AGENDA FOR THE HARINGEY AND ISLINGTON HEALTH AND WELLBEING BOARDS JOINT SUB-COMMITTEE

Members of the Haringey and Islington Health and Wellbeing Boards Joint-Sub-Committee are summoned to attend a meeting which will be held at Haringey Civic Centre, High Road Wood Green, N22 8LE on **06 March 2019 1.30pm**

Bernie Ryan
Assistant Director – Corporate Governance
London Borough of Haringey

Peter Fehler
Acting Director of Law and Governance
London Borough of Islington

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Despatched : 26 February 2019

Islington Membership

Councillors:
Councillor Richard Watts **(v)**
Councillor Janet Burgess MBE**(v)**
Councillor Kaya Comer-Schwartz. **(v)**

Islington CCG:
Tony Hoolaghan, Chief Operating Officer
Dr. Josephine Sauvage, Chair**(v)**
Jennie Williams, Director of Nursing and Quality
Sorrel Brookes, Lay Vice-Chair **(v)**

Islington Healthwatch:
Emma Whitby, Chief Executive**(v)**

Islington Council Officers:
Julie Billett, Director of Public Health
Maggie Kufeldt, Corp. Dir. Housing & Adult Social Services
Carmel Littleton, Corp. Dir. Children, Employment & Skills

Voluntary Sector
Katy Porter - Chief Executive, Manor Gardens Welfare Trust

Local NHS Representatives:
Angela McNab, Chief Executive, Camden and Islington NHS Foundation Trust
Siobhan Harrington, Chief Executive, The Whittington Hospital NHS Trust

Haringey Membership

Councillors:
Councillor Joseph Ejiofor**(v)**
Councillor Sarah James **(v)**
Councillor Elin Weston **(v)**

Haringey CCG:
Tony Hoolaghan Chief Operating Officer
Dr Peter Christian, Chair **(v)**
Dr Dina Dhorajiwala, Vice-Chair **(v)**
Cathy Herman, Lay Member **(v)**

Haringey Healthwatch:
Sharon Grant, Chair **(v)**

Haringey Council Officers:
Dr Will Maimaris, Interim Director of Public Health
Beverley Tarka, Director of Adults and Health
Ann Graham, Director of Children's Services
David Archibald, Haringey Local Safeguarding Board

Voluntary Sector:
Geoffrey Ocen, Chief Executive, The Bridge Renewal Trust

Quorum is 3 voting members of each constituent borough, including one local authority elected representative of each borough and one of their Chair, Clinical Commissioning Group or the Chair, Healthwatch (or their substitutes) Voting members = (v)

Haringey LONDON

A. Formal Matters

1. Filming at meetings

Please note this meeting may be filmed or recorded for live or subsequent broadcast by anyone attending the meeting using any communication method. Although we ask members of the public recording, filming or reporting on the meeting not to include the public seating areas, members of the public attending the meeting should be aware that we cannot guarantee that they will not be filmed or recorded by others attending the meeting.

Members of the public participating in the meeting (e.g. making deputations, asking questions, making oral protests) should be aware that they are likely to be filmed, recorded or reported on. By entering the meeting room and using the public seating area, you are consenting to being filmed and to the possible use of those images and sound recordings.

The Chair of the meeting has the discretion to terminate or suspend filming or recording, if in his or her opinion continuation of the filming, recording or reporting would disrupt or prejudice the proceedings, infringe the rights of any individual, or may lead to the breach of a legal obligation by the Council.

2. Welcome and Introductions

3. Apologies for Absence

4. Notification of Urgent Business

5. Declarations of Interest

A member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting of the authority at which the matter is considered:

(i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and
(ii) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Register of Members' Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure.

6. Minutes of the Previous Meeting held on the 5th of December 2018. **Pages [1-6]**

7. Questions and Deputations

Notice of questions must be given in writing to the Committee Clerk of either or both boroughs by 10 a.m. on such day as shall leave five clear days before the

meeting (e.g. Friday for a meeting on the Monday 10 days later). The notice must give the name and address of the sender.
A deputation may only be received by the Sub-Committee if a requisition signed by not less than ten residents of either or both boroughs, stating the object of the deputation, is received by the Committee Clerk of either borough not later than 10am five clear days prior to the meeting.

B. Discussion Items

8. Developing Locality Based Care in Haringey.**[Pages 7-20]**

9. Progress on Developing Place Based Care and Support in Islington **[Pages 21-32]**

10. NHS Long Term Plan and Implications for Development of Integrated Care**[Pages 33 -52]**

11. Items for Future Meetings

C. **Urgent Items** (if any)

12. New Items of Urgent Business

To consider any new items of urgent business admitted above.

13. Exclusion of the Press and Public

To consider whether, in view of the nature of the remaining items on the agenda, any of them are likely to involve the disclosure of exempt or confidential information within the terms of Schedule 12A of the Local Government Act 1972 and, if so, whether to exclude the press and public during discussion thereof.

14. New Items of Exempt Urgent Business

Any exempt items which the Chair agrees should be considered urgently by reason of special circumstances. The reasons for urgency will be agreed by the Chair and recorded in the minutes.

15. The next meeting of the Haringey and Islington Health and Wellbeing Boards Joint Sub-Committee will be a date to be agreed in June 2019.

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Agenda Item 6

MINUTES OF THE MEETING OF THE HARINGEY AND ISLINGTON HEALTH AND WELLBEING BOARDS JOIN SUB-COMMITTEE HELD AT ISLINGTON TOWN HALL ON WEDNESDAY 5TH DECEMBER 2018, 1.30PM

Attendees:

Cllr Richard Walls – Leader of Islington Council and Co-Chair
Cllr Janet Burgess – Executive Member for Health and Social Care, LB Islington
Dr Josephine Sauvage – Chair, Islington CCG
Sorrel Brookes – Lay Vice-Chair, Islington CCG
Emma Whitby – Chief Executive, Healthwatch Islington
Julie Billett – Director of Public Health, LB Islington
Maggie Kufeldt – Corporate Director of Housing and Adult Social Services, LB Islington
Katy Porter – Chief Executive, Manor Gardens Welfare Trust (Voluntary Sector Representative)
Siobhan Harrington – Chief Executive, Whittington Health NHS Trust

Cllr Peray Ahmet – Cabinet Member for Adults and Health, LB Haringey
Cllr Elin Weston – Cabinet Member for Children and Families, LB Haringey
Dr Peter Christian – Chair, Haringey CCG
Sharon Grant, Chair – Healthwatch Haringey
Dr Will Maimaris – Interim Director of Public Health, LB Haringey
Beverley Tarka – Director of Adult Social Care, LB Haringey
Ann Graham – Director of Children's Services, LB Haringey
Geoffrey Ocen – Chief Executive, The Bridge Renewal Trust (Voluntary Sector Representative)

Also present:

Zina Etheridge – Chief Executive, LB Haringey
Rachel Lissauer, Director of the Haringey and Islington Wellbeing Partnership

Councillor Richard Watts in the Chair

1 FILMING AT MEETINGS (Item 1)

Councillor Watts referred to the information on the agenda and members noted the guidance in respect of filming at meetings.

2 WELCOME AND INTRODUCTIONS (Item 2)

Councillor Watts welcomed everyone to the meeting and members of the Sub-Committee introduced themselves.

It was noted that, in the absence of Councillor Joseph Ejiofor, Councillor Peray Ahmet would co-chair the meeting with Councillor Richard Watts.

3 APOLOGIES FOR ABSENCE (Item 3)

Apologies for absence were received from Councillor Joseph Ejiofor, Councillor Joe Caluori, Tony Hoolaghan, Jennie Williams, Carmel Littleton, Angela McNab, Dr Dina Dhorajiwala and Cathy Herman.

4 NOTIFICATION OF URGENT BUSINESS (Item 4)

No items of urgent business were declared.

5 DECLARATIONS OF INTEREST (Item 5)

None.

6 MINUTES OF THE PREVIOUS MEETING (Item 6)

RESOLVED:

That the minutes of the previous meeting held on 29 January 2018 be agreed as a correct record of the meeting.

7 QUESTIONS AND DEPUTATIONS (Item 7)

None.

8 CONTEXT AND ACHIEVEMENTS OF THE WELLBEING PARTNERSHIP (Item 8)

Rachel Lissauer, Director of the Haringey and Islington Wellbeing Partnership, made a presentation which summarised the achievements of the Partnership to date.

The following main points were noted in the discussion:

- Haringey and Islington had a shared conviction and determination to tackle health inequalities and improve the health of the local population. Joint work was underway in a number of areas to improve health and care services. This included developing shared infrastructure and connecting pathways of care.
- It was important to make best use of public estates. The Wellbeing Partnership was submitting a bid to One Public Estate to maximise the use of estates for housing.
- There were new opportunities arising from developing shared professional networks and training opportunities across Islington and Haringey. It was suggested that improvements to workforce practices may assist with retention and recruitment.
- It was commented that quality improvement work was underway across community health services.
- Multi-agency access to shared digital records would improve services for residents, particularly those with multiple conditions who work with several different professionals.
- Front line staff did not want to work within traditional service boundaries and were keen to break down barriers between services.
- Events would be held with public sector staff across North Central London to consider service integration.
- The Sub-Committee commented on the progress that had been made so far and the positive benefits this had for residents. A member of the Sub-Committee commented

that the improvements to hospital discharge arrangements had been particularly positive.

- It was commented that services for children and young people should be included in the transformation work being carried out by the Wellbeing Partnership; it was thought that further integration between health and care and early help and preventative services would provide more holistic support to children and young people.
- A member commented on the importance of resident engagement and co-production, noting that it was vital for the local community and service users to be involved in the development of services. In response, it was commented that co-production had been limited to date as the majority of work had related to internal staffing and technical arrangements, however resident engagement would be critical to the development of place-based services. Members would be keen to review an action plan for community service user engagement.

RESOLVED:

1. To note the progress made on integrating pathways of care with a focus on people with diabetes, frailty, musculo-skeletal conditions and people needing immediate care.

2. To recognise ongoing work on enablers to integrated care, particularly integrated digital care records, estates and community services.

3. To note the learning to date and plans for the next phase of work.

9 LOCALITY WORKING (Item 9)

Maggie Kufeldt introduced the report setting out the progress made in developing place-based services in North Islington.

- Islington had a strong preventative model that was based on supporting the resilience of service users.
- A place-based services prototype was being developed in the north of the borough and was intended to be replicated elsewhere once arrangements had bedded in.
- Place-based care would bring together health, housing, children's, community and social services. It was intended to significantly increase the collaboration between services.
- Islington Council could not develop place-based services in isolation and was keen to work with NHS and voluntary sector partners, as well as other housing providers and the emergency services.
- Place-based working would reduce duplication between services and enable more joined up service delivery. An integrated multi-disciplinary team working across the public sector would help to address the root causes of the issues affecting residents and develop a connected and efficient workforce.
- It was expected that services would be delivered from fewer, better buildings which would increase the land available for social housing.
- Service redesign events and workshops would be held with council staff and colleagues from partner organisations. Resident engagement would begin in 2019.

Beverley Tarka and Will Maimaris introduced the report on the locality-based care pilot in North Tottenham.

- Haringey was developing locality-based care for similar reasons to Islington. The Haringey pilot had a focus on early intervention and whole-system outcomes.

- The importance of resident engagement was reiterated. Residents are important partners in developing successful locality-based arrangements.
- Haringey's pilot had focused on North Tottenham. It was commented that significant public resources were already being spent to provide services in the area; the pilot would facilitate greater coordination between services, which would make them more effective and responsive.
- Residents in North Tottenham faced significant health inequalities. There was a 17 year gap for women and a 15 year gap for men in heathy life expectancy in Haringey between the most affluent and most deprived populations.
- The North Tottenham pilot involved key partner organisations including Homes for Haringey.
- The pilot was seeking to achieve immediate improvements in the short term. A longer term plan for more transformative work had been developed.

The following main points were noted in the discussion:

- It was queried if voluntary and community sector partners would also benefit from workforce development initiatives, including access to training and information sharing. In response, it was advised that further work around this would be needed, however it was noted that partnership working with the voluntary and community sector on a locality basis would be beneficial.
- It was advised that the NHS had previously debated including voluntary and community sector organisations in Community Provider Networks. To date this had not been fully implemented, however it would be valuable for the voluntary and community sector to be involved in locality working projects.
- It was commented that the views of service users needed to be taken into account in defining measurable outcomes and on the use of public estates. It was suggested that residents may be cynical about locality working and may perceive it as a savings exercise unless they are involved in the development of the locality working pilots.
- It was commented that the use of public estates could be particularly emotive; the needs of communities needed to be considered at neighbourhood level.
- In Islington, new housing development on land currently used for community facilities tended to result in new mixed-use buildings containing both community facilities and housing. It was important to engage with local communities as plans were developed.
- Islington's model of place-based services was a prototype; it would evolve as it developed and learning would be consolidated before any future roll out of place-based services.
- A member welcomed the development of locality based multi-disciplinary teams, commenting that some residents, particularly young people, did not fully appreciate that existing services were delivered by separate local authority, NHS and community organisations.
- Islington residents had reported frustration with separate and linear public services. It was commented that residents arranged their lives around the needs of public services, whereas public services should be arranged around the needs of residents. Place-based services would enable families currently accessing multiple services to draw up a single plan for their family, rather than being told what to do by public services.
- North Tottenham and North Islington faced similar challenges, but they were separate places with unique issues. Providing services on a locality basis allowed services to develop organic structures in a local area to best meet the needs of the local community.

- Place-based working was intended to support and enhance existing local working arrangements. It was commented that front line NHS staff were particularly keen about developing new ways of working with colleagues.
- It was suggested that it would be beneficial for North Middlesex University Hospital to be involved in the development of locality working arrangements in North Tottenham.
- The Sub-Committee noted the risk that sustained financial pressures and the need to meet NHS planning requirements could result in designing out service variation from area to area. However, for locality arrangements to flourish, they would need to recognise and respond to local needs effectively. It was important for local authorities, particularly at a political level, to focus on local priorities rather than centrally set targets.
- It was commented that locality working had the potential to change perceptions about how health and care services are accessed. This would be particularly beneficial to young people, who increasingly expected quick access and convenience.
- It was queried what degree of service variation between local areas would be permissible. In response, it was suggested that all variation would have to be evidenced by local needs.
- It was not appropriate for all services and pathways to operate at the locality level. It was commented that early help and social care services would benefit from a more localised service, whereas acute health services were better provided at a pan-London level. The challenge was to have the right services operating at the right level.
- It was requested that an update on locality working be reported to the next meeting.

RESOLVED:

1. To support the development of Islington's place-based care proposal.

2. To support the development of Haringey's locality-based care proposal.

10 GOVERNANCE AND ROLE OF JOINT SUB-COMMITTEE OF THE HEALTH AND WELLBEING BOARDS (Item 10)

Rachel Lissauer introduced the report which set out the need for further development of local health and care governance arrangements.

It was noted that both Islington and Haringey Health and Wellbeing Boards were reviewing their membership and as a result the membership of the Joint Sub-Committee may be revised.

RESOLVED:

1. To note the evolving governance designed to support the delivery of more integrated care at a locality and borough level.

2. To note that national and local plans to develop more integrated health and care services are likely to prompt further consideration of governance arrangements. These will be brought back to borough Health and Wellbeing Boards and the joint Sub-Committee as appropriate.

The meeting ended at 2.40 pm

CHAIR

Haringey and Islington Health and Wellbeing Boards Joint Sub- Committee

Title: Developing locality-based care in Haringey

Report Authorised by: Beverley Tarka, Director of Adults and Health, Haringey Council

Lead Officers:

Beverley Tarka, Director of Adults and Health, Haringey Council, Dr Will Maimaris, Interim Director of Public Health, Haringey Council, John Everson, Assistant Director of Adult Social Care, Haringey Council, Rachel Lissauer, Director of Haringey and Islington Wellbeing Partnership, Haringey and Islington Clinical Commissioning Groups.

1. Purpose

In December the Joint Health and Wellbeing Board Sub-Committee (JHWBSC) agreed to use the March meeting to review progress in developing place-based care in both Boroughs. This report provides the update for Haringey. It outlines some of the findings of the 'deep dive' interviews that were carried out with people working in North Tottenham in January and how that is informing our approach.

2. Recommendations

The JHWBSC is asked to note the emerging themes and to comment on priorities, opportunities and challenges. The JHWBSC is asked to note areas of common focus and areas of different emphasis between boroughs.

3. Describe the issue under consideration

Background

Locality based care involves focusing our energy and combined resource on supporting residents to remain healthy and fulfilled, providing coordinated and flexible help when needed, in order to enable independence and to avoid crisis and fragmented support. We recognise that the challenges facing individuals and families in our borough are multi-faceted, often cutting across housing, poverty and ill health, to which we often provide a partial response. So our localities work is about coordinating between services and agencies. We also recognise that we have dynamic and thriving individuals and communities. Our work in localities is about engaging and involving residents, community and voluntary sector groups and enabling them to lead in the development of strong and thriving communities.

This community connection and service integration needs to around a recognisable geography that is the right size for a workforce and residents to know each other and develop connections. We have focused on North Tottenham as the place where we are developing a prototype of this approach which we will learn from and roll out to the rest of the Borough.

What we have done so far

On 13th December 2018 we held a facilitated workshop to shape our plans for locality based care in North Tottenham. This brought together frontline and senior managers from Health and Care organisations in Haringey to understand how health and care, community sector, housing and other front line staff teams are currently working to improve health and wellbeing of residents. We heard about issues commonly raised by service users and residents and developed some short and longer term priorities for improving integration and join up of care.

A team from, made up of staff from across different organisations, then carried out a 'deep dive' – a set of interviews over the course of a week in January (w/c 21st January) to meet with a very broad group of people who work in North Tottenham, to test these ideas and priorities.

The findings from this deep dive were fed back at a meeting on the 14th February. We took the opportunity at this meeting, with a range of people in the room who work and live in North Tottenham, to learn from Community First, Islington Bright Start and the Haringey Locality Team who have been identified as examples of good practice.

The emerging priorities will be reviewed at a senior level by a multi-agency group, with the intention that permission is given for immediate actions, which are largely around connecting people and taking opportunities for joint working and training. We are also working together on developing an operating model, across community health, social care and primary care, that enables a more integrated structure between teams. We will be considering the outcomes that will help us to monitor impact and progress.

4. Contribution to strategic outcomes

This work has the potential to contribute to the following strategic priorities and outcomes.

Haringey Health and Wellbeing Strategy 2015-18 (all 3 priorities):

- Reducing Obesity
- Increasing healthy life expectancy
- Improving mental health and wellbeing

5. Statutory Officer Comments (Legal and Finance)

Legal (Haringey)

The issue under consideration and the recommendation falls within the terms of reference of the Board to encourage joint consideration and co-ordination of health and care issues that are of common interest to both Haringey and Islington.

Chief finance officer

There are no immediate financial implications arising from this paper, which at this stage sets out proposals and next steps.

6. Environmental Implications

Environmental implications for the planned work identified in this report includes that associated with office usage (energy and water use, waste generation) and publicity (use of resources for leaflets, if used).

7. Resident and Equalities Implications

The Council has a Public Sector Equality Duty under the Equality Act (2010) to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act
- Advance equality of opportunity between people who share those protected characteristics and people who do not
- Foster good relations between people who share those characteristics and people who do not.

The three parts of the duty applies to the following protected characteristics: age, disability, gender reassignment, pregnancy/maternity, race, religion/faith, sex and sexual orientation. Marriage and civil partnership status applies to the first part of the duty.

Locality based care will aim to tackle health inequalities in Haringey including the 17 year gap in healthy life expectancy for woman and 15 year gap for men between least and most deprived parts of the borough (Public Health England data).

8. Appendices

Slides outlining Haringey approach to locality development

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Our collective vision for the Haringey and Islington Wellbeing Partnership remains:

BORN · LIVE · AGE WELL

A healthier choice is the easier choice

Strong communities, where residents are healthier & live independent, fulfilling lives

Early support for those who have difficulty in maintaining their health and wellbeing

Those who need care and /or health support will receive responsive & high quality services

Our one-slide hypothesis

BORN · LIVE · AGE WELL

Locality working vision

We want to create a step forward in how well we prevent issues arising and nip them in the bud early, through more integrated public services and more resilient local communities.

This means:

- A **simpler, more joined up** local system that offers the right support at the right time that manages the growth in demand and to reduce duplication in the system
- **Integrated, multi-disciplinary** teams from across the public sector working together on the same geography and tackling issues **holistically**, focused on **relationship-building and getting to the root causes**
- A workforce who feel **connected** to each other and able to work **flexibly**, better able to meet people's needs and sharing the principles of a practice model
- A new system **partnership with the voluntary sector** to co-ordinate local activity, networks and opportunities – so that we make the best use of the **strengths and assets of our communities**

Enabled by

A strategic and innovative focus on **culture and behaviour** among staff and residents, sharing practice models and grounded in a strengths based appraoch

A joint approach to the **shared public estate** with services delivered from fewer, better buildings, enabling estate rationalisation and new social housing.

Integrated data and systems and assumptions that we will share information where it makes sense

A **mature approach to finance**, risk and reward across the local system.

More **joined-up governance** of strategy and spend with the Council and NHS – so that we are jointly deploying our resources to achieve the most impact

BORN · LIVE · AGE

Progress on place based care in Haringey

Update for Joint Health & Wellbeing Board Sub-committee

6 March 2019

Context

Sept 18

Launch

- Multi-agency leadership agreed focus on N Tottenham
- All-age, all service
- Prototype locality working

Dec 18

Groundwork

- Resident feedback – how we are doing now
- Launch of hypothesis for place-based care with staff
- Identified priorities

Jan 18

Deep Dive

- 30+ interviews with staff working in N Tottenham, particular focus on voluntary sector
- Listening and learning
- Refining priorities

Feb 18

Framework

- Cross agency senior management group
- Formed to give permissions consider resource implications
- Enabling change

Contents

A progress report for the JHWBSC on developments in the localities programme in Haringey – focused on:

- Building connections between teams
- Engaging the voluntary and community sector
- Our strategic approach to prevention and early intervention
- Supporting primary care networks
- Forming integrated locality teams

Building connections between teams

- **Early help in the places people go:** we have a multi-professional team in Wood Green that provides connected and pro-active help for all residents, across ages and based on need, not eligibility. We are going to consider how this might become more multi-agency and how we can bring it to North Tottenham.
- **Building connected teams to support people needing services:** we have a good model of a multi-agency team that works with people who have very complex problems and are attending and re-attending A&E. The team has strong shared values, works flexibly and pro-actively, shares skills and is prepared to 'hold' high complexity. Managers from our core social care, mental health and community health teams are now considering how we would draw core services together to form a connected, multi-agency 'North Tottenham' team.
- **Connecting for children and families:** whilst all age approaches will be embedded in localities, we will focus on co-ordination of our early years services across the NHS and the Council and are committed to providing an integrated early years service based around localities, initiating this approach in North Tottenham.

Engaging the voluntary and community sector

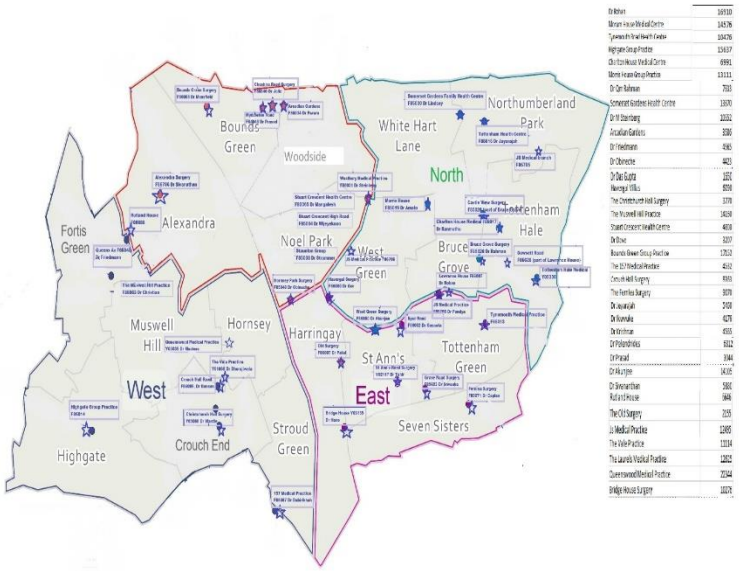
- **Enabling innovation**: In our 'Deep Dive' we were struck by the number of motivated individuals and community groups whose efforts are limited or slowed down by bureaucratic requirements. We are going to work with these groups and individuals to understand these barriers and consider how we move towards enabling and supporting community innovation.
- **A festival**: community groups and frontline staff working in a place want to get to know each other, understand better what's going on locally and make connections. We would like do this around 'cook ups' and informal, locally organised, events.
- **Enabling navigators**: in the 'Deep Dive' we noticed that voluntary groups and navigators (council funded) are often spending time with clients in queues for council and other public sector services. We are going to map this and to see whether, using a quality improvement approach to test changes, we might be able to reduce this inefficiency.

Our strategic approach to prevention and early intervention

- **Shared focus**: we have agreed a shared focus on prevention and early intervention as the core of our locality approach across the partnership.
- **Strategic approach**: We want to develop and implement a Haringey strategy for early support which builds on good practice and the evidence of what is working and can guide decision-making about how this is taken forward. We will do this across the age range, for children, young people and adults.

Supporting primary care networks

- Primary Care in Haringey connects on the basis of four locality areas (West, Central, North East and South East)
- These localities map onto ward boundaries, make sense geographically and will continue to be the key unit of organisation
- However, primary care also needs to be able to group at a smaller level to enable joint working, sharing of staff and managing population health at a very local level.
- Over the next six months we will be going through a process of establishing the layout of primary care networks for Haringey. The CCG will be responsible for ensuring that we take an approach where there is full coverage and networks are geographically linked.



Forming integrated locality teams

- **Organisational process**: each organisation in the partnership is identifying their contribution to a locality model in terms of current services and willingness to contribute in the future.
- **Workforce development:** we will continue to focus on enabling staff to work together through developing a common approach to practice
- **Framework group** established to review inputs: our late February framework session of senior leaders will look at how the organisational inputs fit together as a new model.
- Goal is an operating model to **prototype from April** onwards in North Tottenham.

Report for: **Haringey and Islington Health and Wellbeing Boards Joint Sub-Committee**

Title: **Progress on developing place-based care and support in Islington**

Report Authorised by: Julie Billett – Director of Public Health

Lead Officer: Maggie Kufeldt – Corporate Director – Housing and Adult Social Services

1. Describe the issue under consideration

At the last meeting of the JHWBSC, it was agreed that both boroughs would bring back updates on progress towards an integrated model of place-based support in each borough. The slides attached to this report provide that update for Islington.

2. Recommendations

That the JHWBSC note the report and slides and comment on key opportunities, challenges and priorities within the work – as well as similarities and differences and opportunities for collaboration between the two boroughs' approaches.

3. Background

Since the last meeting of the JHWBSC, Islington partners have been exploring the provision of place-based integrated services, starting with a prototype in North Islington, for an all-age, community-focused approach. We are calling this piece of work a 'localities programme'.

We will take an all age approach that recognises that people are part of families and communities and rely on all of the assets and resources in the place where they live. We will build on the existing work in many parts of the council as well as primary care in a more joined up and holistic way, recognising that health behaviours and social connections, good quality housing, good work and use of community services and assets have more impact on people's health and wellbeing than good quality clinical care.

We know that people are experts in their own lives. Providing high quality advice, support and universal services that keep people healthy, independent and able to care for themselves and their families will be at the heart of what we do. We want to support people at home and in their communities with high quality,

consistent care when needed. We will make best use of all the assets in a place, whether that be the budget, the multi–agency workforce, buildings, leisure and recreation facilities or the local voluntary and community sector offer. We will aim to co-locate and integrate the workforce where possible.

This place-based approach and integration across care pathways requires a very different way of managing resources, involving joint decision-making between health and the council, sharing estates and potentially even management and services.

The key partners involved in this work are: Camden & Islington Foundation Trust, Whittington Health, Islington CCG, Islington GP Federation and Islington Council. Within the council, a whole range of departments are involved, principally children's and adults services, housing, Public Health and employment and skills services, reflecting the breadth of contribution local government services can make to wellbeing and the wider determinants of health. We want to work closely with the voluntary sector and have already begun engagement through Voluntary Action Islington.

We are proposing to develop this work as a partnership through a co-design and prototyping approach. We will start with North Islington as a locality, then seek to move to full roll-out across the borough fairly rapidly but in a test-and-learn way that enables each locality to learn from the others and to develop its own ways of working within the overall parameters and according to the needs and priorities of the locality.

Since the last report to this Sub-Committee, we have held a number of successful co-design events, within the council (28 November), all local public sector partners (29 November) and with frontline staff from the council and NHS (20 December). These were very positive and supported us to develop the model in more detail. In addition, there have been a number of events focused on the governance we will need in order to drive forward integration across the local system, including an away day organised by the STP team for each borough.

4. Contribution to strategic outcomes

Helping residents live healthy independent lives
Making Islington the best place to grow up
A fair and inclusive local economy
A safe and cohesive borough

5. Financial implications:

A significant cost driver for the council and partner organisations is the demand for services across Adult Social Care, Children's Services, Housing and Health. A key aim of developing placed based services is to manage and reduce this demand more effectively across the system.

For future years (20/21 onwards) the council has built in significant savings within its MTFS predicated on placed based services, with their focus on prevention and early intervention, reducing demand.

If this work is successful, then the long-term impact should lead to savings for both the council and the partner organisations.

However, in the short and medium term there may be efficiency savings identified but there is also likely to be investment required to transform the offer, potential double running costs and a potential initial increase in demand in the short term.

Once placed based services has been scoped in detail the finance leads and senior teams of all organisations will need to work together to resource the programme, estimate the phasing of the savings and consider how to share any potential savings.

6. Legal Implications:

No legal implications although any proposals changing service delivery will require individual legal advice to ensure legal compliance.

7. Environmental Implications

None.

8. Resident and Equalities Implications:

The council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding.

This proposal should represent a significant opportunity to advance equality of opportunity and promote good relations, by improving the partnership between public sector partners and with the voluntary sector to strengthen community connectedness, health and wellbeing outcomes, and focus on the wider determinants of health, all of which are significant factors in inequality in Islington.

9. Use of Appendices

None

10. Background Papers: None

Slides : detailed overview of progress since December meeting

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Progress on place based care in Islington

Update for Joint Health & Wellbeing Board Sub-committee

6 March 2019

Context

- Since the last joint meeting, we have held a number of really successful workshops including a large staff ‘groundwork’ design event on 20 December.
- We have been developing our operating model and broadening the engagement with a range of services and organisations to build a common sense of the ‘locality approach’.

Contents

A progress report for the JHWBSC on developments in the localities programme in Islington – focused on:

- Building connections between teams
- Engaging the voluntary and community sector
- Our strategic approach to prevention and early intervention
- Supporting primary care networks
- Forming integrated locality teams

Building connections between teams

- **Strengthening and expanding the integrated networks:** we have a really successful model in the integrated network meetings to work together on the most complex health and social care cases – we are now working together to expand that to a broader range of people whose lives indicate some kind of 'rising risk'.
- **North Islington 'asset-based walkabout'**: we are running a series of walkabouts in North Islington to help staff working there get to know the place, its assets and strengths – and one another – better.
- **Managers' OD programme:** each organisation volunteering a first line manager working in North Islington to be part of our operational leadership group and prototype design team, with an intensive professional development programme embedded in that.
- **Marketplace event**: we are intending to launch our new integrated model with a marketplace event in early April that brings people together and helps them to get to know the range of opportunities and services working in the locality.

Engaging the voluntary and community sector

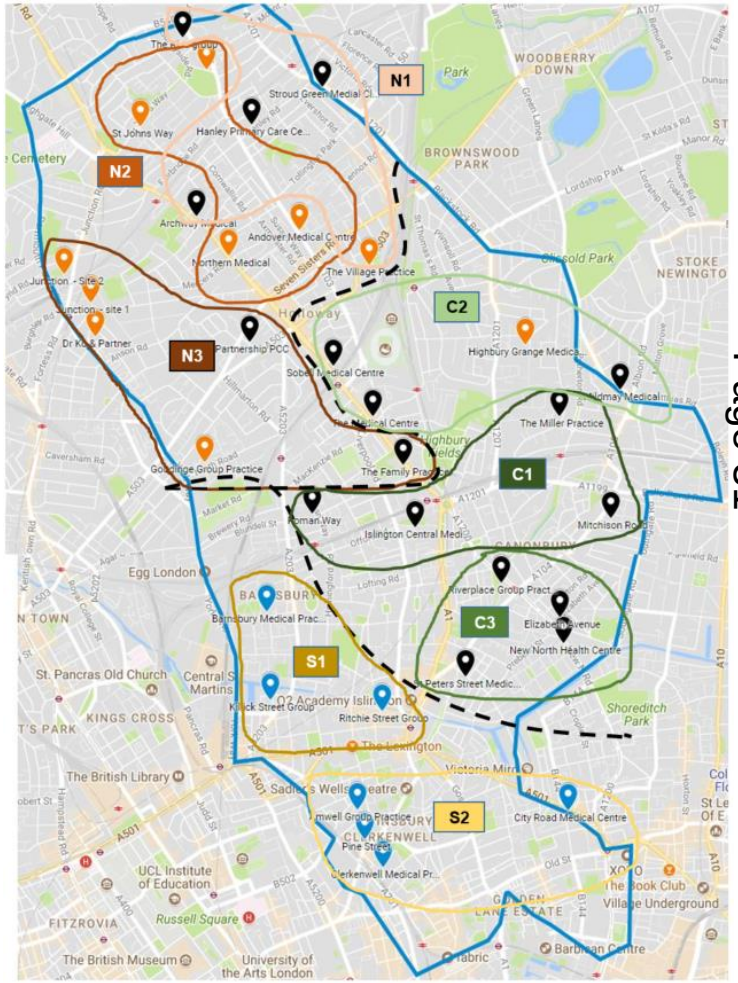
- **South Islington prototype**: to complement the work in North Islington, we are supporting a couple of VCS organisations in the south locality to prototype some new ways of working there.
- **North Islington event planning**: we are planning a set-piece event to bring together our VCS partners in the North on how we work together with them in the new model.
- **Direct engagement with key North Islington organisations**: we want to have a series of conversations individually with our key VCS partners in the North locality to make sure they are fully engaged with the development of the prototype.

Our strategic approach to prevention and early intervention

- **Shared focus**: we have agreed a shared focus on prevention and early intervention as the core of our locality approach across the partnership.
- **Understanding activity on the prevention pyramid:** we are mapping all the activity and services working across the locality model in terms of the pyramid of prevention.
- **Connected Communities**: we have begun a focused workstream on how we work with the voluntary sector to strengthen our shared prevention efforts.
- **Islington Together:** Islington Council are working jointly with Islington Giving to explore new ways of supporting grassroots activities.

Supporting primary care networks

- We are in a strong position as primary care networks come into national priority – with 8 established networks working within our 3 localities.
- The GP Federation are leading the work to support those networks to work to the new requirements and to make the most of that opportunity – and our locality teams will wrap around and work closely with each network.



Forming integrated locality teams

- **Organisational process**: each organisation in the partnership is identifying their contribution to a locality model in terms of current services.
- **Framework group** established to review inputs: our late February framework session of senior leaders will look at how the organisational inputs fit together as a new model.
- Goal is an operating model to **prototype from April** onwards in North Islington.

Report for: **Joint Sub-Committee of the Islington and Haringey Health & Wellbeing Boards**

Title: **NHS Long-Term Plan and Implications for Development of Integrated Care**

Report Authorised By: **Julie Billet, Director of Public Health, London Boroughs of Camden and Islington**
Beverley Tarka, Director of People, Haringey Council

Lead Officers: **James Blythe, Strategy for Islington Council**
Rachel Lissauer, Wellbeing Partnership

1. Purpose

This paper provides a summary of the NHS Long Term Plan with a particular focus on its implications for the development of Integrated Care Systems in both boroughs.

2. Describe the issue under consideration

In 2018, the NHS was tasked with producing the Long-Term Plan as a blueprint for the NHS's ambitions over the next 10 years. The resulting Plan was published in Jan-19 and focusses on building an NHS fit for the future by:

- Enabling everyone to get the best start in life;
- Helping communities to live well;
- Helping people to age well.

The Plan sets out its ambitions for improving patient care in 5 categories:

- *Transforming health and care* through greater collaboration at a local level between GPs, their practice teams, community health and social care through integrated care;
- *Investing in prevention and tackling health inequalities*: The NHS will increase its contribution to addressing the causes of ill health such as smoking, unsafe alcohol consumption and developing diabetes, particularly for those groups most affected;
- *Creating a workforce that meets demand* through improving recruitment and training of more professionals, particularly clinical and medical staff;
- *Making better use of data and digital technology* through greater use of tools, shared patient records and improvements to analytics to support service planning and delivery;
- *Getting the most out of taxpayers' investment in the NHS:* Working with health and care professionals to identify ways to reduce duplication, make better use of the NHS's combined buying power and reduce spend on administration.

The details of the NHS Long Term Plan are summarised in Appendix A. Many of the expectations set out in the plan are in line with the current direction of travel and are already being addressed through actions at borough and STP level. Although there will be challenges in meeting expectations in some areas, such as digital and financial balance across the system.

The focus for the joint board is particularly on the outlined new model of care and requirements within the Long Term Plan for the development of Integrated Care Systems. It is timely to reflect on the Inter-Great simulation events in both boroughs and to consider, drawing on insights from these events, how members of the joint board would want to shape the development of integration for our boroughs.

Expectations set within the Long Term Plan for the development of Integrated Care Systems

A range of expectations are outlined for Integrated Care Systems:

- Integrated care and place based systems will be consolidated in the establishment of ICSs in each STP area.
- The level for an ICS is not set. However, there is an expectation that there will be one CCG per ICS.
- There is an expectation that ICSs will provide a plan of their approach for NHSE by April 2019.
- ICSs will agree system wide objectives with NHSE / Improvement Regional Directors
- Each ICS will have a partnership board, drawn from a representing commissioners, trusts, primary care networks and – with the clear expectation that they will wish to participate – local authorities, the voluntary and community sector and other partners
- A non-executive chair (locally appointed, but subject to approval by NHS England and NHS Improvement)
- Sufficient clinical and management capacity drawn from across their constituent organisations to enable them to implement agreed system-wide changes
- Full engagement with primary care, including through a named accountable Clinical Director of each primary care network;
- Greater emphasis by the Care Quality Commission (CQC) on partnership working and system-wide quality in its regulatory activity, so that providers are held to account for what they are doing to improve quality across their local area;
- Contributions of partners to ICS goals will potentially be backed up by longer term contracts in which there is a duty of collaboration between partners

Health and care budget alignment

Councils and CCGs will be supported in bringing health and social care budgets together where there is agreement. A range of potential ways of doing this are outlined but there are no set expectations:

- voluntary budget pooling between a council and CCG for some or all of their responsibilities;

- individual service user budget pooling through personal health and social care budgets;
- the Salford model where the local authority has asked the NHS to oversee a pooled budget for all adult health and care services with a joint commissioning team; or
- the model where the CCG and local authority ask the chief executive of NHS England to designate the council chief executive or director of adult social care as the CCG accountable officer.

Primary Care Networks

Primary Care Networks feature strongly within the Long Term Plan as a unit of organising primary care, community health, care and navigation/social prescribing at a local level. There is an expectation of clinical leadership at this level, with contract payments for additional services being paid at a network level rather than to individual practices. Within London there is likely to be an acceptance that networks may be larger than the specified 30-50,000 population. Within North Central London it is likely that primary care network configuration will, wherever possible, be in line with existing network/CHIN/locality configurations.

NHS England see 2019/20 as a transitional year in which local NHS and care partners have the opportunity to shape local implementation for their populations over the next 5 years. NHSE anticipate there will be a number of iterative steps to local planning between local CCGs, NHS providers and Council who will be expected to collaborate to:

- Develop plans for implementing the Plan's commitments in 2019/20 (for April 2019, though no detailed guidance has as yet been released);
- Develop more considered plans for a five-year system plan (for September 2019).

3. Recommendation

The joint board is asked to discuss responses to the Long Term Plan and to consider learning and insights from the InterGreat events.

It is not clear yet what responses on the development of integration will be required from boroughs. However, the joint board is asked to note that Haringey and Islington will be continuing to work 'on the ground' through our prototypes and will also be starting to set out at borough level, our proposed and preferred models for integration. These can then contribute towards an NCL response. The joint board is asked to approve that these responses should be developed collaboratively and brought to a future joint board meeting for consideration.

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NHS Long-Term Plan

Overview

Much that is familiar:

- Priorities from the Five Year Forward View
- A focus on prevention…
- Synergy with current work in NCL – primary care networks; alternatives to outpatient appointments

Additional emphasis on:

- Full coverage of Integrated Care Systems by April 2021
- Systems – update STP by Autumn 2019

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New Service Models for 21st Century

Boosting out of hospital care:

- Primary Care Networks aligned with multi-disciplinary teams;
- Community 2-hour rapid response service;
- Re-ablement offered within 2 days of referral;
- Admission avoidance - falls prevention; support to care homes; incentives to primary care networks;
- NHS 111 booking directly into GP practices and refer to community pharmacies;
- Changes to Quality Outcomes Framework to support more personalised care and Quality Improvement;
- Targeted support for unmet physical and mental health needs provided by GP networks;
- Increase identification and support for carers, and people with dementia;
- Portable and digital home monitoring to prevent escalation of need;
- Closer working with voluntary sector;
- Above supported by increased investment in primary care, community services and mental health services;

Reduce pressure on emergency hospital services:

- By 2023 Clinical Assessment Service (CAS) will typically act as single point of access for integrated urgent care and discharge from hospital;
- Fully implement the Urgent Treatment Centre model by autumn 2020;
- Improve the range of support offered by the Ambulance services;
- Type 1 A&E will move to comprehensive model of same day emergency care, provide an acute frailty service;
- NHS Clinical Standards review will develop new ways of looking after patients with most serious illness and injury;
- Continue to improve discharge support.

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New Service Models for 21st Century

Increase patient control and personalisation:

- More personalised therapeutic options
- Expand the choice and control people have over their own care
- Roll out personalised care model nationally by 2023/24
- Increase support to help people manage their own health e.g. diabetes prevention, asthma and respiratory, maternity and parenting, online therapy for common mental health issues
- Expand Social prescribing and link workers for this
- Accelerate roll out of personal health budgets
- Personalised end of life care

Digitally enabled primary care and outpatient care:

- Digital options for patients to get advice and care using NHS App
- Digital first to access primary care – by telephone or on line form networks or alternative providers
- Outpatient redesign to reduce face to face by a third in next 5 years and support online booking

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Integrated Care Systems and Population Health

By April 2021 all Integrated Care Systems (ICS) will have:

- Partnership board of providers and commissioners;
- Non Exec chair (locally appointed but subject to NHSE approval);
- Clinical and managerial capacity to implement system wide changes;
- Full engagement of primary care including a clinical director for each Primary Care network;
- Greater emphasis by Care Quality Commission (CQC) on partnership working;
- All ICS providers contributing to ICS goals and performance;
- Clinical leadership aligned to ICSs.

Enablers for establishing Integrated Care Systems:

- Commissioner function will be leaner and more strategic;
- NHS Improvement will support mergers of Trusts;
- Funding flows and contract forms (incentives) to support move to Integrated Care Systems;
- New Integrated Care System and accountability framework (integrated regulatory system);
- ICSs will agree system wide objectives with NHS England/Improvement Regional Director;
- Blending and pooling health and social care budget to continue;
- Better Care Fund (BCF) to be reviewed.

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Building System Change

Focus on prevention and reducing health inequalities:

- **Evidenced based action on reducing –** Obesity, Smoking, Alcohol, preventing Diabetes, Air Pollution;
- **Improved support for -** People with learning disabilities and autism; Homeless; People with mental illness to find employment; Screening and early diagnosis of cancer

Progress on care quality and outcomes:

- Builds on existing improvements in childbirth, cancer survival, reducing cardiovascular deaths, and lower male suicide rates;
- Building on the priorities set out in the Five Year Forward View for cancer, mental health (adults and children's), diabetes, multi-morbidity and healthy ageing including dementia;
- Focuses on children's health, maternity, cardiovascular and stroke, respiratory conditions, learning disabilities and autism, carers.

Supporting NHS Staff and Workforce

- NHS workforce implementation plan will be published later in 2019;
- Focus on matching workforce to rising demand;
- Increasing the pipeline of training and university places;
- Improving access to, and funding for, clinical placements;
- Expanding international recruitment;
- Incentives for recruitment in hard to reach specialities and geographies;
- Developing flexible employment conditions to improve recruitment and retention (flexible rostering, funds for continuing professional development, support diversity, create new roles and inter-disciplinary credential programmes);
- Development of primary care networks;
- Increasing the number of volunteers.

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Building System Change

Digitally enabled care:

- Investment in technology as an enabler for delivery of the NHS Long Term Plan
- Focus on digital access to services;
- Self-care by patients and carers;
- Interoperability (access integrated health and care records);
- Access to decision support tools;
- Use of Artificial Intelligence;
- Use of predictive techniques to plan and optimise care in integrated care systems;
- Use of secure linked clinical, genomic and other data to support medical breakthroughs and consistent quality of care;
- Reducing face to face outpatients appointments.

Value for money:

- Five year funding settlement from 2019/20 with average real-term annual funding increase of 3.4% to account for the current NHS financial pressures;
- Support the phased commitments in the plan to address ageing population and unmet need;
- Funding uplift assumes the ability to invest in mental health and primary/community services at an increased rate;
- Funding assumes will maintain recent investment trends in hospital services, but plan expects a reduction in hospital demand on implementation;
- Delivery supported by changes to NHS financial architecture, payment systems and incentives. References reduction in admin costs – the 20% reduction in management costs, and annual 1.1% efficiency requirement.

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Next Steps

Next steps are:

- Publication of clinical standards review and implementation framework for the plan in Spring 2019;
- Establishing NHS Assembly in early 2019 to strengthen engagement on implementing the plan;
- Refresh of local systems plans by Autumn 2019 to support development of national implementation programme;
- Plan can be implemented without changes to primary legislation, but changes would support speed of delivery and being recommended;
- Current legal framework allows creation of integrated care systems (ICS) by April 2021, working with local authorities at "place" level. ICS remove barriers referenced in Five Year Forward View – primary and specialist, physical and mental health, and health and social care;
- Green paper on Adult Social Care.

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For reference
NHS Long Term Plan – Key Deliverables

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Clinical Priorities

Area	Goal	Timeframe
Cancer	Extend screening and overhaul diagnostic services with the aim of diagnosing 75% of cancers at stages I or II	2028
	A new waiting time standard will be introduced requiring that most patients get a clear 'yes' or 'no' diagnosis for suspected cancer within 28 days of referral by a GP or screening.	In 2020
Cardiovascular disease; Stroke; Respiratory disease, Diabetes; Dementia	Prevent up to 150,000 cases of heart attack, stroke and dementia	2028 (10 years)
Maternity and Neonatal Health	Halve still births, maternal mortality, neonatal mortality and serious brain injury in new-born babies by improving: continuity of care, bed capacity of neo-natal care, mental health support to pregnant women and new mothers	2025
Children and Young People's (CYP) health	Commitment to improve outcomes for children with cancer, increase support for children and young people with learning disabilities and autism, and improve CYP mental health	

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Primary and Community Care

Area	Goal	Timeframe
Primary Care Networks	From 2020/21 GP networks will assess the needs of their local population to identify people who would benefit from targeted, proactive support (typically 30 – 50K population)	From 2020/21
	• Network contracts will be introduced alongside existing contracts to include a single fund through which network resources will flow • Shared savings scheme is proposed, under which networks will benefit financially from reductions in accident and emergency (A&E) attendances and hospital admissions.	
	The existing incentive scheme for GPs (Quality Outcomes Framework) – will also see 'significant changes' to encourage more personalised care	
Digital	All patients will have the right to access GP consultations via telephone or online within five years.	2023 (Over 5 years)
Care Homes	Networks to roll out Enhanced Care in Care Homes approach (ECCH). All care homes, residents and staff, should be supported by teams of health care professionals (including named GPs)	By 2023/24
MDTs	As part of Integrated Community based healthcare all areas will have MDTs that include GPs, Pharmacists, District Nurses and allied health professionals working across primary care and hospital sites – a specific commitment to increase capacity in MDTs so that crisis response services can meet response times set out in NICE guidelines	2023 (Over next 5 years)
Social Prescribing	More than 1,000 trained link workers in place to support social prescribing by 2020/21	By end of 2020/21

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Mental Health and Learning Disabilities

Area	Goal	Timeframe
Mental Health	As pat of wider increase in spend on mental health - Create a single point of access for crisis support for adults and children - offering 24/7 support with appropriate responses across NHS 111, ambulance and A&E services.	By 2023/24
	Redesign core community mental health services, reinforcing components such as psychological therapies, physical health care and employment support, as well as introducing personalised care and restoring substance misuse support.	By 2023/24
	Create a comprehensive offer for children and young people, from birth to age 25, with a view to: providing mental health support teams in schools, tackling problems with transitions of care.	
	New waiting time standards for emergency mental health New waiting time standard for children and young people's mental health and Adult community mental health	2020 Over next 10 years
Learning Disabilities	Inpatient provision for people with learning difficulties or autism will have reduced to less than half of the 2015 level in the next 5 years by improving: access to support for children and young people with a diagnosis of autism, investment in intensive, crisis and forensic community support.	By 2023/24

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Acute Services

Area	Goal	Timeframe
Urgent and Emergency Care	AS part of the plans to reduce pressure on A&E departments – continued roll out of urgent treatment centres (UTCs) across the country led by GPs, simple diagnostics and bookable appointments via 111	By 2020
	Introduce a multidisciplinary clinical assessment service (CAS) as part of the NHS 111 offering advice to patients and community staff	In 2019/20
Same Day Emergency Care	Plan estimates that up to one-third of all people admitted to hospital in an emergency could be discharged on the same day and to support this all major A&E depts. will introduce a same day emergency care service SDEC (also known as ambulatory emergency care) to provide same day diagnostics and treatments with fast discharge	
Outpatients	Avert up to a third of face-to-face consultations through a fundamental redesign of outpatients including use of technology aims to free up time and resources and improve patient experience	2023 (over next 5 yrs)
Discharge	Cut the average number of daily delayed transfers of care (DTOC beds) to around 4,000 and maintain that level over the next two years (DTOC beds averaged 4,580 in November 2018).	
Provider fines for extended waits	Reintroduction of fines for providers and commissioners where patients wait 12 months or more	
Trust reconfigurations	Hospitals will be encouraged to split their sites into hot and cold sites (for emergency and planned work respectively) and supported to collaborate. Consolidation of spec stroke services	

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Finance and Productivity

Goal	Timeframe
Return the provider sector to balance – supported by an accelerated turnaround process worst performing (financially) 30 trusts and a financial recovery fund	By 2020/21
Return all NHS organisations to balance	By 2023/24
Shift away from activity-based payments to population-based payments.	
Changes to the Market Forces Factor MFF – an adjustment made to tariffs to reflect the differential costs of providing services in different areas	By 2023/24
Commissioning allocations to support resource going to primary, community and mental health as well as tacking health inequalities	
1.1% productivity growth per annum to be achieved through continued focus on: e-rostering, centralised procurement, e-prescribing, stopping low value treatments, improving access to information	2023/24
Savings in administrative costing over 5 years worth £700 million – commissioners £290m and providers £400m	By 2023/24

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Digital

Goal	Timeframe
People will be able to use the NHS app to access their care plan and communications from health professionals By end of plan patients will increasingly be monitored remotely at home and supported in community by technology solutions and outpatients reorganise using technology	By 2020/21
Patients will have a new 'right' to access digital primary care services (e.g., online consultations), either via their existing practice or one of the emerging digital-first providers.	From 2024
All secondary care providers become 'fully digitised' – e.g. digital records	By 2024
NHS organisations will be required to have a chief clinical information officer or chief information officer at board level	By 2021/22

Leadership and Workforce

Goal	Timeframe
Workforce Implementation Plan to be published by the end of 2019	2019
As part of the Workforce Race Equality Standard, every NHS organisation will set a target for black, Asian and minority ethnic (BAME) representation across its leadership team and workforce and increase CPD	By 2021/22
Reduce the nursing vacancy rate from 11.6 per cent to 5 per cent increasing undergraduates, clinical placement, access into nursing, recruitment internationally	By 2028 By 2023/24 (5 yrs)
Increase medical school places from 6,000 to 7,500 a year Increase the number of other roles supporting GPs including volunteers in NHS generally	tbc

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Role of Patients and Carers

Goal	Timeframe
As part of a 'fundamental' shift in the way clinicians work alongside and with patients towards a shared responsibility: • Roll out the NHS comprehensive model of personalised care, so that it reaches 2.5 million people in 5 years • Training for staff on how to work with patients for shared decision making about their treatment • Increasing opportunities and support for self care e.g. diabetes prevention • Referrals to social prescribing to increase	By 2023/24
Personal health budgets accelerated to be provided for up to 200,000 people in the next 5 years	By 2023/24
Roll out of national carer's passport, as well as better identification and support by GPs (including young carers)	

Integrated Care and Population Health

Goal	Timeframe
Integrated care and place based systems will be consolidated in the establishment of ICSs in each STP area Increasingly focused on population health	By April 2021
As part of the system of STP area control totals in 2019/20 STPs , ICS's will be given: • Flexibility to agree neutral changes to control totals for individual organisations across the system. • Reforms will give ICSs opportunity to earn financial autonomy following a performance and finance test • Bringing together of health and social care budgets are encouraged to support integrated working	
Accountability and performance framework for ICSs to be introduced Duty to collaborate for providers and commissioners to be introduced	

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Prevention

Goal	Timeframe
The provision of alcohol care teams in a quarter of hospitals with the highest rate of alcohol dependence-related admissions.	By 2023/24
NHS-funded tobacco treatment services will be offered to all smokers admitted to hospital	By 2023/24
Double the number of places on the Diabetes Prevention Programme and plans to include programmes for specific diseases and conditions	2023 (over the next 5 years)
NHS to make a contribution to reducing air pollution by reducing mileage and emissions by 20%	2023/24

Health Inequalities

Goal	Timeframe
Greater continuity of midwife care for black, Asian and minority ethnic women and women from deprived groups	
An increase in physical health checks for people with severe mental health	
Specific measurable goals will be set nationally to support work on health inequalities	
Specific funding to support rough sleepers and ensuring better access to specialist mental health support	