The **Primary Care Network** model is at the core of both the development of General Practice in its own right, and as the foundation of place-based, integrated care. The **GP Federations** are a key platform to expand on the benefits of PCNs and enable further commissioning and to achieve economies of scale at both a borough (single GP Federation) and multi borough (e.g. three BHR Federations working together) level.

BARKING AND DAGENHAM

GP Federation:
Together First Limited

Chair: Dr Arun Sharma



Source: Google maps

North Primary Care Network; 8 practices List size 43,239	
Green Lane Surgery	3740
Dr S Z Haider & Partners	5704
Dr A K Sharma	9872
Dr A Arif	4533
Five Elms Medical Practice	4057
Gables Surgery	6876
Dr M Ehsan	3042
Dr B K Jaiswal	5415
	43,239

North West PCN; 3 practices List size 32,637	
Marks Gate Health Centre	4943
Tulasi Medical Centre	21062
Becontree Medical Centre	6632
	32,637

West One Primary Care Network; 7 practices list size 42,919	
Dr P. Prasad	2430
Drs Chibber & Gupta	4465
Drs Sharma & Rai	5492
Highgrove Surgery	7961
Dr Ansari & Ansari	8270
The Barking Medical Group Practice	11348
The John Smith Medical Centre	2953
	42,919

New West PCN: 5 practices List size 30,973	
Abbey Medical Centre	6949
Dr G. Kalkat	8538
Dr N. Niranjan	4869
Drs John & John	8415
Shifa Medical Practice	2202
	30,973

East Primary Care Network; 4 Practices List size: 39,458	
Broad Street Medical Centre	6553
Porters Avenue *(merged 01.04.2019 with Child & Family)*	8898
Church Elm	6204
Halbutt Street Surgery	6779
Child and Family Health	11,024
	39,458

East ONE Primary Care Network; 7 Practices List size: 37,134	
Dr Alkaisy Surgery	4682
First Avenue Surgery	5401
Heathway Medical Centre	4895
Hedgemans rd	5717
Parkview	4598
St Albans Surgery	8076
The Surgery (Dr Ola)	3765
	37,134

North East London Commissioning Alliance (NELCA)

East London Health & Care Partnership

- Commissioner landscape in NEL
- 7 CCGs = 3 local integrated care systems (ICS)

- Barking and Dagenham
- Havering
- Redbridge
- Waltham Forest
- Newham
- Tower Hamlets
- City and Hackney

- 7 NELCA CCGs to merge into a single CCG by April 2021

Questions?

NELFT NHS
NHS Foundation Trust

Barking, Havering and Redbridge NHS
University Hospitals
NHS Trust

PROVIDER ALLIANCE UPDATE

WHAT IS THE PROVIDER ALLIANCE

The Provider Alliance was set up in October 2017 following recommendations from the BHR Joint Delivery Review (July 2017) produced by PWC.

The Provider Alliance wants to work with system partners to create a coordinated approach to delivering services and to look at opportunities to integrate services differently in order to better meet the needs of our local population.

As the NHS nationally moves towards more integrated and collaborative care across the country, we are looking at ways to work more closely together in Barking & Dagenham, Havering and Redbridge (BHR).

The approach of the Provider Alliance is to work in partnership with the public to ensure that services are fit for future generations and take into consideration the views and ideas of our local people.

MEMBERS OF THE PROVIDER ALLIANCE

The main providers involved in the BHR Provider Alliance are:

- BHRUT (Barking, Havering and Redbridge University Hospitals NHS Trust)
- Barking and Dagenham GP Federation
- Havering GP Federation
- Redbridge GP Federation
- NELFT (North East London NHS Foundation Trust)
- London borough of Barking and Dagenham
- London Borough of Havering
- London Borough of Redbridge

We are also supportive of working collaboratively with other health care providers in the BHR system including voluntary services.

CONTEXT AND PURPOSE OF THE PROVIDER ALLIANCE

Demand for services is increasing and we know this will continue as our local population grows over the coming years.

We need to deliver health and social care differently to support this and ensure patients get the right care, at the right time, in the right place.

Providers of health and care across our boroughs are coming together to review how we can ensure high quality services for our patients in future years.

We want to work together to deliver a more coordinated approach to delivering services, and to look at opportunities to design and deliver services differently, to better meet the needs of our local population.

The approach of the Provider Alliance is to work in partnership with the public to ensure that services are fit for future generations, and take into consideration the views and ideas of our local people.

WHAT THE PROVIDER ALLIANCE HAS DONE SO FAR

Since the creation of the Provider Alliance, all necessary terms of reference and memorandum of understanding have been established.
Membership to the Provider Alliance ensures that all care and health providers are represented with meetings scheduled monthly.

Work of the Provider Alliance has concentrated on forming relationships between providers in the system and promoting a collaborative culture towards creating integrated care pathways.

It has focused particularly on:

- Place Based Care for Frailty
- Innovation and population growth
- Engagement with the Primary Care Networks (PCNs)

Place Based Care for Frailty
We want to better support frail people who are independently living in their own homes.

The aim is to plan how we join up services in each borough to help frail people remain independent and to receive the right care at the right time.

We are working with external support commissioned by BHR CCGs to develop a model of place based care that can provide integrated services in each of our boroughs. We are doing this through the BHR Older People Transformation Board.

Innovation and population growth
We will be supporting the work to develop innovative new models of care for BHR system, including the health centres at Barking Riverside and St George's (South Hornchurch) and the Health and Care Hubs in Redbridge.

Primary Care Networks
The CCGs have tasked the Provider Alliance in supporting the development of the Locality Teams that will work in the Primary Care Networks neighbourhoods.

LOOKING FORWARD AND NEXT STEPS

The Provider Alliance are seeking to support a BHR system Care and Clinical Strategy that will reflect the BHR Clinical Financial Recovery Plan, and that will link to the transformational work currently proposed.

The Provider Alliance will provide leadership on the journey towards a BHR Integrated Care System in line with the NHS Long term plan which states that all of England will be covered by integrated care systems (ICSs) by April 2021.

HEALTH SCRUTINY COMMITTEE

3 September 2019

Title: Consultation on Proposed Continuing Healthcare Placement's Policy	
Report of the Barking & Dagenham, Havering and Redbridge Clinical Commissioning Groups	
Open Report	**For Information**
Report Author: Masuma Ahmed, Democratic Services Officer	**Contact Details:** Tel: 020 8227 2756 E-mail: masuma.ahmed@lbbd.gov.uk
Accountable Director: Fiona Taylor, Director of Law and Governance	

Summary

NHS continuing healthcare (CHC) is the name given to a package of ongoing care that is arranged and funded solely by the NHS for adults who have been assessed as having a 'primary health need', as set out in the Department of Health and Social Care's national framework for continuing healthcare (see https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care).

In line with other Clinical Commissioning Groups (CCGs) across England, the Barking & Dagenham, Havering and Redbridge CCGs are looking to introduce a written 'placements policy' to support how decisions are made as to where CHC patients receive their individual packages of care. The policy will also outline how patients and their families or carers can appeal decisions. This policy is **not** about deciding whether an individual is eligible for CHC – this continues to be managed in accordance with the national framework for continuing healthcare.

The key content of the proposed policy includes:

- Considerations taken into account when deciding the most appropriate location for a person's CHC package (e.g. at home or in a care or nursing home);
- Exceptional circumstances taken into account when deciding the most appropriate location for a person's CHC package;
- How CHC packages are funded;
- The review process for CHC packages; and
- The appeals process for when patients or their families/carers disagree with a decision.

A full copy of the proposed CHC placements policy along with an initial equality impact assessment (EIA) can be found on www.barkingdagenhamccg.nhs.uk/CHC-consultation.

Dr Amit Sharma, Clinical Lead for Continuing Healthcare and Sharon Morrow, Director of Transformation and Delivery – Unplanned Care, will deliver the presentation at Appendix 1 to this report, which provides further detail on the proposals, and take the Committee's questions and comments.

Recommendation(s)

The Health Scrutiny Committee is recommended to:

i. Note the presentation;
ii. Ask questions of the Clinical Lead for Continuing Healthcare and the Director of Transformation and Delivery– Unplanned Care to determine how the potential changes will affect the Borough's residents and
iii. Delegate authority to Councillor Keller, the Chair, to formally respond to the consultation by the consultation deadline (5pm, 30 September 2019).

Reason(s)

This consultation relates to the Council's priorities to enable greater independence whilst protecting the most vulnerable and strengthen our services for all.

NHS bodies have a statutory duty to provide information and consult the Health Scrutiny Committee on proposed development or changes to the provision of health services.

Public Background Papers Used in the Preparation of the Report:

BHR CCGs' CHC Consultation Document:
http://www.barkingdagenhamccg.nhs.uk/downloads/BHR-CCGs/Our-work/CHC-consultation/July-2019-BHR-CCGs-CHC-policy-consultation-doc-FINAL.pdf

List of Appendices:

Appendix 1 – BHR CCG Presentation on proposed Continuing Healthcare Placements Policy

Appendix 1

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

Continuing healthcare placements policy

Barking and Dagenham Health Scrutiny Committee
3 September 2019

Dr Amit Sharma, Clinical Lead for Continuing Healthcare
Sharon Morrow, Director of Transformation and Delivery – Unplanned Care
BHR CCGs

NHS
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Clinical Commissioning Groups

Aim of tonight's presentation

- ✓ Provide members with an overview of the continuing healthcare process
- ✓ Brief members on BHR CCGs' proposed written continuing healthcare placements policy
- ✓ Update members on the public consultation approach
- ✓ Seek feedback from members on the proposed policy.

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

What is continuing healthcare?

NHS continuing healthcare, often called CHC, is the name given to a package of ongoing care that is arranged and funded solely by the NHS for adults who have been assessed as having a ‘primary health need’, as set out in the Department of Health and Social Care’s (DHSC) national framework for CHC.

DHSC. National framework for NHS continuing healthcare and NHS-funded nursing care. October 2018 (revised). Available at: https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

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CHC eligibility and assessment

- The CCGs work to the National Framework for NHS Continuing Healthcare and NHS funded Nursing Care, which sets out the principles and processes of NHS CHC. This includes:
  - Screening for CHC
  - Assessment of eligibility for CHC
  - Decision making on eligibility
  - Care planning and delivery
  - CHC reviews
  - Requests for review of CHC eligibility
- Eligibility for NHS CHC depends on the assessed needs, and not on any particular disease, diagnosis or condition.

CHC eligibility and assessment, cont.

- Patient, their family or carer inputs into the assessment
- Multi-disciplinary team recommends to the CCG whether a patient meets the DHSC criteria for NHS funded CHC
- CCG decides if the patient is eligible for CHC based on the recommendation, assessment and supporting evidence
- Eligibility reviewed at least once a year – if needs change the package of care may change.

Location of care

- CHC packages are provided in different settings, including:
  - In an individual's own home – the NHS will pay for healthcare, such as services from a community nurse or specialist therapist, and personal care, e.g. help with bathing, dressing and laundry
  - In a care or nursing home – the NHS will pay, along with healthcare and personal care, for care or nursing home fees, including board and accommodation.

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Who receives CHC and where?

- Approximately 530 people in BHR currently eligible for CHC
  - Barking and Dagenham – 149 people
- 70% of eligible patients receive CHC in a care or nursing home
- Factors considered when deciding location of care:
  - Clinical safety
  - Support available from family or friends
  - Suitability of home setting
  - Comparable costs of home versus care or nursing home care.

Cost of CHC

- Cost to the local NHS of a CHC package is:
  - For care at home – cost ranges from around £70 to £8,000 per week (around £3,640 to £416,000 per year)
  - For care in a local care or nursing home – cost ranges from around £868 to £6,870 per week (around £45,136 to £357,240 per year).

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What's changing?

Introduction of a written CHC placements policy

Why are we introducing a CHC placements policy?

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

- In line with other CCGs across England, we intend to introduce a written CHC placements policy
- The proposed policy will:
  - Support how decisions are made about the location of CHC packages
  - Balance clinical need, wishes of patients, and the limited financial resources available to the local NHS
  - Ensure consistency, fairness and transparency in the decision-making and appeals processes.
- Development of the policy is being led by our GP clinical leads and will align to the DHSC's national framework.

Who will the proposed policy apply to?

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- **Will apply** to all new patients eligible for CHC, and in a few cases to existing patients whose care needs have changed considerably since their last review (e.g. if a person's condition has deteriorated and they require significant extra care)

- **Will not apply** to anyone under 18 years or people assessed as needing 'fast-track' CHC (i.e. care which is provided to people who have a rapidly deteriorating condition and may be approaching the end of life).

How will the proposed policy affect patients?

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

- **Eligibility to receive CHC will not change** - all new and existing patients will continue to receive the most clinically appropriate care for their assessed needs

- Where a patient's care needs are very high it's likely the clinical decision will be that their care would be most appropriately provided in a care or nursing home, rather than in their own home

- For a small number of patients this might not be with the provider or in a location of their choice. It's expected this would be the case for around 20-25 patients a year - four per cent of all CHC patients in BHR.

What's included in the proposed policy?

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

- Key content of the proposed policy includes:
  - Considerations taken into account when deciding the most appropriate location for a CHC package
  - Exceptional circumstances taken into account when deciding the most appropriate location for a CHC package
  - How CHC packages are funded
  - Review process for CHC packages
  - Appeals process for when patients and/or their families/carers disagree with a decision.

Funding of CHC packages

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- The proposed policy explains that BHR CCGs will generally not fund a CHC package in a person's home if the cost of doing so is more than 10 per cent higher than providing the same care in a care or nursing home

- Where exceptional circumstances may apply, the local NHS will consider whether it should fund a placement that will cost more than the 10 per cent limit

- During the public consultation we are asking for views on what a reasonable upper cost limit is.

Appeals process

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

- The proposed policy explains how patients or their family/ carers can appeal decisions made about the location only of their CHC package
- Appeals about CHC eligibility are subject to a separate process set out by the DHSC
- Appeals will be heard by a panel consisting of lay members and clinicians
- During the public consultation, we are asking for views on the membership of the appeals panel and the amount of time individuals have to make an appeal.

Engagement activity in B&D

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- Patients currently receiving CHC in their own home have been written to and invited to attend an engagement workshop
- Engagement workshop being held on 4 September at the Ripple Centre
- Sent email to scrutiny officer, Healthwatch and Council for Voluntary Services requesting suggestions of additional community groups to invite to the workshop
- x2 articles included in B&D CVS e-news, promoting the consultation and engagement workshop
- Article in OneBorough council newsletter
- Requested inclusion of article in Healthwatch newsletter
- Article and dedicated webpage included on CCG's website
- Regular tweeting to promote consultation and encourage responses
- Questionnaire distributed to BHR members of the East London Citizens' Panel.

Public engagement

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

- **No decisions have been made on the final policy content**
- 12 week public consultation
- E-copies of proposed policy, consultation document and questionnaire sent to GP practices, care/nursing homes, trusts, councils, MPs, community and voluntary groups, and Patient Engagement Forum
- Current CHC patients and/or their family or carers have been written to
- Working closely with Healthwatch and community and voluntary groups
- Engagement workshop to be held in each BHR borough
- Please complete the questionnaire at: www.barkingdagenhamccg.nhs.uk/CHC-consultation
- Engagement period ends **5pm, Monday 30 September 2019**.

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Clinical Commissioning Groups

Any questions?

HEALTH SCRUTINY COMMITTEE

3 September 2019

Title: Update on Barking Riverside: Developing the health and care model, and specification for a Health & Wellbeing Hub	
Report of the Director of Public Health	
Open Report	**For Information**
Report Author: Matthew Cole Director of Public Health	**Contact Details:** Tel: 0208 227 3953 E-mail: matthew.cole@lbbd.gov.uk
Accountable Director: Matthew Cole Director of Public Health	
Accountable Strategic Leadership Director: Elaine Allegretti Director of People & Resilience	

Summary

On the 25th April, a large workshop was held with a mixture of professionals (mainly from the developer, the council/councillors and the Clinical Commissioning Group) and residents who had been involved in the Healthy New Towns programme and local voluntary groups with an interest in wellbeing to discuss the health and wellbeing outcomes sought for the Barking Riverside development. This was the beginning of a five-workshop series looking at elements of health and care delivery and the specification for a Health & Wellbeing Hub in the new district centre.

The single client brief for the Hub has been developed based on the discussions at the workshops and has been shared with the developers for their initial consideration. It is grounded in an emerging health and care model for the locality. There is a strong field of community engagement activity underway in this part of the borough, and the initial design brief has been shaped by involving those leading that activity, as well as a small number of further specific conversations with community members. For the next phase, a stronger and deeper emphasis on co-production will be employed, and the initial approach to this work is currently being designed.

Recommendation(s)

The Committee is recommended to:

i. Note this report and the presentation at Appendix 1, which will be delivered by Dr John Jagan, Chair of Barking & Dagenham Clinical Commissioning Group, and

ii. Ask questions of the Director of Public Health and Dr John to ensure that the project is on track to deliver on its status of 'healthy new town'.

Reason(s)

The Barking Riverside development is a unique opportunity to build health and wellbeing into a major new town in this part of London, building on its formal designation by NHS England as London's only Healthy New Town. The first stage has been to develop a specification for the Hub so that developers can consider the physical building requirements, but this is very much an initial stage, and the presentation will describe the important elements of a programme to ensure that the community, both existing and new, can shape the delivery of innovative and responsive health and care in the communities of Thames ward.

1. Introduction and Background

Both the Council in the *Borough Manifesto* and NHS England in their 5 *Year Forward View*, emphasise the need to refocus on prevention, integration and the joining up of services within health and social care. This vision for Barking Riverside Health and Wellbeing Hub (BRHWH), is to enable Thames Ward to flourish –working together to plan, develop and deliver the Healthy New Town by 2031. BRHWH is intended to be an example of outstanding community healthcare and integrated multi-agency work, in a way that exemplifies and catalyses the strategic direction of travel within Barking and Dagenham, NHS England and the public sector more generally.

BRHWH aims to:

- Bring providers together across the spectrum of health and social care, leisure and community to enable, empower and treat where appropriate
- Be inclusionary and accessible to all, promoting social interaction and fostering a sense of community
- Place service users and their experience at the heart of the service model
- Operate at a larger geography, by integrating with existing health and community infrastructure in Thames Ward and the wider Barking, Havering and Redbridge system
- Open its doors in 2021, with phased opening until fully functional by 2031

2. Thames Health & Social Care Locality Board

As part of the implementation of the Integrated Care System we have agreed with the CCG to establish the Thames Health & Social Care Locality Board chaired by Cllr Worby. The first meeting will be held on 25th September. Thames is the first Locality Board to be established in the BHR Integrated Care System. The Locality Board's purpose is to support the health and wellbeing of the population of Thames Ward by ensuring that health & care services (including wellbeing and prevention programmes) are:

- Commissioned and delivered in ways that are consistent with the agreed System for Health/Care Model
- High quality
- Holistic and joined-up
- Responsive to the needs and aspirations of the local community

The scope is for Locality 4, which is currently Thames Ward. This includes Barking Riverside, Scrattons and Thames View. However, longer-term development and boundary changes may impact on the scope. The system scope is to bring together the following stakeholders:

- Barking Riverside Ltd
- Community representation (both VCS and resident)
- LBBD, service blocks; plus BeFirst (as LBBD's Arms-length planning and infrastructure body)
- NHS

2.1 Locality Board Responsibilities

- Securing the voice of residents in decision-making about health & care (including the prevention and wellbeing agenda) services and activity in Thames Ward;
- Ensuring health and wellbeing provision is commissioned and delivered in line with the agreed System for Health/Model of Care
- Working with the BHR Provider Alliance to ensure these services are high quality and responsive to the needs of the local population;
- Working with local commissioners to inform commissioning decisions;
- Working closely with the Public Health team to embed a prevention and wellbeing agenda and activities within the locality.

3. The Legacy of Healthy New Towns

NHS England finalised the Healthy New Town Programme in April 2019. Whilst the initial funding has been spent on over 24 local projects, pilots and testbeds that were established to help make Thames Ward a happier and healthier place, there has also been work since April to ensure the health and wellbeing agenda in the neighbourhood doesn't lose momentum. In particular, the Healthy New Towns programme sets a strong precedent for genuine partnership working with residents by both commissioning a cohort of residents directly to deliver health projects and beginning to co-produce the model of care within the community.

On the 25th April, a large workshop was held with a mixture of professionals (mainly from the developer, the council/councillors and the Clinical Commissioning Group) and residents who had been involved in the Healthy New Towns programme and local voluntary groups with an interest in wellbeing. During this workshop, those in attendance felt the following collaborative working groups should be established to ensure the legacy of Healthy New Towns is being monitored through several lenses:

Working Group One:	A collaborative co-design group for the health hub that will be built at Barking Riverside
Working Group Two:	A collaborative co-design group to monitor, evaluate and transform the physical environment in Thames Ward so it becomes more health promoting
Working Group Three:	A collaborative commissioning group to encourage more local groups and residents to receive funding and recognition for their health work

Those who attended the workshop nominated one another to lead the various groups and to join those boards.

3.1 Working Groups

Co-design Group for the Health Hub: This group is being led by Mark Harrod from the CCG and Sarah McCready from Barking Riverside. The purpose of this group is to ensure that passionate residents and community groups can partner with the developer, the NHS and the council in designing the new health and leisure hub that is proposed for Barking Riverside. Co-production and co-design will be used throughout the process, and the emphasis is to ensure that this working group is equally formed of residents and professionals. It is also envisaged that this working group will consider other health assets in the area, such as the Thames View Health

Centre, as the goal is to make sure that changes to primary care is equitable across the whole of Thames Ward. This group will also consider the “model of care” for Thames Ward, by which we mean the decisions about how primary care is specifically delivered in the Thames Ward community, and what exactly is available for local people to access. This working group has already been meeting and has committed to targeted work over the summer with an architecture practice to undertake design feasibility on the centre.

Co-design Group for the Built Environment in Thames Ward: This group is being led by Matt Carpen from Barking Riverside Limited and Tessie Briton from Participatory City. The purpose of this group is to acknowledge that the built environment should have a major role to play in making local people healthier and happier if the urban design is health promoting. It is envisaged that this group will not only consider the design at Barking Riverside, where lots of the neighbourhood is still being developed and designed, but also what interventions can be put into the environment in Thames View and Scrattons Farm to make wellbeing choices as easy as possible for local people. This group is yet to meet, but it is envisaged that other developers in the area as well as BRL, the council and local people/community groups will work together to bring forward innovative physical interventions. It is also hoped that these interventions will be monitored and evaluated by the group so that we can all learn of the impact that these ideas can achieve.

Collaborative Commissioning Group for Community Led Health: This group is being led myself from the council as well as a local resident who has been involved in a community research project in Thames View. The purpose of this group is to connect both the local people and the local groups who are interested in creating health programmes with commissioners in the council and the NHS. One of the great aspirations for the emerging model of care is to empower more local people and groups to become the pathways where patients can access community support, particularly regarding social prescribing for areas like chronic pain, loneliness, mood disorders, physical activity and healthy eating. Therefore, creating a forum where commissioners can meet and be inspired by local people, and where local people can help inform commissioners about what the neighbourhood needs could be a very positive step. The leaders of this group have already met to strategize, with the first meeting of this working group being diarised for early September.

Membership for all these groups is being decided collaboratively during the meetings, with working group members taking the lead on cascading invites to other professionals or residents that the group feel is needed for input.

Appendices

Appendix 1 Presentation by the Chair of BD CCG

Appendix 1

BHR Integrated Care Partnership
Better care, better lives, together

Barking Riverside and Thames Ward; a new approach to wellbeing – model of care update

Barking and Dagenham Overview and Scrutiny Committee

Dr Jagan John, Chair, Barking and Dagenham CCG

3 September 2019

Recap: the Barking Riverside development

- 443 acres in south of Barking between Barking Town Centre and the River
- By 2037 – development in four phases will see:
  - 10,800 new homes
  - c22,000 new residents
- Thames Ward will eventually develop into 4th locality in B&D
- Announced as one of NHSE's 'Healthy New Towns' – the only one in London
- Developers are required to provide financial contributions to the development of health and care infrastructure to support the new population
- Opportunity to develop a genuinely integrated service with a focus on prevention, where there is currently a 'blank slate'

The building that will house the new model of care is now expected to be 'live' from 2022

Recap: Health provision now and in the future

- In the short term (2016/17– 2020/21), the CCG is working with three existing practices in the vicinity - Dr John's and Dr Kalkat's practices at Thamesview, and St Albans GP practice - to increase capacity and extend opening hours to provide primary care access to local people from 2017 to 2020/21 (up to potentially early 2022), until the new facility is in operation. Each practice developed a business case for the additional capacity, which underwent due scrutiny and review before approval.

- We expect that Barking Riverside residents will be able to register with the new wellbeing hub from 2022 - this timeline has slightly extended from April 2021, based on an update from the Developers

- The new facility / model needs to be flexible, seamless and person-orientated, with a focus on wellbeing, getting things right first time, and improving outcomes for local people.

- There is an opportunity to link health and wellbeing services to the physical assets of the site:
  - There will be a leisure centre in the footprint of the hub, alongside the clinical space. The principles emerging from the workshops and engagement with local people suggest that these spaces should feel integrated and seamless.
  - There is particular opportunity to capitalise on linking health and wellbeing services with the gym/leisure facilities, and to community assets such as education campuses e.g. the nearby Riverside Campus School, and other schools in the area.
  - The design of the wider environment is essential to the promotion of wellbeing i.e. green spaces that support walking and cycling and a commercial offer that promotes a nutritious food environment

Recap: where?


New station
Rivergate Primary School
New primary school
New primary school
Riverside Campus
Integrated Health & Wellbeing Hub

Key work streams for the Barking Riverside / Thames Ward development

With the Healthy New Town programme coming to an end, a workshop focussed on creating a thriving Thamesward took place on Thursday 25th April 2019 to ensure local people and community organisations are able to co-produce conversations about health and wellbeing in the South Locality of Barking within which Barking Riverside is situated. There was clear passion from all attendees including a number of local people to create a new environment and way of integrated working for the South Locality.

Next steps which are being taken forward following this workshop include establishment/continuation of the following groups:

- **Built Environment Group**; being taken forward by the Developer and Graeme Cooke (Director of Inclusive Growth from LBBD) – focussed on the wider Barking Riverside/Thames View environment
- **Community Focussed Group**; Matthew Cole (Director of Public Health, LBBD) and Leila, a member of the Community are leading establishment of this group; focussed on designing the community element of the space within the new building
- **Leisure Group**; Focussed on the development of proposals for the leisure element that will be housed in the new building
- **Model of Care Group**; this is led by Dr John, is comprised of health, care and community partners, and is working to develop the proposed model of care for Barking Riverside. This gropu has been meeting since February 2019
- **Thamesview**; There is also a group who meets to discuss testing elements of the proposed model of care at Thamesview Health Centre, for example, proposals to create a single welcome desk a the front door
- **Wellbeing Hub Design Group;** who will focus on the physical design of the building

These groups will feed into an overarching **Board**, the first meeting of which is taking place on 25th September 2019. The name of this is to be confirmed; it is currently being referred to as the 'not a traditional Locality Board, Board' – to reflect the desire to move away from corporate branding and traditional approaches to health, care and wellbeing.

Barking Riverside Model of Care Design Group

Stakeholders have convened a 'Model of Care Design Group' who have been meeting monthly since 27th February 2019 as a task and finish group, with meetings planned up to 30th October 2019 when it is anticipated that we will have a strong articulation of the proposed model of care.

Current membership includes:

Membership	
Organisation	**Name and Role**
NELFT	Mohan Bhat, Associate Medical Director
	Melody Williams, Integrated Care Director, Barking and Dagenham
	Laura Stuart-Neill, Allied Health Professional Lead (Deputy for LSN) Clare Linger, Deputy Allied Health Professional Lead (Deputy for LSN) Wendy Ennifer, Deputy Allied Health Professional Lead
Barking and Dagenham, Havering and Redbridge University Hospitals	Fiona Peskett, Director of Provider Alliance Development
Barking & Dagenham, Havering and Redbridge Clinical Commissioning Groups	Dr Jagan John, B&D CCG Chair and GP
	Dr Kalkat, Clinical Director and GP
	Dr Amit Sharma, Clinical Director and GP
	Dr Uzma Haque, Clinical Director and GP
	Simon Clarke, Primary Care Delivery Manager
	Emily Plane, Head of Primary Care
	Sarah See, Director of Primary Care
Jointly funded post – BHR CCGs and LBBD	Mark Harrod, Director of development – Barking Riverside
Dentistry	Dr Hirekodi, Local Dentist
BHR GP Federations	Dr Ravi Goriparthi, B&D GP Federation Lead and GP
NEL Pharmacy Federation	Nader Siabi, Clinical Pharmacist
	Faisal Chowdhury, Pharmacist
London Borough of Barking & Dagenham	Stephan Liebrecht, Operational Director, Adults Care and Support
	Susanne Knoerr, Head of Service for Integrated Care
	Dr Usman Khan, Consultant in Public Health
	Rhodri Rowlands, Community Solutions
	James Hodgson, School Investment Advisor
East London Health and Care Partnership	Alison Goodlad, Head of Primary Care
	Gohar Choudhury, Assistant Head of Primary Care
GP Trainees via Health Education England	James Cook, GP Trainee Mayukh Bhattacharyya, GP Trainee
Community leads	Matt Scott, Thames Ward Community Partnership

In addition the group plan to keep the following organisations/leads briefed:

- Care City, John Craig, Innovation Partner
- NEL CSU, Danny Lawlor, NELFT contracts
- Health Education England
- BHR CEPN
- East London Health and Care Partnership
- Citizens Advice Alliance Network
- Riverside Residents Association

The framework for the model of care design

A series of five key workshops, alongside a programme of engagement with local people to feed into the development of the proposed model of care were held between September and October 2018 to ascertain key requirements of the physical building and wider Riverside environment.

The following key principles were agreed through this process and are deeding in to the design of the model of care:

- The service will be jointly procured/commissioned by B&D CCG and LBBD
- The service will be delivered by a single provider alliance through a single contract, the form of which is to be explored
- There is particular opportunity to capitalise on linking health and wellbeing services with leisure facilities, and to community assets such as education campuses e.g. the nearby Riverside Campus School, and other schools in the area
- Exploration of the GP as a point of escalation rather than the first port of call, and a universal nursing role
- There will not be a traditional GP practice with a list size, however, GPs will be key to leading the team / model of care
- Access to the leisure and community facilities will be key to the model of wellbeing and should feel part of an integrated offer, not a separate service
- The model of care should be based on the approach of 'getting it right first time' with a strong focus on Care Navigation and ensuring that local people have access to high quality information and advice
- Neutral branding will be employed (not NHS-focussed) that embodies empowerment, community and friendship to promote the concept of 'wellness' rather than a focus on illness
- The space will be as flexible as possible to ensure that it is able to adapt to a model of care that will evolve over time to meet the changing needs of local people
- There will be a strong focus on supporting local people to stay well, intervening further upstream where possible, enabled by technology and different ways of working

Our approach: Experience Based Design – The Kings Fund

Experience Based Design is described by the Kinds Fund as;

'A change method and process aimed at improving patient and staff experiences of health [and] care.'

It focusses on designing **experiences**, not just improving performance, and brings decisions around the design of health and care services back to what works best for local people, and the health and care staff delivering the interventions.

Because services are designed with the end user in mind, they are streamlined, with a strong focus on quality. This also lends itself to services which are naturally more efficient.

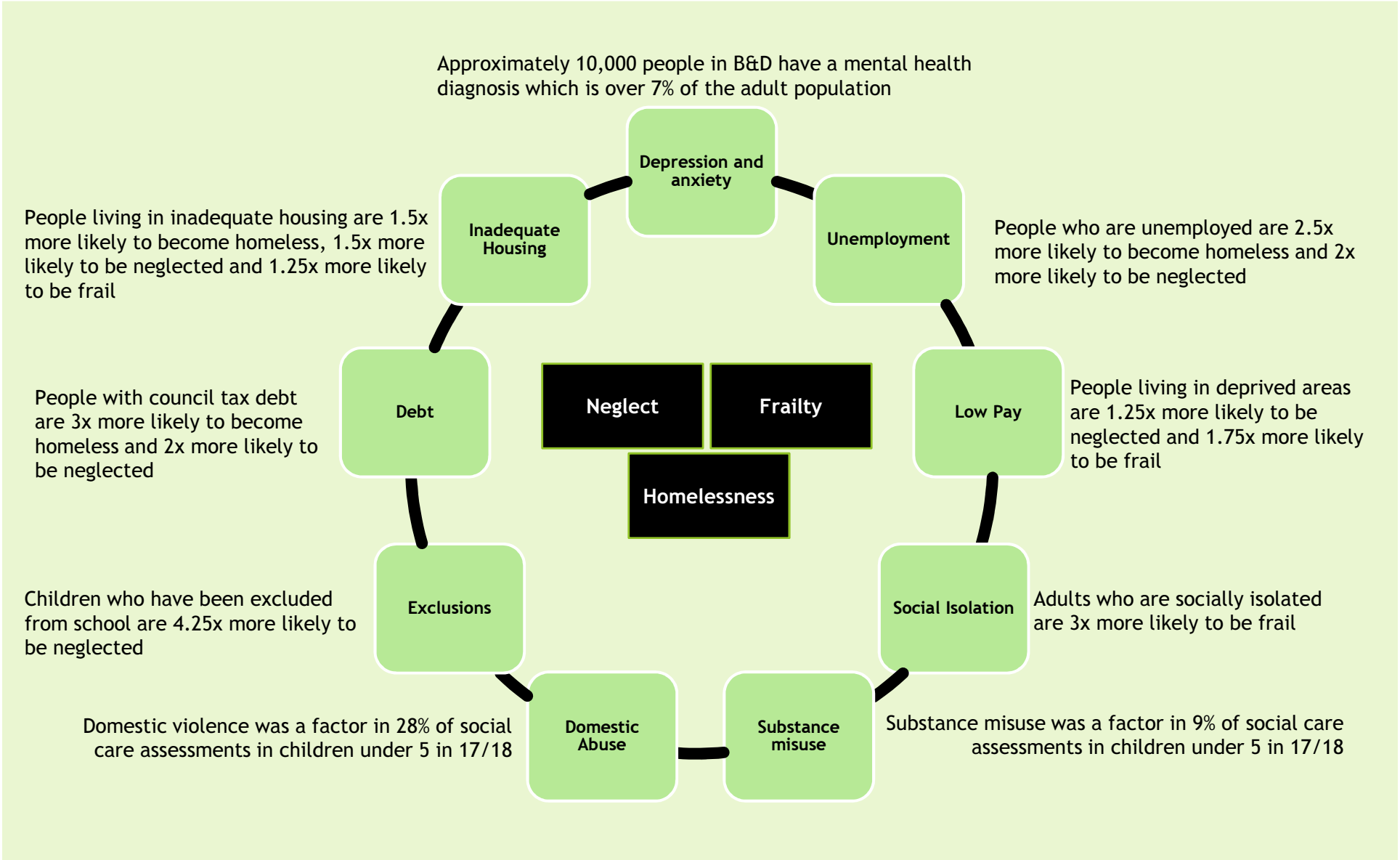
The approach to designing services is therefore;

- consider what the ideal experience of support would be to deliver the outcomes that local people want
- map the interventions that need to take place to achieve this
- map the workforce/team/services that need to be in place to deliver this

Through this approach the Model of Care group are designing what the team delivering care will look like within the framework of the principles already agreed. Personalised Care will also feature strongly.

Key information being played into the model of care design

Key information from public health, secondary and primary care data is being fed into the 'model of care' design to ensure that it will address local needs. The key statistics below are taken from Local Authority analysis on the wider determinants of health (part of the B&D Borough Manifesto work).



Key progress since our last update

- Working with Health Education England, we have identified two local GP trainees who have chosen Barking Riverside as their Quality Improvement project and will support development and design of the model of care and physical building of the wellbeing hub as part of this. Their time is fully funded by Health Education England and their perspective and input will be invaluable to embed innovation in the model of care for Barking Riverside and wider South Locality. We are continuing to brief leads at Health Education England of the progress to develop a new model of care for Barking Riverside and the wider South Locality; this will enable us to work together in the future to create tailored education and training programmes to support new roles and ways of working if it is identified that these are required to deliver the new model of care. Health Education England leads are also sharing learning with us from other areas who are exploring new and innovative ways of working.

- The 'Model of care' design group has been established to design a proposed new model of care for Barking Riverside, led by local people and health and care staff, including leads from the community and voluntary sector. This is a task and finish group, meeting monthly until the end of October 2019 at which point it is anticipated the group will have developed a clear proposal articulating what the new model of care is and how it will operate in practice. The group are taking an 'Experience Based Design' approach, described by Kings College London as 'a change method and process aimed at improving patient and staff experiences of health [and] care.' It focusses on designing experiences, not just improving performance, and brings decisions around the design of health and care services back to what works best for local people, and the health and care staff delivering the interventions. Because services are designed with the end user in mind, they are streamlined, with a strong focus on quality. This also lends itself to services which are naturally more efficient. Input from local people will be key to this process and the group are using case studies (**see appendix one**) based on real experiences of those living in the area, to begin to design optimum experiences and pathways. The outputs and proposals from this group will be robustly tested with local people.

Key progress since our last update

- North east London and Barking and Dagenham, Havering and Redbridge (BHR) Primary Care Leads developed a paper to explore contracting options for the proposed new model of care for Barking Riverside. The paper was reviewed at the BHR Primary Care Commissioning Committee on Wednesday 17th April 2019 who agreed that, in line with the recommendation of the paper, an Integrated Care Provider contract should be **explored** for the Barking Riverside new model of care. A working group has been convened to explore the financial modelling for the health element of the model of care, which will include updated detail of the ramp up of the population in the area, to inform which contracting model is used.

- Through the course of partnership discussion around a new model of care for Barking Riverside, workforce has been clearly identified as a key enabler and the multidisciplinary leads involved in the discussion have identified opportunity to link with local schools to promote careers in health and care. We will continue to explore further opportunities to promote careers in health and care with local children and people, and to work together to find strategic, integrated solutions to some of the biggest challenges we are facing.

Next steps

- Continue to develop/design a new model of care for Barking Riverside through the Barking Riverside New Model of Care Design Group, working closely with local people.

- Establish the key groups described in this update, following the 'creating a thriving Thamesward' workshop on the 25th April, to drive forward the programme of work at pace.

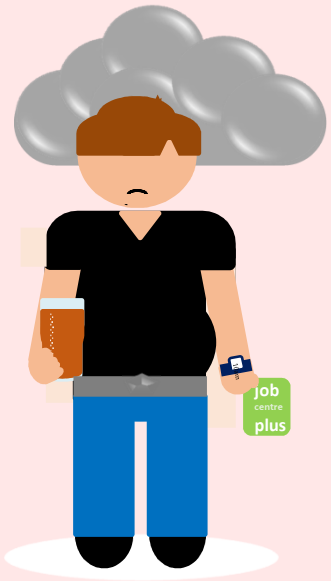
- Receive and discuss/respond to feedback from the Developer on the Single Client brief at the 'South' locality boar, and progress agreed next steps following the first meeting on 25th September 2019

- Work with North east London and Barking and Dagenham, Havering and Redbridge (BHR) Primary Care leads and contracting leads, alongside finance leads via the newly established working group to explore the financial modelling for the health element of the model of care, which will include updated detail of the ramp up of the population in the area, to inform which contracting model is eventually adopted for the health and care element of the new model of care

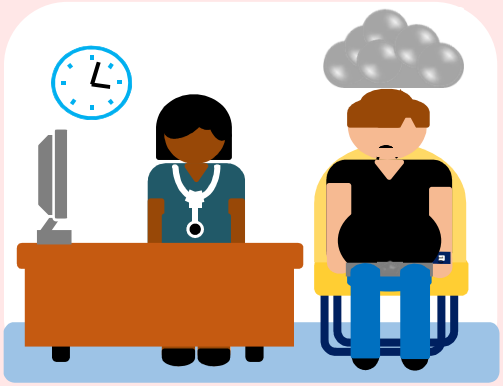
Appendix one
Experience Based Design Case Studies

Case study one: Bob

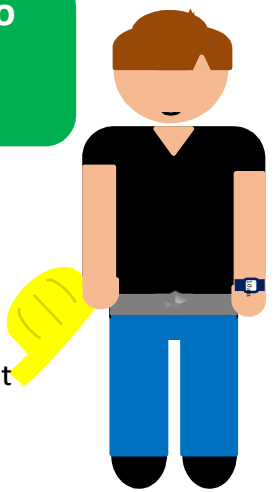
- **45 year old Bob was made redundant in 2015**
- **Despite looking, has struggled to find work**
- **He has become less active and put on weight**
- **He has started drinking every evening**
- **Bob feels depressed about his situation and doesn't know who to speak to for support. He feels embarrassed to speak about how he is feeling with his family and friends**



- **Bob visits his GP because he feels depressed**
- **His GP really wants to help but cannot get to the route of Bob's depression within a 10 minute appointment**
- **The GP suggests that Bob cuts down his drinking and exercises more but Bob doesn't feel in the right frame of mind to achieve this on his own**
- **Bob's GP isn't aware of local services that could help in this situation, or how to refer him for support**



The outcome that Bob really wants is to feel happy again; he feels that if he is able to get back to work, and find an outlet to socialise that doesn't involved drinking, this would have a big impact on his wellbeing.

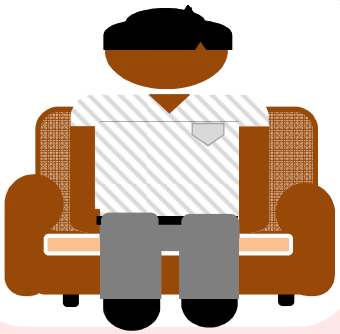


CONSIDER:

- What are our opportunities to support Bob to achieve the outcomes that he wants?
- What do we need to build in to the model of care to achieve this? What roles/competencies are required? Do we have these within the current workforce / community or is this something that we need to build in/develop?
- How will Bob be identified for support/intervention at the RIGHT time before things get worse? Can he self refer? What if it's not in his nature to seek help? What do we need to have in place to enable early referral/intervention at the right time for Bob? In practice; what will the 'front door' to the service look like?
- What is our list of requirements of the key enablers e.g. workforce and IT?

Case study two: Parvinder

- Parvinder is 30 years old
- He is in severe financial difficulty and relies on short term loans, often struggling to keep up with repayments
- Pavinder is very embarrassed about the situation and hasn't even told close family and friends
- The stress of being in significant debt is taking a toll on Parvinder's emotional and physical health and is beginning to impact on his relationships and ability to work



- Parvinder has been to see his GP as he feels very anxious all the time and is having trouble sleeping; he has even had to take some time off of work due to feeling on the brink of a nervous breakdown
- His GP signed him off of work for a number of weeks to recover, but Parvinder didn't have time to go into the details of the cause of his stress during his consultation

Parvinder really wants support and guidance from a confidential and trusted source so that he can see a way out of his debt situation which will significantly alleviate his stress levels.

CONSIDER:

- What are our opportunities to support Parvinder to achieve the outcomes that he wants?
- What do we need to build in to the model of care to achieve this? What roles/competencies are required? Do we have these within the current workforce / community or is this something that we need to build in/develop?
- How will Parvinder be identified for support/intervention at the RIGHT time before things get worse? Can he self refer? What if it's not in his nature to seek help? What do we need to have in place to enable early referral/intervention at the right time for him? In practice; what will the 'front door' to the service look like?
- What is our list of requirements of the key enablers e.g. workforce and IT?

Case study three: Amanda

- **Amanda is 85; up until a year ago she had a voluntary job in a local school library which she loved, and an active social life**
- **Amanda's only relative, her niece, lives 2+ hours away and she has always lived alone**
- **Amanda's friends notice a significant decline in Amanda's functional mobility, but don't know how to address this with her. It's possible she has stopped drinking as much water and due to feeling lightheaded, hasn't been walking as much as she used to**

- **Following an initial fall and 2 month stay in hospital, Amanda has a series of falls over a period of six months, visiting hospital numerous times**
- **Eventually Amanda is transferred to a nursing home**
- **Amanda's condition deteriorates significantly following admission to the home and it becomes apparent that she may be entering the last six months of her life**
- **Amanda is having significant difficulty breathing and the home dial 999**
- **Amanda is transferred to hospital via ambulance**
- **Amanda spends 10 weeks in hospital and eventually passes away there**

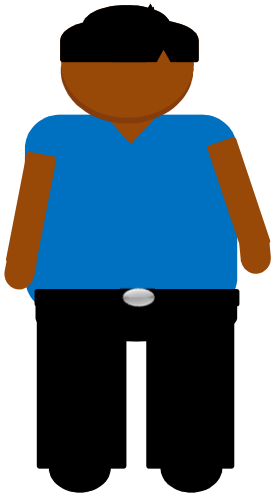
The intervention that Amanda really wanted was support when she started to forget to drink enough water and her mobility was beginning to decline. This would have supported her to remain independent, at home for longer. When she did reach the last six months of life, her preference would have been to die peacefully at home.

CONSIDER:

- What and where were the opportunities to support Amanda earlier in her journey to give her the outcomes that she wanted?
- What do we need to build in to the model of care to achieve this? What roles/competencies are required? Do we have these within the current workforce / community or is this something that we need to build in/develop?
- How could Amanda be identified for support/intervention at the RIGHT time before things get worse? Can she be supported to self refer? What if it's not in her nature to seek help? What do we need to have in place to enable early referral/intervention at the right time for Amanda?
- What are our requirements of the key enablers e.g. workforce and IT?

Case study four: Amit

- **Amit is 15 years old**
- **He has experienced bullying at school which focussed on his weight, and he feels like he doesn't have many friends**
- **Amit never goes out after school or at the weekends and playing computer games is his main hobby**
- **Amit has never been to see a dentist and sometimes experiences tooth pain**



- **His teachers and friends don't know that Amit is a child carer for his mother who had a stroke when he was 12 related to her diabetes**
- **She finds it difficult to mobilise and carry out tasks so Amit helps her with cleaning, cooking, and other household chores, including helping her to move around and put her shoes on etc.**
- **Amit is continuing to be physically inactive and his BMI is increasing each year**
- **He is falling behind with his studies because he feels tired all the time and struggles to find time to support his mother as well as do his homework every evening**

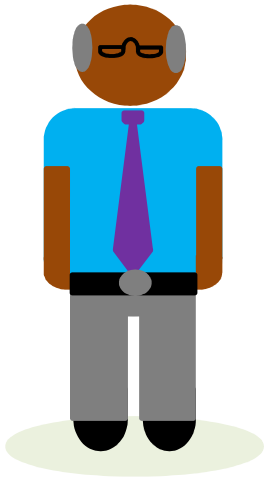
The outcome that Amit wants is to have support to care for his mother, giving him more time to explore opportunities to increase his physical activity

CONSIDER:

- What are our opportunities to support Amit to achieve the outcomes that he wants?
- What do we need to build in to the model of care to achieve this? What roles/competencies are required? Do we have these within the current workforce / community or is this something that we need to build in/develop?
- How will Amit be identified for support/intervention at the RIGHT time before things get worse? Think of the people in his life who may spot that he is struggling. What do we need to have in place to enable early referral/intervention at the right time for Amit? In practice; what will the 'front door' to the service look like?
- What is our list of requirements of the key enablers e.g. workforce and IT?

Case study five: Abel

- **Abel is 60 years old**
- **He has a number of long term conditions but is struggling to manage his COPD**
- **Because of his COPD, he finds it very difficult to walk and doesn't get out of his flat much**
- **He feels very lonely; his son has moved out of the country for work and Abel now only sees him about three times a year**
- **Abel's wife also has a long term condition and Abel tries to support her as much as possible as her mobility is more limited than his**
- **Abel's wife receives a care package of two visits a day in the morning and evening but may need an increase in visits due to her increasing needs**



- **Abel's COPD exacerbations are getting worse and in the past year he has had to call an ambulance three times**
- **On one occasion he was admitted to hospital for two days**
- **He is feeling very stressed about the impact this is having on his wife and the amount of support that he can give her**
- **He fears for the future for him and his wife and doesn't want to be separated from her, particularly if she has to be transferred to a care home which neither of them want**

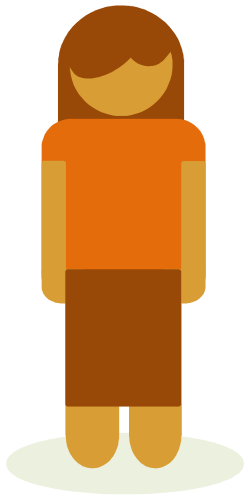
The outcome that Abel wants is to be supported to manage his COPD and maintain his independence at home. He would like some support to look after his wife, and would love to be able to be able to go out, particularly to socialise if there was the opportunity.

CONSIDER:

- What are our opportunities to support Abel to achieve the outcomes that he wants?
- What do we need to build in to the model of care to achieve this? What roles/competencies are required? Do we have these within the current workforce / community or is this something that we need to build in/develop?
- How will Abel be identified for support/intervention at the RIGHT time before things get worse? Can he self refer? What if it's not in his nature to seek help? What do we need to have in place to enable early referral/intervention at the right time for Abel? In practice; what will the 'front door' to the service look like?
- What is our list of requirements of the key enablers e.g. workforce and IT?

Case study six: Lena

- **Lena has a 2 year old child**
- **English is not Lena's first language and she struggles to converse in English at the moment although she is trying to learn more**
- **Lena recently moved to the UK/B&D, and doesn't have any family or friends who live close to her**
- **Lena is unsure where to go for advice or the process to get support, and isn't aware of the support she is eligible for**
- **Lena is not currently registered with a General Practitioner**
- **Lena lives in a rented flat**



- **Lena has attended the ED at KGH three times this year with her child when they became unwell; each time upon investigation in the ED, her child has been found to have an ambulant condition that could have been addressed through her local pharmacy or by calling NHS 111**
- **Lena may not be aware that she can register with her local GP and book an appointment, or that she can call NHS 111 for information and advice, see her local pharmacist, or take her child to an Urgent Care Centre**
- **Lena may also not be aware of the wider support and services that she may benefit from accessing**

The outcome that Lena really wants is to understand what services and support are available to her and the best place to take her child when she is unwell. She would also love to build her social network and make new friends, particularly with other young mothers.

CONSIDER:

- What are our opportunities to support Lena to achieve the outcomes that she wants?
- What do we need to build in to the model of care to achieve this? What roles/competencies are required? Do we have these within the current workforce / community or is this something that we need to build in/develop?
- How will Lena be identified for support/intervention at the RIGHT time before things get worse? What do we need to have in place to enable early referral/intervention at the right time for Lena?
- What is our list of requirements of the key enablers e.g. workforce and IT?

HEALTH SCRUTINY COMMITTEE

3 September 2019

Title: New Primary Care Networks	
Report of the Director of Public Health	
Open Report	**For Information**
Report Author: Matthew Cole, Director of Public Health	**Contact Details:** Tel: 020 8227 3657 E-mail: matthew.cole@lbbd.gov.uk

Summary

From 1 July 2019, all patients in England have been covered by a primary care network (PCN) – the most significant reform to general practice in England in a generation. PCNs should help to integrate primary care with secondary and community services and bridge a gap between general practice and emerging Integrated Care Systems. Since January 2019, practices in the Borough have been organising themselves into six local networks to provide care at greater scale by sharing staff and some of their funding. The presentation at Appendix 1 provides information on what PCNs are, how they operate and the potential benefits and risks they bring.

Recommendation(s)

The Health Scrutiny Committee is recommended to note the information provided at Appendix 1 and ask questions of the Director of Public Health to obtain a better understanding of how PCNs operate in the Borough.

Reason(s)

This agenda item discusses recent changes in general practice which relates to the Council's priorities to enable greater independence whilst protecting the most vulnerable and strengthen our services for all.

Public Background Papers Used in the Preparation of the Report:

None.

List of Appendices:

Appendix 1 – New Primary Care Networks in Barking & Dagenham

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Appendix 1

New Primary Care Networks in Barking and Dagenham

Matthew Cole

Director of Public Health

Key Points

From 1 July 2019, all patients in England will be covered by a primary care network (PCN) – the most significant reform to general practice in England in a generation.

PCNs should help to integrate primary care with secondary and community services, and bridge a gap between general practice and emerging Integrated Care Systems.

Since January 2019, B&D practices have been organising themselves into 6 local networks to provide care at greater scale by sharing staff and some of their funding.

While PCNs offer huge potential to integrate care and improve services, there is a risk that the speed of implementation will undermine the best intentions of the policy.

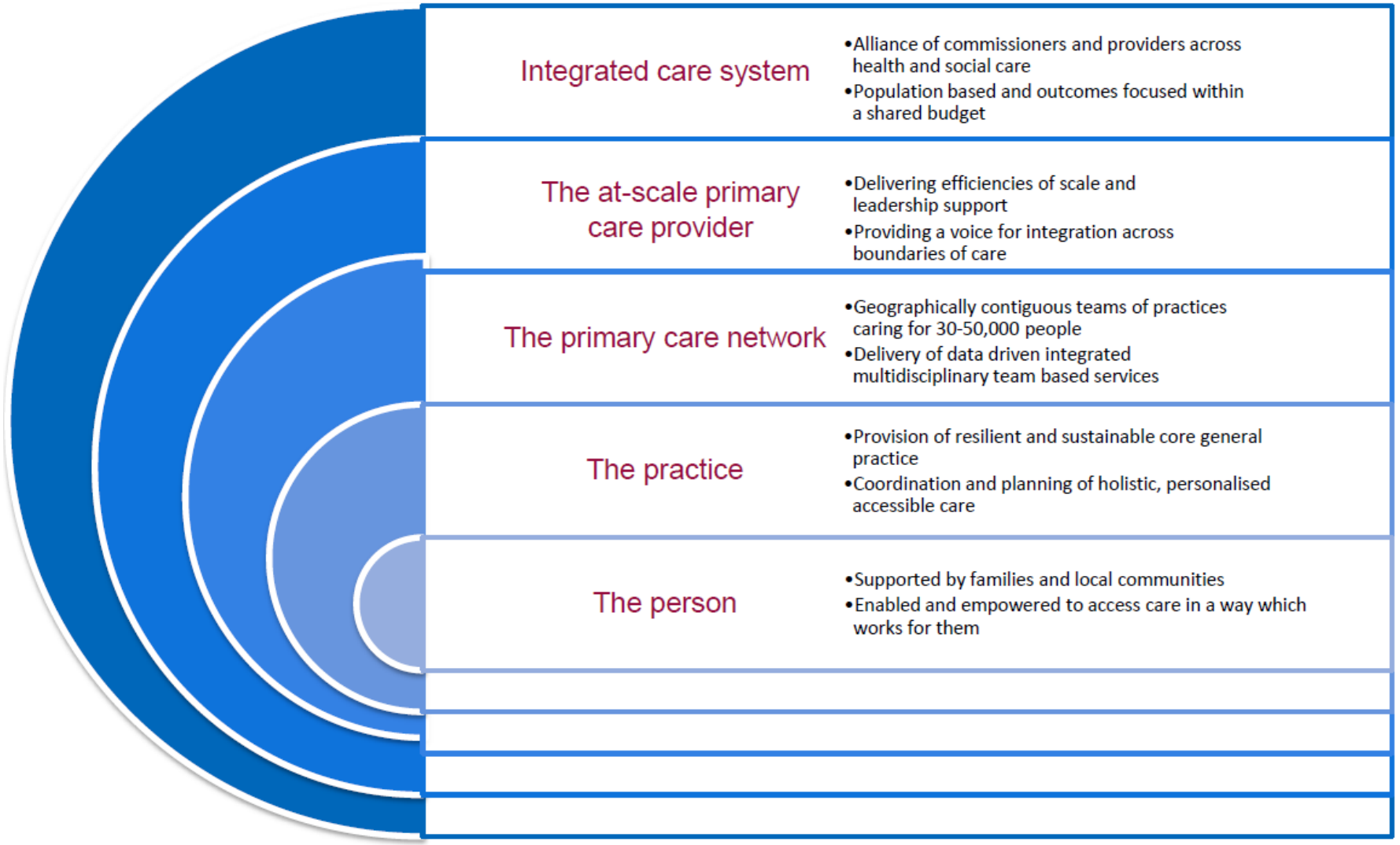
Nature of the Change

Integrated care and system reform offers new opportunities to work as part of a whole systems approach, focused on improving resident's health & wellbeing outcomes

ICS enable the planning healthcare treatment, social care and prevention activity to address residents needs and improve outcomes

PCNs do represent a potential revolution in the delivery of neighbourhood-level health and care across the country. The promised speed of change is rapid, with PCNs aiming to impact the way that the whole population experiences local health and care over the next five years.

THE MODEL OF CARE



Central to the work of Integrated Care Systems

Delivery of population health

Improving the health of the borough population. Includes action to reduce the occurrence of ill-health, including addressing the wider determinants of health and requires working with communities and partners.

Delivery of population health management

Improving residents health by data-driven planning and deliver of care to achieve maximum impact. Includes segmentation, stratification and impartibility modelling to identify local ‘at risk’ cohorts.

What are primary care networks?

General Practice as the foundation of the wider ICS, working in partnership with other health and care providers to collaboratively manage and provide integrated services to a defined population within a shared budget.

Provide a wider range of services to patients and to more easily integrate with the wider health and care system.

The NHS long-term plan and the new five-year framework for the GP contract, published in January 2019, put a more formal structure around this way of working, but without creating new statutory bodies.

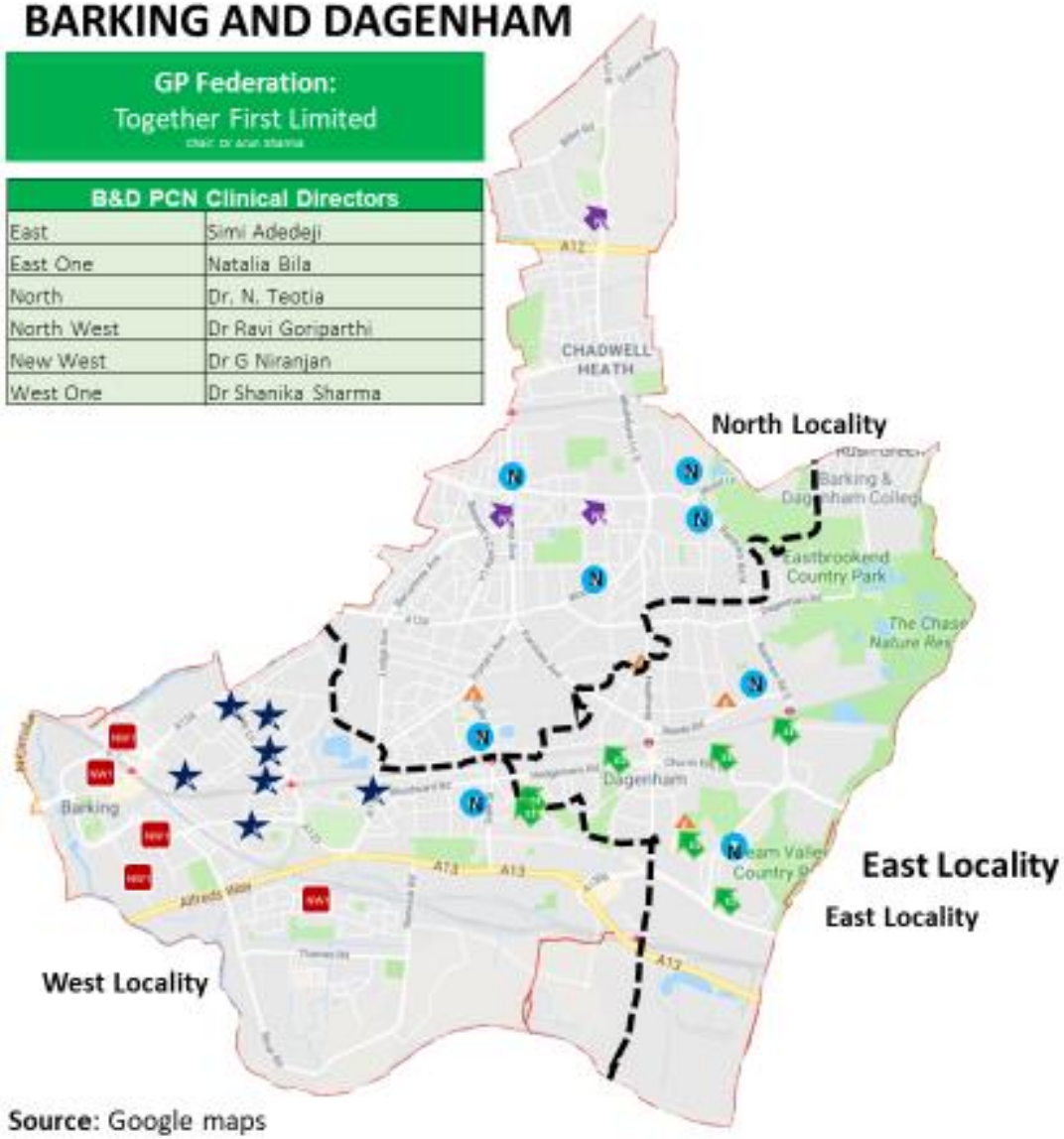
While practices are not mandated to join a network, they will be losing out on significant extra funding if they do not.

Since 1 July 2019, all GP practices in B&D have come together in 6 geographical networks covering populations of approximately 30–50,000 patients.

BARKING AND DAGENHAM

GP Federation:
Together First Limited

B&D PCN Clinical Directors	
East	Simi Adedeji
East One	Natalia Bila
North	Dr. N. Teotia
North West	Dr Ravi Goniparthi
New West	Dr G Niranjan
West One	Dr Shanika Sharma



Source: Google maps

North Primary Care Network; 8 practices List size 43,259	
Green Lane Surgery	5740
Dr S Z Haider & Partners	5704
Dr A K Sharma	8872
Dr A Arif	4553
Five Elms Medical Practice	4057
Gables Surgery	8879
Dr M Ehsan	3003
Dr R S Jaiswal	5415
	43,259

North West PCN; 3 practices List size 32,637	
Marks Gate Health Centre	8803
Tulasi Medical Centre	11061
Becontree Medical Centre	9653
	32,637

West One Primary Care Network; 7 practices list size 42,919	
Dr P. Prasad	2430
Drs. Chibber & Gupta	4466
Drs. Sharma & Rai	5482
Highgrove Surgery	7961
Dr Ansari & Ansari	8270
The Barking Medical Group Practice	11348
The John Smith Medical Centre	2963
	42,919

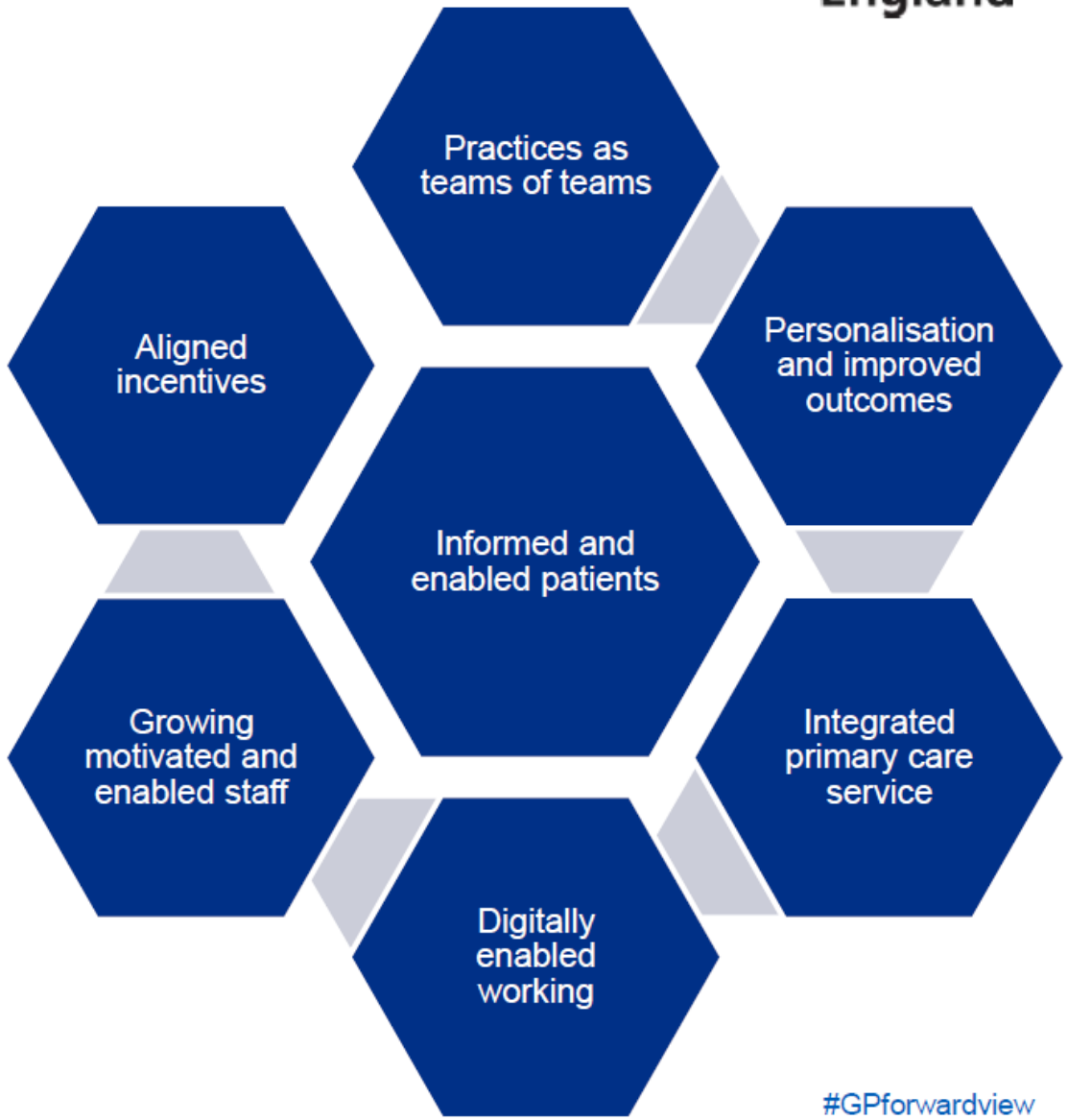
New West PCN; 5 practices List size 30,973	
Abbey Medical Centre	8949
Dr O. Kalkat	3538
Dr N. Niranjan	4869
Drs. John & John	8415
Shifa Medical Practice	3202
	30,973

East Primary Care Network; 4 Practices List size: 39,458	
Broad Street Medical Centre	6555
Porters Avenue (merged 01.04.2020 with Clinic & Homes)	8888
Church Elm	6204
Halbutt Street Surgery	6779
Child and Family Health	11,032
	39,458

East ONE Primary Care Network; 7 Practices List size: 37,134	
Dr Alkaby Surgery	4681
First Avenue Surgery	5401
Heathway Medical Centre	4695
Hedgemans rd	5717
Parkview	3888
St Albans Surgery	5076
The Surgery (Dr Ola)	3765
	37,134

Primary care networks – key to the future

- Primary care networks are small enough to give a sense of local ownership, but big enough to have impact across a 30-50K population.
- They will comprise groupings of clinicians and wider staff sharing a vision for how to improve the care of their population and will serve as service delivery units and a unifying platform across the country.



#GPforwardview

What will primary care networks do?

- PCNs will eventually be required to deliver a set of seven national service specifications.

From	Service Specification
April 2020	Structured Medication Reviews and Optimisation Enhanced Health in Care Homes Anticipatory Care Supporting Early Cancer Diagnosis Personalised Care
April 2021	CVD Prevention and Diagnosis Tackling Neighbourhood inequalities

PCNS will provide a wider range of primary care services to patients, involving a wider set of staff roles.

Networks will receive specific funding for clinical pharmacists and social prescribing link workers in 2019/20, with funding for physiotherapists, physician associates and paramedics in subsequent years.

They will also be the footprint around which integrated community-based teams will develop, and community and mental health services will be expected to configure their services around primary care network boundaries. These teams will provide services to people with more complex needs, providing proactive and anticipatory care.

What will primary care networks do?

- Going beyond care
- Provider or Commissioner?

Going beyond care

PCNs will also be expected to think about the wider health of their population, taking a proactive approach to managing population health and, from 2020/21, assessing the needs of their local population to identify people who would benefit from targeted, proactive support.

Provider or Commissioner?

PCNs will be focused on service delivery, rather than on the planning and funding of services, responsibility for which will remain with commissioners, and are expected to be the building blocks around which integrated care systems are built.

PCNs will be the mechanism by which primary care representation is made stronger in integrated care systems, with the accountable clinical directors from each network being the link between general practice and the wider system.

We have examples of how integrating services improves services for patients…

NHS England

East London Utilising the power of voluntary and community services	• In **Tower Hamlets**, care co-ordinators in primary care can refer patients to 1500 local voluntary sector organisations that support residents to manage their health and wellbeing • Patients have been supported to engage in arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports.
Yorkshire Integrating care teams across organisational boundaries	• In **Wakefield**, multi-disciplinary teams have been formed between care homes and primary care to manage the needs of residents in 27 care homes and 6 supported living facilities • Local analysis showed that ambulance call outs have been reduced by 9% and bed days have reduced by 26% from the 2015/16 baseline.
Lancashire Providing flexible access to specialist support	• University Hospitals of **Morecambe Bay** NHS Foundation Trust has been working with local out-of-hospital providers, to implement electronic advice and guidance across 16 specialities • The service has enabled patients to seek specialist support without being referred to secondary care, saving around 1700 referrals.

Who are primary care networks accountable to?

Practices are accountable to their commissioner for the delivery of network services.

Practices will sign a network agreement, a legally binding agreement between the practices setting out how they will discharge the responsibilities of the network.

PCNs can also use this agreement to set out the network's wider objectives and record the involvement of other partners, for example community health providers and pharmacies, though these partners will not be part of the core network, as that can only be entities who hold a GP contract.

Each network has an identified accountable clinical director The main purpose of this role seems to be to provide a voice upwards to the wider integrated care system, and to be a single point of contact for the wider system, rather than to be accountable for the performance of the network or its constituent practices.

Clinical directors are appointed by the members of the network.

What does the evidence show makes for successful collaboration in general practice?

Most successful when it had been generated organically by general practices over a number of years, underpinned by trust, relationships and support, and where there was a clear focus and agreement on the role of the collaboration.

Least successful where there was a lack of clarity of purpose or engagement or over-optimistic expectations.

PCNs will need support to build the trust and relationships needed for successful collaboration, resisting attempts to be over-optimistic in what can be achieved in the short term. The scale and complexity of the implementation and leadership challenge should not be underestimated, and those leading PCNs will need significant support if they are to deliver the ambitions set out for them.

What difference will primary care networks make for patients?

PCNs have the potential to benefit patients by offering improved access and extending the range of services available to them, and by helping to integrate primary care with wider health and community services.

Previous research on the impact of larger scale general practice on patient experience found mixed views.

While some patients prioritise access above all else and are interested in the potential of larger collaborations to improve that access, others are more concerned about continuity and trusting relationships and are concerned these may be lost.

Practices will need to work with their patient participation groups and the wider local community if they are going to address the needs of their local population.

Challenges of PCN Establishment

- Relationships require development between PCNs and Federations to enable delivery. – in part mitigated by the CCG who will commission via the Federations.
- Need to strengthen governance – in part mitigated by a new assurance process. PCN Boards to be set up.
- Infancy regarding data sharing, finances and HR policies, disputes, Liabilities, VAT - Mitigation - CCG support re GDPR training, Federation support re finance and HR training.
- Ability to recruit to new workforce roles to support PCNs where there has been no pipeline development for these to date – also has the potential to impact on other areas e.g. physios moving into PCNs.
- Development of PCN leaders to support them to take on the challenges of their new roles.
- Significant amount of work across the system with a number of requirements on PCNs including requirement to deliver transformation and deliver business as usual.

What are PCNs doing this year?

Priorities for 2019/20 – 2020/21:

- Establishment of PCNs
- Work with the BHR Integrated Care Partnership and Federation to adopt a single system vision, set of values and goals
- Understand the needs of local neighbourhoods/localities to begin to inform current and future service planning further develop PCN Development Plans
- Development of relationship with Federations to support delivery of System Financial Recovery Plan through the Transformation Board Programmes with a focus on Long Term Conditions, Older People and Frailty and Outpatients
- Initiate recruitment of PCN workforce e.g. Social Prescribers and Clinical Pharmacists in 2019/20
- Establish Extended Hours DES
- Begin to prepare for DES' from April 2020:
  - Structured medication reviews
  - Enhanced health in care homes
  - Anticipatory care with community services
  - Personalised care
  - Supporting early cancer diagnosis
- Consider how GP practices and individual GPs within the PCNs will receive key message and engage with PCN priority setting and development going forward

HEALTH SCRUTINY COMMITTEE

3 September 2019

Title: Joint Health Overview and Scrutiny Committee: Update	
Report of the Director of Law and Governance and Human Resources	
Open Report	**For information**
Wards Affected: None.	**Key decision:** No
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Accountable Strategic Leadership Director: Fiona Taylor, Director of Law and Governance and Human Resources	
Summary: This report updates the Health Scrutiny Committee (HSC) on the issues that were discussed at the last meeting of the Outer North East London (ONEL) Joint Health Overview and Scrutiny Committee (JHOSC), held on 9 July 2019. A weblink to the full minutes of the meeting is provided at the end of this report.	
Recommendations The HSC is recommended to note the update.	
Reason To keep the HSC updated on issues discussed at JHOSC meetings.	

1. Introduction and background

1.1 The Outer North-East London JHOSC is a discretionary joint committee made up of three health scrutiny members representing each of the following local authorities to scrutinise health matters that cross local authority boundaries:

- Barking & Dagenham
- Havering
- Redbridge and
- Waltham Forest.

(The Essex County Council Health Overview and Scrutiny Committee is permitted to appoint one member to the JHOSC).

1.2 As agreed by the HSC at its meeting on 25 June 2019, the London Borough of Barking and Dagenham's representatives on the JHOSC for 2018/19 are Councillors Keller, P Robinson and M Khan.

Four JHOSC meetings are usually held per municipal year and are chaired and hosted by each constituent authority on a rota basis. This report covers the matters that were discussed at the last meeting of the JHOSC which was on 9 July 2019 at

Barking Town Hall. The next meeting will be held at 4.00pm on Tuesday 15 October 2019 at Havering Town Hall.

A joint meeting of the ONEL JHOSC and the Inner North East London JHOSC to primaril, discuss the work of the East London Health and Care Partnership (which was originally scheduled to take place on 18 September 2019) has been rescheduled to 4.00pm on 30 October 2019, in Stratford Town Hall.

2. Matters discussed at the meetings of the JHOSC held on 9 July 2019

2.1 East London Health and Care Partnership (ELHCP) Update

2.1.1 Representatives of the ELHCP explained that the Partnership covered 8 Councils and 12 NHS organisations. The Partnership's Long-Term Plan for the next 4-5 years was currently being evaluated and aimed to make integrated care a reality. Primary care networks had already been established as well as an integrated care system, focussing on prevention. Cancer and digital work streams remained priorities and a lot of engagement work on the Long-Term Plan was taking place at borough level, including Healthwatch organisations being commissioned to undertake surveys at. Following submission of the Long-Term Plan to the Department of Health, it was planned to bring this to the JHOSC at a future meeting. The ELHCP has also scheduled a second key engagement event for 16 October 2019.

2.2 Cancer Services

2.2.1 Barking, Havering & Redbridge University Hospitals Trust representatives provided an update on the issues that arose from ongoing discussions around the changes to cancer services at the Trust, which included the following:

- The providers of the A & E reception service had received clarification around the use of 'red cards' for patients undergoing chemotherapy;
- Overall feedback from patients using the chemotherapy suite was good;
- The introduction of fake skylights in part of the ward as a result of a lack of natural lighting had led to some improvement;
- Parking for cancer services had been an issue whilst a clinical diagnostic unit had been parked in part of the cancer services car park, following a fire. This had now been resolved and more patient parking was available. All cancer patients were assessed for transport needs; and
- Chemotherapy patients could also access 24:7 support from oncology nurses which often avoided the need to attend A & E.

2.2.2 Members made comments around:

- Issues around the rebooking of oncology appointments;
- The lack of public consultation on the removal of chemotherapy services from King George Hospital;
- A possible audit of the incidence of sepsis among chemotherapy patients and of the demand for chemotherapy services over the next ten years;
- The lack of diversity of users of the Cedar Centre; and
- Details of the friends and family test scores for cancer services.

2.2.3 The Trust responded that efforts were in progress to disseminate information on the Cedar Centre services to patients and a refurbishment of the area was planned; the Trust wished for the Cedar Centre to be one of the best cancer hubs in the UK. BHRUT cancer services had one of the highest patient satisfaction scores in the Trust.

2.3 Estates Update

2.3.1 The Committee was advised that there was currently a constrained capital environment and CCG budgets, but it was possible that some additional capital may be made available in the spending review. Current policy was that the receipts from the sale of NHS property assets were retained centrally, unless the vendor was a Foundation Trust. Members requested copies of the original bids and confirmation of who had signed the bids on behalf of the relevant Local Authorities.

2.4 Amendments to Committee's Terms of Reference

2.4.1 A report before the Committee proposed some amendments to the Committee's terms of reference in light of the recent decision by the London Borough of Waltham Forest to reduce its representation on the Committee from three Members to one. Some minor amendments to reflect recent changes to health service structures were also recommended. The changes were agreed.

4. Implications

4.1 There are no legal or financial implications arising directly from this report.

Background Papers Used in the Preparation of the Report:

Minutes of the JHOSC meeting held on 9 July 2019:
http://democracy.havering.gov.uk/ieListDocuments.aspx?CId=273&MId=6352&Ver=4

List of appendices:

None.

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Work Programme 2019/20

Relevant Cabinet Member: Councillor Worby, Social Care and Health Integration

Health Scrutiny Committee Chair: Councillor Keller | Deputy Chair: Councillor Robinson			
Meeting	**Agenda Items**	**Officer/ Organisation**	**Final Report Deadline**
22 Oct 2019	▪ Scrutinising Local NHS Finance ▪ Verbal JHOSC update from October meeting	BDCCG HSC Chair	7 Oct
17 Dec 2019	▪ Using the Borough Data Explorer in Healthcare and Targeted Care ▪ Communicating with the Local Population on Where to get the Right Care ▪ Outcomes of the Social Prescription Model ▪ Progress Report on Childhood Obesity Scrutiny Review	Pye Nyunt (LBBD) Andy Strickland (BHRCCGs) Mark Fowler (LBBD) Public Health (LBBD)	2 Dec
10 Feb 2020	▪ Mental Health update ▪ The Health Response to OFSTED	Cllr Chris Rice (Mental Health Champion, LBBD), Melody Williams (NELFT), CCG representative Chris Bush (LBBD)	27 Jan

	▪ The Vision for, and the Wider Delivery of the new Locality Structure ▪ Healthwatch – Overview of Key Projects' Findings ▪ JHOSC update	Mark Tyson (LBBD) BD Healthwatch Democratic Services Officer (LBBD)	
24 Mar 2020	▪ Older People's Transformation Programme ▪ Primary Care networks	BHRCCGs Director of Public Health (LBBD)	9 March
23 June 2020 (first meeting of next municipal year)			

Notes

To be rescheduled - Priorities of the Health and Well-being Board