

London Health Commission – Call for Evidence

Response by London Councils

London Councils represents London's 32 borough councils and the City of London. It is a cross-party organisation that works on behalf of all of its member authorities regardless of political persuasion. London Councils makes the case to government, the Mayor and others to get the best deal for Londoners and to ensure that our member authorities have the resources, freedoms and powers to do the best possible job for their residents and local businesses. We also run a number of direct services for member authorities. And we act as a catalyst for effective sharing among boroughs – be that ideas, good practice, people, resources or policies and new approaches.

1. Introduction

London Councils welcomes the opportunity to respond to the London Health Commission's call for evidence. We have also helped to find local government representatives to sit on the Commission and its Expert Groups and are happy to continue to support engagement with boroughs and understanding of the local government perspective in the Commission's work.

This response starts with some general comments and context, before grouping some thoughts under each of the four main themes. We are conscious that there are significant linkages between the themes and would be grateful if all our evidence was considered as contributing to each theme's overall evidence base. Our submission ends with some thoughts about implementation. We have sought to identify case studies and examples to illustrate our points, with contact points to follow up for further information where possible. We would be happy to discuss our response and/or provide further examples, facilitate links with boroughs and their partners who are grappling with issues on the ground and/or identify witnesses for any further evidence sessions the Commission may wish to hold.

2. General comments & context

The Commission's 'Call for Evidence Questions' appear to reflect a largely health/NHS focus. It is vital that its focus is not allowed to be so narrow – and we understand that this is not the intention. The success of the Commission should be judged in how it contributes to the improving the overall health and wellbeing of the citizens of London. To do this, it will need to help build understanding between key partners who operate in very different systems – the NHS, local government and the private and voluntary &

community sectors – who all have critical roles to play. This needs to be reflected through the Commission’s communications and language.

The Commission should be seeking to support the refocusing of health and care systems in London onto the overall health and wellbeing of individuals, helping them and their families maintain independence and the ability to lead their lives as fully as possible for as long as possible. This means that prevention in its widest sense should have a prominent focus in the Commission’s work. As well as improving overall population health, prevention should play an important role in reducing the need for services, so prevention should be part of all health and social care pathways. The Commission’s work should also emphasise the role and importance of reablement, self-care and other means of avoiding people becoming more dependent on health and care services than absolutely necessary.

It also means that, while the scientific and technological developments in medicine must of course be welcomed, we should constantly be striving to avoid ‘medicalising’ people. The health and care system, as well as being co-ordinated itself, needs to link appropriately to organisations and services addressing people’s wider needs that contribute towards maximising their wellbeing and, as far as possible, minimising their need for and dependence on intensive and intrusive health care. Even when people have long term health care needs, it is important that their and their families’ independence, choice and control is maximised.

The health and care systems need to unite around person-centred approaches in which care is co-ordinated, to make the experience of the individual and their family as supportive, compassionate, tailored and simple to navigate as possible. The ambition should be that the boundaries between organisations and services should be invisible to those with health and care needs. All planning and delivery of services should be genuinely focused on the patient or user perspective. There is still some way to go in developing a real understanding of what this means, drawing out and sharing the strongest examples, and considering how regulatory and performance regimes can support and reinforce this. The Commission should consider what would best support commissioners and providers in London to accelerate understanding and delivery.

Finally, we have two broad comments on scope:

- i. We would like to see children’s health issues given explicit attention. Too often discussions about health and the integration of health and care focus only on adults and older people. There are significant challenges that need to be addressed both to improve outcomes and to provide integrated care for children. But it is also vital that children’s health is given sufficient attention because there are real opportunities to improve lifelong health through early intervention, encouraging good health habits and prevention; and
- ii. If the focus is on people’s overall health and wellbeing, that must require more co-ordination between physical and mental health and care (including that of children and adolescents). We are pleased to see representation of mental health expertise in the Commission’s structures and would urge that the better alignment of mental and physical health and care services should be one of the explicit goals of its work. The work being developed under the aegis of the London Health Board;

2.1. The role of local government in promoting health and wellbeing of citizens

Local authorities have long-standing responsibilities for adults and children's social care. From 1 April 2013, they also took on significant public health responsibilities. While it is still early days, there are an emerging range of examples of how this is enabling public health considerations to be woven through wider services (some case studies are provided in the annex).

Since 1 April 2013, boroughs also have statutory responsibility for convening and supporting Health & Wellbeing Boards, to provide strategic local leadership and co-ordination across health and care. These have been key in the development of Joint Strategic Needs Assessments and Joint Health & Wellbeing Strategies, and they will play a key role in signing off local Better Care Plans and influencing CCG 2 year operational and 5 year strategic plans. Through this they will have a key role in providing strategic leadership on integration and service development plans for their communities.

Beyond this, of course, local government has extensive experience in delivering a range of services that impact on the wellbeing and health of its citizens – including wider children's services and youth services, housing and planning, local economic development and regeneration, employment & skills, regulatory services, etc. But as well as specific services, local authorities have a wider community leadership role, with a unique focus on places and the communities and people who live in them. This involves engaging regularly in complex issues, with the driving objective of improving the lives and opportunities of their citizens. Citizen and community engagement is an integral part to how local authorities operate to deliver this.

It is important the Commission understands and appropriately reflects the wider landscape for local government. Key issues we would flag are:

a) **Funding**

At the beginning of the current Spending Review (SR2010) period, local government faced a higher level of funding reductions, proportionately, than most other parts of the public sector – 28 per cent in real terms over the four year period up to 2014/15 compared to 8 per cent on average for central government departments. Since SR2010, further incremental cuts have meant that by 2014/15, core funding to local government will have fallen by 35 per cent in real terms.

The recent Spending Round 2013 (SR2013) has confirmed that local government will once again be required to deliver a disproportionately higher level of savings in 2015/16. The 10 per cent real terms cut for local government was one of the largest of all departments, compared to the average real terms reduction of 2.2 per cent across other Whitehall departments.

This means that local government will have seen its core funding from central government reduce by 44 per cent in real terms from 2010-11 to 2015-16.

Within this, analysis undertaken by London Councils shows that there is a clear correlation between those authorities assessed to suffer from higher levels of deprivation and their levels of funding reductions. As a consequence, London, as a whole, will be disproportionately affected by the cuts in comparison to other parts of the country.

By way of illustration, research by Newcastle City Council shows that between 2010/11 and 2015/16, the average reduction in spending power¹ per dwelling in England is £300. In London, the reduction per dwelling is £544, this is £244 (81 per cent) higher than the national average. In 2014/15 and 2015/16 alone, London will face an overall reduction in spending power per dwelling of £294 compared to the England average of £117.

Against this backdrop of reduced resources, population growth and demographic changes are putting unprecedented pressure on the full range of local authority services, including adult and children's social care, education, housing, waste and transport.

In other words, London is facing the double impact of disproportionately high funding cuts and significant increases in demand. Our latest modelling suggests that London local government faces an overall financial pressure of as much as £3.4 billion (31 per cent) by 2019/20. Looking to the future, it is clear that without significant changes to the way cuts are applied across the public sector, many London boroughs will quickly reach an unsustainable position.

Within this overall financial outlook, expenditure on adult and children's social care is a critical element. In 2013/14, London boroughs budgeted to spend £2.3 billion and £1.3 billion on adult and children's social care respectively. This represents approximately 48 per cent of London's overall net budget of £7.5 billion. While many local authorities have sought to protect frontline services as far as possible, the scale of the cuts means that social care has of course been affected. At the same time, local authorities have faced significant demographic pressures through an ageing population and rising birth rate, as well as the impacts of medical advances that mean that the number of people with significant care needs for physical or learning disabilities are growing.

Boroughs have sought, and will continue to seek, ways of redesigning services and driving efficiencies, to try to minimise the impacts on outcomes on vulnerable people. Given the likely scale of future funding reductions and the fact that social care is such a significant proportion of local authority expenditure, the pressure on social care budgets is likely to continue into the foreseeable future.

From April 2013, local government also assumed responsibility for public health. In 2013/14 and 2014/15, London boroughs have been allocated £553 million and £578 million respectively from the ring-fenced public health grant. It should be noted that there is considerable variation in grant levels and funding per head across the country and within London. In 2014/15 as base year for London, overall grant levels vary from £7.6 million in Bexley to £32.3 million in Tower Hamlets and on a funding per head basis, from £32 in Bexley to £185 in the City and £133 in Westminster and Kensington & Chelsea.

Such variation in distribution raises significant questions about the sustainability of the current funding methodology. The current allocations were significantly influenced by the previous levels of spend in individual PCTs, whom we know gave very different levels of priority – and therefore investment – into public health. The major cost drivers for local authorities in London are services for sexual health and substance misuse, which are, to a large extent, demand led and as such, difficult to control. In

¹ Spending power, as defined by Government, measures the overall revenue funding available for local authority services, including Council Tax, locally retained business rates and government grants.

London, these two areas will account for close to 58 per cent of spend compared to 53 per cent for the rest of the country. But these are not reflected in the current funding formulae. While the additional funding that the government put into the overall pot for these two years was strongly welcomed, we remain concerned both at the overall level of public health budgets and at the allocations formulae, which do not reflect well the characteristics and challenges of London.

b) Significant legislative changes on the way

There are two Bills in Parliament that will lead to significant transformation programmes in adults and children's services in the next few years.

i. The Care Bill

The Care Bill is due to complete its passage through Parliament by this spring. Its measures constitute a series of significant changes for adult social care, which are broadly welcomed by local government, but will create considerable implementation challenges and additional costs over the coming years.

The Bill is a key measure to give effect to the government's vision for adult social care that:

- the focus of care & support will be to promote people's wellbeing and independence instead of waiting for people to reach a crisis point; and
- the system will be transformed to put people's needs, goals and aspirations at the centre of care and support, supporting people to make their own decisions, to realise their potential, and to pursue life opportunities.

While adult services have been moving in this direction for many years, key changes in the Bill include:

- legally embedding personalisation & the need to integrate health and care services;
- duties to secure the provision of services to prevent or reduce the need for care and support, and to provide information and advice on care and support for adults and carers whether or not they are within the local authority system;
- a national eligibility standard for care;
- creating rights for assessment and support for carers;
- creating rights around the portability of care from one authority to another if a person moves;
- making Adult Safeguarding Boards statutory; and
- legal entitlement to deferred payments.

In addition, the Bill will give effect to the new 'paying for care' regime, flowing from the Dilnot Review. This will introduce a cap of £72,000 on what a person has to spend on their eligible care needs, as well as significantly raising the threshold that determines whether a person is entitled to financial support for their care costs from £23,250 to £118,000. These reforms will bring a significant new range of people into the local authority social care system, who previously planned and funded their care themselves.

London Councils has estimated the costs of the Care Bill on London boroughs as around £827.8 million between 2014/15 and 2019/20. The government's funding commitments so far are some way off meeting these. In addition, we estimate in

the region of £421 million pressures from demographic changes and inflation between 2011/12 and 2015/16, which will increase further in subsequent years.

ii. **The Children & Families Bill**

This Bill will introduce new requirements for new joint Education, Health and Care (EHC) assessment and plans for children and young people with special educational needs aged 0 – 25. Health and social care will be required jointly to commission services to deliver integrated support for them. Those with EHC plans will be offered the option of a personal budget to meet their needs. The Bill is expected to complete its passage through Parliament by the spring, and implementation will be from September 2014.

2.2. **London's population and characteristics**

At its first meeting in May 2013, the London Health Board considered a paper that highlighted key characteristics of the capital and the significant health and wellbeing outcomes and inequalities, and service challenges², to which we refer the Commission. It is important that in the Commission's consideration of how to improve health and wellbeing outcomes in London, it reflects the impact of the scale and pace of change that we are all facing over the coming years.

Demographics are clearly an important part of this – with the picture in London overall markedly different from that in other parts of the country. However, it is important to recognise that within the London story there is considerable variation between places – be that boroughs or communities. The impact of current health and wellbeing challenges and the way future pressures will play out cannot simply be considered on a London-wide basis if we want to effectively tailor ways of addressing them. Therefore, it will be important for the Commission to reflect the picture at smaller geographical levels, as well as across different population groups, and at the city-wide level.

The importance of social expectations and technological developments are going to be other factors that need to be taken into consideration. The potential of social media, people's expectations about their role in relation to services (eg the shift in the last 10 years to internet banking) and their expectations of levels of service are all important if we are to build sustainable health and care systems for the future. As well as considering practical actions to deliver the changes needed in the next few years, the Commission should have some debate about the longer term ambitions for health and wellbeing in London.

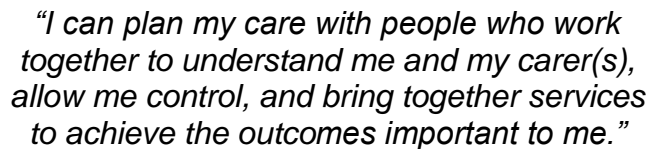
3. **Theme A – Improving the quality and integration of care**

3.1. **What do we mean by integration**

London Councils supports the definition of integration as 'person-centred co-ordinated care' developed by National Voices³, and particularly their definition from a service user perspective of:

² <http://www.londonhealthboard.org.uk/meetings/default.htm>

³ <http://www.nationalvoices.org.uk/coordinated-care>



“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”

This is further unpacked through a series of “I” statements. We would urge the Commission to adopt this as its basic definition of integration as well and focus its attentions on what is required to make this a reality in London, building on the work already going on in many quarters.

The one element that we feel this definition does not give sufficient focus is prevention, early intervention and wider population health improvement, because it starts from the perspective of someone already in or entering the health and/or care systems. In grappling with the challenges of delivering person-centred co-ordinated care, which are significant, it is important that we explicitly build prevention into these pathways and plans. Indeed, with the demographic and financial pressures facing the NHS and local government, this is a vital.

3.2. Integrating from the bottom up

London Councils believes that the key to making a reality of ‘person-centred co-ordinated care’ that maximises the health and wellbeing of individuals and their families, is the integration of out-of-hospital services ie social care, community care and primary care (general practice, pharmacy, community nursing, etc) – ie what is often referred to as ‘horizontal integration’. We recognise that overall success will also require the right co-ordination and interfaces with acute, emergency and other specialised hospital services. But it is vital that the shape of future health services is not defined through ‘vertical integration’ approaches that do not clearly fit into co-ordinated out-of-hospital services.

The focus on “horizontal integration” means that boroughs have a strong interest in the capacity and competence of other key local partners. The challenges faced by General Practice in London – including the scale of funding, workforce issues including a high number of GPs approaching retirement, structural issues like the number of single-handed practices and the development of better linked or federated arrangements, the confidence and expertise of GPs and practice staff and their awareness of and links into other services, etc – are all therefore of critical interest to boroughs. So too is the way that NHS community services may be developed in future years. We strongly urge close working with local government and other partners in developing the plans for change and improvement, so that boroughs can provide support in appropriate ways and be confident about future partnerships.

The success of health and care integration will need to involve significant shifts of funding from expensive acute and emergency care into co-ordinated local care. This will need to be planned and delivered carefully to avoid destabilisation of the acute and emergency sectors, and to ensure that citizens and patients/users can be confident that reductions in hospital capacity will lead to improved services and outcomes for them and their families.

We believe the only way this can be done effectively is from the bottom up. London is already in a good position in terms of commitment to such an approach overall, and many areas have been working on delivery for several years, and are starting to show real progress. Four of the 14 ‘integration pioneer’ areas announced by the government last

autumn are in London, and cover 13 boroughs and their NHS partners – Greenwich, Islington, North West London and Waltham Forest, East London & the City (WELC). The LGA's Integrated Care Value Case Toolkit⁴ includes summaries of the approaches in several of these, along with similar examples in other parts of the country. If the Commission would like further information on any of the London pioneers, we would be happy to put provide contacts.

A London Integrated Health & Care Collaborative has also been meeting since the middle of 2013, bringing together partners from local authorities, CCGs, NHS England (London Region) and London Councils. This informal partnership is aiming to support the locally-led development of person-centred co-ordinated care across London, where activity at a London level can help. Just before Christmas the London Collaborative published a 'case for change' for integrated care in the capital⁵ and has been developing a common list of the 'key ingredients' that need to be considered in developing integrated care systems (at Annex B).

The Collaborative is now exploring further ways in which it can add value, including through information and best-practice sharing, joint problem-solving and joint engagement or lobbying to overcome common structural barriers to integration.

One of the challenges that can face progress on the ground is the proliferation of national 'top-down' initiatives and programmes. Often developed in response to specific challenges (eg winter pressures), these may be logical if viewed in isolation. But, the cumulative impact of such approaches, which have overlapping players and agendas, is an increase in bureaucracy and reporting and an impediment to the focus and delivery of meaningful progress on the ground. This can be even more significant in fragile local health economies (eg where key partners may be facing significant financial pressures or organisational weaknesses, or where relationships are particularly poor). Generally, we would like to see the development of new 5 year strategic plans by CCGs and NHS England and increased pooling of budgets and alignment of investment, with close involvement of local government and other partners, lead to a significant reduction in the range of initiatives/programmes overseen from the centre. Once local priorities and strategic approaches are agreed, and assured as a means of meeting a range of central interests and concerns, it will be important to leave local areas to get on with developing and delivering them. Where support is needed, or new issues arise, these should be approach in a way that works with the local plan and delivery arrangements, rather than cutting across them.

3.3. Better Care Fund

The announcement in the Spending Round 2013 of a Better Care Fund of £3.8 billion of pooled funding between local authorities and CCGs in 2015/16 is intended to support a major step forward in the integration of health and care in all areas. Boroughs and CCGs are developing joint plans for 2014/15 and 2015/16, setting out how they will work together to deliver progress in their areas with the use of this fund. These plans have to be signed off by local Health & Wellbeing Boards, and be the subject of consultation with providers and the public. Draft plans are being submitted by 14 February, with revised plans by 4 April. CCGs will be aligning these plans with their wider 2 year operating plans and 5 year strategic plans.

London Councils welcomes the Better Care Fund and is working closely with NHS England (London) colleagues and nationally to influence the handling, particularly of

⁴ http://www.local.gov.uk/web/guest/health/-/journal_content/56/10180/4060433/ARTICLE

⁵ http://www.icase.org.uk/pg/cv_content/content/view/91675

national assurance and reporting, to ensure that the positive incentive of this approach is maximised while reflecting the different starting points and challenges of individual areas.

The London Health & Care Integration Collaborative is considering ways of supporting joint problem-solving and information sharing to help all parts of London agree meaningful plans, and then considering any support needs to enable them to delivery real and ambitious change.

We would hope to see this model of pooling funding and joint planning as one that can be built on and expanded in future years. As boroughs and CCGs start to gain experience of implementing their Better Care Plans, we will want to explore what would be required to support this from 2016/17. This will include considering the interface with wider programmes, like those for improving and developing general practice and primary care, that will have critical impacts on the ability to integrate services effectively locally.

The London Health Commission should recognise that these local plans should form the basis of integration in the capital, and ensure that any work they do or recommendations they draw clearly reflect the rapidly developing realities on the ground.

3.4. Strengthening personalisation and control

As previously explained, London Councils believes that the focus of the London Health Commission's work should be on how to improve overall health and wellbeing, including supporting individuals and their families to maximise their independence, opportunities and control.

A key theme in social care in the last decade has been the development of the personalisation agenda. This emphasises that people are not passive recipients of services and have assets and expertise that can help improve services. It also reflects a stronger recognition of the differences in needs and circumstances of each person and enables a better tailoring of services to these. Between 2010/11 and 2012/13, we have seen a 90% rise in the number of people using self-directed support or personalisation mechanisms in London (compared to 66% across England). For some people, this will mean direct payments over which they have total spend control, but others will continue to use the council's commissioned services but with greater engagement in their support planning. Latest data (2012/13) shows 93,770 Londoners' care needs are being managed through self-directed support mechanisms.

The development of personalisation has had broader implications for the role of local authorities and for the range of providers involved in delivering services. The roll-out of personal budgets is widening and deepening the market of care providers and boroughs have an increasingly important role in market development. They also have a key role, linked into their safeguarding responsibilities, for ensuring appropriate quality assurance to support people's choices (eg through approved provider portals). Individual boroughs are establishing clear evidence about benefits from improved service quality, to increased user satisfaction and reduced costs to meet people's care needs.

It is vital that the principles of personalisation and control are factored into the heart of integrating health and care services. This includes thinking about:

- tailoring of care packages to reflect the range of issues they are facing, including both health needs (eg multiple long-term conditions) and their personal circumstances and wider support networks. This is at the heart of the multi-

disciplinary team case conferencing and support planning approaches that is key to many parts of the integration agenda;

- improving self-care and the support for patients and service users to manage their own conditions and needs. As part of their integration pioneer, Islington Council and CCG have been undertaking a review of self-management and using Professor Judith Hibbard (Professor in public health, University of Oregon)'s Patient Activation Measure (PAM) tool to help inform the commissioning of tailored self-management support⁶;
- the combination of social care personal budgets and new personal health budgets to meet the overall health and care needs of individuals. For example, as part of their integration pioneer work, the Royal Borough of Greenwich and Greenwich CCG are building on the existing use of a local voluntary sector consortium to provide support for choice and control for social care, to also provide support planning and direct payment support for personal health budgets⁷. A case study of Harrow's tool for support planning and personal budgets is also included in the annex;
- the use of telecare and telehealth to enable people to remain in/return to their homes with confidence;
- care co-ordination and system navigation support as means of both helping people within the system, but also aiming to get them back to as much independence and wellbeing as possible;
- the opportunities that the Care Bill requirements for information and advice provide to help people take preventive steps to retain or improve their wider health and independence;
- the opportunities around the transfer of Health Visitor commissioning to local authorities in 2015 to integrate health and wider early intervention services more closely to improve health and care outcomes and life-long health; and
- the potential of the development of community assets as a model to help to strengthen the networks and support within communities. Wandsworth and Barking & Dagenham have recently been exploring the potential of such approaches⁸.

4. Theme B – Enabling high quality and integrated care delivery

Some of the key challenges that are regularly raised across a range of areas through the London Collaborative and work on Better Care Plans are:

- challenges in sharing information between NHS and local government;

⁶ Contact: Sarah Pallis, Islington CCG. Sarah.Pallis@islingtonccg.nhs.uk

⁷ Contact: Jay Stickland, Senior Assistant Director (Care Management) Adult & Older People's Service, RB Greenwich. jay.stickland@royalgreenwich.gov.uk

⁸ http://www.communitycare.co.uk/2014/01/03/using-asset-based-social-work-enable-older-people-stay-independent/#.UvjyzGJ_teg

- constraints to innovation and service redesign created by the NHS payment systems;
- workforce flexibility and how to facilitate more working across professional boundaries, including the training and development requirements to enable this; and
- organisational cultures and how to improve awareness of the offer from and strengthen the mutual value and respect between different professions.

4.1. Information sharing and information transparency

The implications and interpretation of Caldicott II have created significant challenges for joint working and effective co-ordinated care. We understand that the government is reviewing this and expects to clarify some issues shortly, but also believes that some of the perceived constraints do not really exist. One way or another, this is an issue that everyone has been talking about for over a year, but on which resolution is still not clear. Any assistance the London Health Commission can give to resolving blockages and in securing clear guidance if the government's legal position is that some issues are not problems, would be of great value.

In addition to the frustrations of the information-sharing rules, there are potential challenges around making the information systems in different parts of health and care work effectively together. The significant changes to social care IT systems that will be required to implement the Care Bill provide potential opportunities to seek to make other adjustments to support information transfer between health and care partners' systems. How to take advantage of this opportunity to strengthen links between social care and health systems in the most cost-effective way across London – including considering the potential for common core specifications etc – could be an area for the Commission to explore.

Finally on information, London Councils strongly supports greater transparency of health information both to support patients' choice and control, and to act as an incentive for improvement. The London Health Board considered this agenda at its December 2013 meeting⁹ and supported the proposal that London should seek to be a national – and indeed world – leader in health information transparency. We would welcome work by the Commission with partners to build on this commitment.

One particular information challenge that has arisen through the NHS restructuring is that public health teams in local authorities have lost access to information they would previously have been able to use to plan public health strategies and interventions, eg performance information on immunisation and screening. We would welcome support from the Commission to accelerate solutions to this.

4.2. NHS payment mechanisms

The London Health & Care Integration Collaborative is planning to scope out the nature of the challenges arising around NHS payment mechanisms, with a view to trying to clarify which are the systemic problems and where there are examples of people finding ways of overcoming issues that can be shared more widely. Where real systematic barriers are identified, the Commission might be able to play a role in seeking their resolution.

⁹ <http://www.londonhealthboard.org.uk/media/item.htm?pk=1713>

4.3. Workforce

Better understanding of the respective contributions and ways of working between different health and care professionals will be vital if we are to see improved joint working on the ground which is key to delivering integrated services. We understand that the Local Education & Training Boards (LETB) in London are looking at how to ensure this is incorporated into future education and training programmes, and would expect this to include working closely with Skills for Care, the sector-skills council for social care.

Training future professionals in different ways will be critical to accelerating and embedding new ways of working. London faces particular challenges around workforce now in and the coming years (eg with the numbers of GPs approaching retirement there are serious concerns about the future coverage in some boroughs, which could be a critical risk both to existing services, but also to attempts to better integrate and co-ordinate care).

There is also a need for retraining and CPD-accredited courses to support changes in approaches within existing staff and managers, and to address current areas where skills and competences may not already be sufficiently strong (eg in some boroughs there is growing evidence of a lack of paediatric skills or confidence among some GPs which is contributing to increased attendances at A&E). We would welcome some further consideration by the LETBs and Skill for Care about how they can support and share the learning within local integration programmes, and draw out the best practice from this for wider dissemination.

As well as considering the health and social care workforces, if we are to develop the prevention and population health agendas in the way needed to improve outcomes, we also need to ensure we have the right workforce in public health. The latest Association of Directors of Public Health (ADPH) survey¹⁰ shows workforce issues, including the challenges of recruiting suitably specialised staff, remain a high concern for Directors of Public Health.

5. Theme C – Healthy lives and reducing health inequalities

Since the start of their new public health responsibilities in April 2013, local authorities have a key leadership role in tackling health inequalities, influencing wider determinants of health and improving the overall health and wellbeing of their populations. Poor health outcomes and health inequalities correlate very closely with other inequalities and deprivation. Locally tailored responses to particular communities or groups, focussing on a range of factors, are therefore often the most effective way of genuinely making a difference. Case studies exemplifying different ways in which public health is working with other services and organisations are at Annex B¹¹. London Councils believes that close working by boroughs, health partners, other sectors (eg transport, employment, education, etc) and the voluntary sector at a local level, tailored to particular communities and linked with other community engagement and development work, is therefore vital.

We also recognise that there are some issues on which a multi-borough or pan-London approach may add value, from the sharing of information, intelligence and evidence to the

¹⁰ <http://www.adph.org.uk/wp-content/uploads/2013/11/ADPH-PRESS-RELEASE-2013-DPH-survey.pdf>

¹¹ The King's Fund's recent publication also provides further examples of public health considerations being integrated across other services and summarises evidence of the impact this can have. http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/improving-the-publics-health-kingsfund-dec13.pdf

development of common models or frameworks through to joint commissioning. London faces some particular health outcome and inequality challenges including late diagnoses of major diseases, high levels of serious mental illness, high levels of sexually transmitted diseases and HIV, childhood obesity, etc. London Councils has welcomed and supported the fact that Directors of Public Health in London have established mechanisms to work together as ADPH London, to provide leadership for the range of joint working across boroughs, in addition to the partnerships and joint work that emerge more organically locally. Earlier this year we worked with the Directors to secure agreement to a pan-London approach to the commissioning of some HIV prevention services, worth £3.4 million¹².

We also believe there is a key role for Public Health England in providing intelligence, information and wider support and facilitation to such joint working, as well as more locally tailored contributions. Their recent work in facilitating partners to come together to determine where the London Health Board could add value to existing work on mental health in the capital is a good example of doing this, and building buy-in that should help lead to real added value actions.

We need speedy resolution of the current blockages to appropriate data sharing between the NHS and public health teams in boroughs to support planning and delivery of effective interventions, as mentioned above.

As budget pressures continue to increase, it can become increasingly difficult to make the case for preventive measures, particularly when they might have significant impact for several years. Most of the work on business cases for prevention activity focuses on the health outcomes and potential savings to the NHS. While this will continue to be important, the evaluating of wider benefits and savings, including to local government who will often be funding prevention activity now, needs to be better developed. This could be an area where the Commission might support some work, including the development and testing of methodologies.

Another significant challenge that we believe needs to start to be addressed, at multiple levels, is how to help people and communities to make healthier choices. As part of this, the role of regulation and visible political leadership can be particularly important. We would be interested in consideration by the Commission of whether there are particular challenges in London that might lead to collective political and professional lobbying for regulatory change or to a case for devolution of regulatory powers to either the city-wide or local levels.

6. Theme D – Health economy, research and education

London Councils strongly supports closer working between the London Enterprise Panel, Academic Health Science Centres and Academic Health Science Networks, NHS and industry to support growth in the health and life sciences sectors with a view to improving London – and therefore the UK's – overall competitiveness and attractiveness in this field. We recognise that a wider geography in the South East, including the London-Stansed-Cambridge corridor is appropriate for this work. We believe there is a sound base to start from and opportunities that are not currently being fully exploited. We are therefore engaged in the work, being led by the London Health Board team, to develop clear actions to help unlock this potential.

¹² <http://www.londoncouncils.gov.uk/news/current/pressdetail.htm?pk=1700>

For some London boroughs (eg Camden, Sutton) the life sciences sector has an important profile in their local economic development and growth plans. It is important that any work to develop this sector engages those boroughs with key interests from the earliest stage. They will have critical roles to play in any planning and physical development for new businesses moving to or starting in London. Their planning and regeneration responsibilities also give them opportunities to explore the potential for unlocking incubator and 'follow on' facilities as part of wider developments. Some of the key to attracting new players into this market in London are also the wider issues like housing, quality of life and leisure offers, skills and workforce, in all of which boroughs can play a key role.

7. Implementation

7.1. Leadership and governance

There are some voices that argue for a clear, single point of leadership for health in London. However, the health and care system is complex and multi-layered – reflecting the complexities and breadth of the issues and outcomes it is addressing. There has never been a single point of leadership across this whole system. London Councils does not believe that the Commission should seek to find simplistic single leadership solutions as part of its work. This would be likely to be a significant point of disagreement and therefore an impediment to action. But also, we believe that any such model would be actively ineffective because it always ends up ignoring issues in one silo or another. It also misses the importance of leadership of place, reflecting the different characteristics of local communities and the role of local democratic accountability. The evidence from Community Budgets and the health and care integration work already going on at the local level demonstrates the importance of local tailoring and accountability, as means of improving outcomes and driving efficiencies.

Therefore, the Commission should work with the structures and systems which exist, seeking to understand and reflect the different powers and responsibilities, cultures, incentives and operating approaches. In considering how its recommendations might be implemented, the Commission should consider the key coalitions that are needed to take responsibility for each one and what might help to support, incentivise and enable these.

This consideration should include reflection on the geographical scale at which leadership and co-ordination is required. At the local level, Health & Wellbeing Boards provide the vehicle for doing this. They are still in their infancy, but Boards exist in all London boroughs. How these embed themselves and develop their role over the next few years is key – including how they engage in both services issues (eg currently the Better Care Fund plans) and improving local outcomes (building on Joint Strategic Needs Assessments and Joint Health & Wellbeing Strategies). London Councils believes that a critical factor in their future success will be the nature of the relationships that are developed through these Boards, including how national and regionally focused organisations are able to engage in tailored ways with them.

London Councils recognises that the wider 'local health economy' (generally taken to refer to the core area served by a major hospital or trust) is another geographical scale that needs to be considered, so that the collective implications of local plans can be considered in a strategic and cumulative way. Many boroughs are already working in 'sub-regional' groupings with CCGs around major provider footprints. We believe that such arrangements need to be developed in a way that makes sense from a local perspective and should not, therefore, be centrally imposed. We are watching the

development of the ‘Strategic Planning Groups’ of CCGs who are starting to develop their 5-year strategic plans in the light of the recent NHS Planning Guidance with interest, and are keen to see local authorities engaged in the discussions that inform these plans, so they can take account of social care and wider considerations.

The London Health Board – a coalition of a number of the key partners, committed to working together to improve the health and wellbeing of Londoners – provides the basis for a vehicle for joint leadership at a London-wide level where that adds value. This might in future include oversight of key strands of activity that flow from the Commission’s review. As the Commission starts to clarify its recommendations, discussions can start with the London Health Board about whether any changes are needed to how it is organised and operates in order to play an appropriate role in future, that secures the buy-in of key leaders and constituencies.

7.2. Engaging the public and the role of citizens in their own health

We know the Commission wants to secure the perspective of patients/users and citizens more widely as part of its work, and we welcome this. We support the Commission developing appropriate ways of engaging with people to inform its work. But we strongly recommend, not least for reasons of practicality, that some of the public/user perspective is garnered through existing engagement activity. For example, as part of their Better Care Plans, all boroughs and CCGs have to undertake community engagement. Given that this will explicitly be around ways of improving health outcomes through integration, the Commission might want to invite areas to share the outputs and key issues from their engagement, rather than duplicating such activity. Boroughs also will have a number of other sources of intelligence from engagement and surveys that could be drawn on to give a greater richness of input than the Commission will be able to secure by itself in the time available.

We get the impression that ‘politics’ is often seen as an obstruction in the health world, which prizes medical expertise. There is a challenge for both local government and the NHS to better understand and value the different benefits that their respective expertises can bring. Local government’s political accountability and legitimacy has strongly influenced the development of its expertise in community engagement and political leadership has been a key contributor to handling the financial challenges that boroughs are facing. We believe that local political engagement in health issues needs to continue to develop – and the Health & Wellbeing Boards should be the focus for developing the debate and engagement across political, professional and other partners through which the collective leadership for significant change in health and care can be created.

8. Conclusion

London Councils’ key messages to the London Health Commission at this stage are:

- The focus must be on health and wellbeing (both mental and physical), with the goal of improving health outcomes and inequalities to maximise people’s opportunities, independence and control over their own lives;
- Prevention and support to live as independently as possible from the health and care systems, eg through self-care, care in the home and information and advice to manage your own health and wellbeing, must be strengthened;

- Integration – meaning ‘person-centred co-ordinated care – must be driven from the development of locally meaningful models of “horizontal integration” of out-of-hospital health and care services;
- We should be focussing on ensuring there are robust, joint, local plans for addressing the current and future challenges of local health and care economies at borough or multi-borough level as appropriate. These should be supported by mechanisms like pooled budgets (like the Better Care Fund) and aligned investment plans, and top-down initiatives or programmes should be reduced to avoid diverting energy from delivering these; and
- We should work with the structures and responsibilities we have, recognising that health and care are complex agendas. The key is building the right kinds of relationships and co-ordination, and seeking to remove any barriers to effective joint working to provide a seamless experience for patients and users. As part of this the value of local leadership and democratic accountability must be recognised.

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LONDON HEALTH & CARE COLLABORATIVE – COMMON INGREDIENTS FOR INTEGRATION

A shared analysis, probably touching these areas of service development, with these key characteristics and with both quality and system outcomes			
WHY	WHAT	HOW	OUTCOMES
<p>Poor citizen experience Lack of independence and control Fragmented services that are difficult to navigate</p> <p>Poor outcomes Poor quality of life for people and carers Too many people living with preventable ill-health and dying prematurely Avoidable emergency and residential care admissions/readmissions Unsafe transfers and transitions</p> <p>Increasing demand Aging Population Medical innovation Poor population health</p> <p>Unsustainable models of care “30%” of people in hospital and care institutions who do not need to be there Insufficient prevention/early intervention Unrealised citizen and community capacity Limited primary care offer Limited community services Uneven quality across many services</p> <p>Unprecedented financial challenge NHS – flat real Local Govt. -28% Add size of funding gap for London (our share of the 30bn) Financial system not fit for purpose, encouraging acute activity and cost-shunting</p>	<p>Greater integration of services around the patient: Risk assessment Care coordination and care planning Integrated case management Single point of access 24/7 urgent response Admission avoidance and timely transfers of care Reablement</p> <p>A greater emphasis on self and home care: Personal budgets Expert patient Carers strategy Technology for independence Support related Housing</p> <p>Building Community Capacity to manage demand: Early diagnosis Care navigators Mutual support Micro enterprises Information for all Population Health</p> <p>A new Primary Care offer Accessible Proactive Coordinated</p> <p>Reconfiguration of acute services Reduced activity in acute / realigned acute services</p>	<p>Whole Health and Care System Leadership Joint Governance Joint Outcomes Joint public / patient engagement strategy</p> <p>3-5 year local plans signed off by Health and Wellbeing Boards</p> <p>Local and City wide coherence Acute Service reconfiguration</p> <p>Scale / Focus 20% at highest risk of needing urgent health and/or social care</p> <p>Aligned commissioning LA/CCG/NHS England Engagement of providers</p> <p>A way to move the money around the system - to address the perverse effects of activity-based payments. That might include:</p> <ul style="list-style-type: none"> contracting for populations and outcomes Risk-sharing by commissioners and providers <p>Shared information across agency boundaries</p> <p>Flexible, engaged workforce</p> <p>Transparent measurement of outcomes</p> <p>A developing evidence base</p>	<p>Improved citizen experience People “in control and independent”</p> <p>Improved health and care outcomes Enhanced quality and safety of services – to agreed standards</p> <p>Improved sustainability of the health and care system</p> <ul style="list-style-type: none"> Increased investment in, quality of and productivity of primary and community services Large scale reduction in unplanned attendances, admissions to hospital and length of stay Reduction in admissions to residential Care <p>Effective demand management Management of demand at the front door of care and support services,</p>

CASE STUDIES

London Borough of Enfield: Improving and narrowing the gap in healthy life expectancy



London Borough of Enfield has undertaken a widespread engagement process and developed a subsequent work-plan to reduce the gap in life expectancy in one of the most deprived wards in the Borough, Upper Edmonton.

A multi-agency workshop was held in July 2013 to engage statutory and voluntary stakeholders. The principal output of the workshop was a work programme with specific deliverables and measurements centring around 12 work streams:

- a) Cardiovascular Disease
- b) Children & Young People
- c) Respiratory Illness
- d) Diabetes
- e) Cancer
- f) Sexual Health and Teen Pregnancy
- g) Mental Health
- h) Alcohol and Tobacco
- i) Physical Activity and Nutrition
- j) Housing / Environment
- k) Employment / Education
- l) Social Care / Community Wellbeing

The workshop was designed to inform colleagues from departments across the London Borough of Enfield about health inequalities. The vision for the day was for activities developed as a result of the workshop to specifically target Upper Edmonton with the aim of increasing healthy life expectancy. Achieving a multi-directorate response was a central element of the approach and multi-directorate buy-in was successfully achieved throughout the authority to make improvements across all determinants of health.

Additional to the council directorates involved in the workshop, a broad range of voluntary groups were invited and involved in the discussion and development of the work-plan. Multi-agency groups involved included faith groups, multi-racial groups and special interest groups e.g. Diabetes UK and Stroke Action. The work-plan developed as a result of the workshop has been implemented with multi-agency support. A wide range of organisations were involved in this process, these include:

NHS community services	General Practitioners in Upper Edmonton
Patient participation group members	Pharmacy lead
Local pharmacies	Nursing

Teenage pregnancy	Metropolitan Police
Police	Community Safety
Charities	CRUK
Diabetes UK	British Heart Foundation
Clinical commissioning group	North Middlesex Hospital
CVD clinicians	Mental health team
BEH Mental Health Trust	Education
Enfield Homes	Education groups
Sport England	Voluntary Groups
Community leaders	Youth groups
EREC	The local community
Local ethnic community group	Over 50's forum
Public health – NHS health checks	Enfield parents and children
Schools	Officers and members from the Council.
Health Visitors	Licensing
Health intelligence	Jobcentre Plus

Key successes of the programme to date have been:

- The introduction of a project to manage heart disease in hard-to-reach patients, specifically cholesterol and hypertension;
- Pharmacists carrying out community reviews of medicines for patients with COPD;
- Working jointly with GPs and consultants in Endocrinology to re-design the diabetes pathway with a preventative stream;
- Increased commissioning of health checks and smoking cessation sessions;
- Joint working to increase the number of local people employed in the local hospital, North Middlesex. Work is on-going to deliver another 20 objectives.

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London Borough of Newham: Developing healthy urban planning

The London Borough of Newham is the third most deprived local authority area in England. It has a population of around 308,000 people. The borough has an unusually young age profile compared to the profile for England, with only 6.7 per cent aged over 65, compared to 16.5 per cent nationally. The borough is considerably ethnically diverse, with large populations of Asian and Black African origin, as well as White, and many other people with family origins all over the world.

Whilst life expectancy and death rates from major diseases in Newham are improving (81.1 years for women and 82.6 for men, on average), the gaps between Newham and the London averages remain. Health inequalities are also emerging between different parts of Newham. The gap in life expectancy between the best and worst wards was in 2012, 11.5 years for men and 13.5 years for women. The borough's premature mortality rate is the third worst in London and it has the

second worst one year survival rate for cancer in England. Newham has high rates of children living in poverty and of deaths occurring in the first year of life. Newham has the highest tuberculosis rate in England. It also has the highest unemployment rate. The proportion of homes not meeting the 'decent homes' standard is higher than the London average at 27 per cent. Recent data suggest that Newham has the highest proportion of housing classified as 'overcrowded' in London, at just under 18 per cent. It is against this context of deprivation, poor housing and overcrowding that Newham's public health team has been working with the council's planning department for some years to promote the idea and the reality of a planning strategy that supports the health of residents.

In Newham's Core Strategy document, its local spatial development plan. This core policy explicitly refers to how planners will work with health partners to implement it and how it will 'promote healthy lifestyles, reduce health inequalities, and create healthier neighbourhoods'.

The Core Strategy sets out a requirement for developers to undertake a health impact assessment of all major development proposals. This idea is increasingly being taken on board by developers, especially as planners are able to point to health policies in the strategy and to the need for developers to show that their proposals will fulfil health-related criteria. The core policy, SP2 Healthy Neighbourhoods, states that development proposals which respond to the following contributors to health and well-being will be supported:

- the need to promote healthy eating through taking into consideration the cumulative impact of A5 uses (hot food takeaways)
- the need to improve Newham's air quality, reduce exposure to airborne pollutants and secure the implementation of the Air Quality Action Plan, having regard to national and international obligations
- the need to improve employment levels and reduce poverty, whilst attending to the environmental impacts of economic development including community/public safety, noise, vibrations and odour and the legacy of contaminated land
- the need to improve housing quality and reduce crime, insecurity and stress and improve inclusion through better urban design.
- the need for new or improved health facilities, and importance of protection and promotion of local access to health and other community facilities and employment, including sources of fresh,
- healthy food in line with Policies SP6 (Successful Town and Local Centres) and INF5 (Town Centre Hierarchy and Network)
- the importance of facilitating and promoting walking and cycling to increase people's activity rates
- the need for new or improved inclusive open space and sports facilities to encourage greater participation in physical activity and provide relief from urban intensity
- the role of Newham University Hospital as a key provider of clinical care and expertise, employment and training provision.

Newham contributed to developing the London Healthy Urban Planning Checklist. This provides planners with a guide to the main likely implications for health of the proposed development and also provides them with an easy guide to the local policies and standards that apply to each one of the criteria mentioned in the guide. The checklist also provide planners with prompts for questions or for requests for further information to support an application and allows planners to understand and identify where the health-related impacts from development may be, and the extent to which adverse impacts can be mitigated through planning conditions or obligations on development granted planning permission.

The overall objective is to embed the healthy planning agenda deeply into the culture of the local authority, so that the issues can be raised and prioritised by the whole local authority and embedded within every department.

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Royal Borough of Kingston upon Thames: Refugee and Migrant Strategy

Context

The Royal Borough of Kingston upon Thames is a small compact outer London borough. Kingston is an ancient market town and is one of the least populated London boroughs and the seventh smallest in geographical area. A total of 194,163 people were registered with Kingston GPs in 2013, over 33,000 more than the 2011 resident population. It has approximately 25.5 per cent minority ethnic residents, among whom the Asian community is the largest, making up 16.3 per cent of the total. Life expectancy for people in Kingston is 2.2 years more than the England average for men and 1.6 years more for women. Kingston has the fifth lowest life expectancy gap in London. There is a strong record of partnership between local government, the NHS and the voluntary sector. Improving health and reducing health inequalities is Objective 8 of an overarching Kingston Plan.

Refugee and Migrant Strategy

The Refugee and Migrant Strategy (RMS) is a good example of how ECET is ensuring that addressing health and wider determinants of health is central to the council's and strategic partners' approach and plans. The needs assessment undertaken as part of the RMS showed that many refugees and asylum seekers in the Royal Borough of Kingston experienced problems accessing health services, such as GP services. This was sometimes due to a lack of understanding how the health system worked, confusion over the specific paper work required or language barriers. The vision for change developed as part of the strategy made a commitment to:

- commission services that support refugees and asylum seekers
- develop clear guidelines for healthcare staff about eligibility and access
- create a culture of "register patients first, then investigate eligibility"
- work with other commissioned healthcare providers to ensure that equal access guidelines are clear and to promote the needs of these communities.

The RMS was reviewed for the inception of the Health and Wellbeing Board (HWB) and in response to the Joint Health and Wellbeing Strategy, one of whose four key priorities is improving the health of disadvantaged communities. The HWB's first major piece of work for disadvantaged communities was to endorse and take on responsibility for developing, implementing and monitoring RMS key performance indicators. Reports on progress are made to the HWB every six months and decisions are taken on future direction, where necessary. For example, in response to the numbers of refugees and migrants fleeing the warzone in Syria, funding has recently been increased for crisis support of this community.

Further interventions of the Joint Health and Wellbeing Strategy for disadvantaged communities include ECET supporting groups with development and releasing capacity through utilising

community development approaches to education and empowerment. A small sample of these initiatives include:

- **Training community health advocates** A public health-funded Community Development and Health course,
- **Empower and Inspire** Kingston's Empower and Inspire programme has won a £240,000 European Union Integration Fund bid. The programme will focus on the positive health outcomes it can bring for community members who are often isolated and vulnerable – particularly women and young people who don't have English as a first language.
- **Income Maximisation Project** ECET's public health-commissioned work on income maximisation in association with Kingston's Citizen's Advice Bureau (KCAB) was a very early example of work to mitigate the impact of welfare reforms and the recession.
- **Learn English at Home** One-to-one home tuition is provided by trained volunteers, community classes and social activities.

To further develop its work with disadvantaged communities, the ECET Plan is currently being refreshed as a three year plan for 2014-2017. The Plan is being revised under the headings of the 6 Marmot objectives. Interventions that fall under the main Marmot objectives include strategic and community development work to tackle poverty issues, further researching the needs of refugees and asylum seekers and developing localised partnership plans, developing a strategy for prioritised work in geographical locality areas of deprivation and further developing volunteer community advocates who can reach into marginalised and vulnerable groups.

Concurrently, the core data set of the JSNA is also being revised and compiled under the Marmot objectives. This involves public health working across council supported by data specialists in the Kingston Data Observatory. Developing work streams for public health include partnership groups focussed on creating fair employment and good work for all.

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London Borough of Harrow: My Community ePurse – personal budget and support planning tool

Context

The London Borough of Harrow is diverse in so many ways. Its roughly 239,000 residents comprise the 5th most ethnically diverse Borough in England, and the single most religiously diverse Borough in England and Wales. It is a Borough of variety and contrast; containing the type of affluence epitomised by Harrow School alongside areas of high-level deprivation.

In Harrow, we consistently promote personalisation because we recognise that encouraging people to exercise their choice, power and flexibility results in far better outcomes. This is particularly true for vulnerable adults, whose individual needs may require a tailored service.

There are many pieces we are using to complete the puzzle of personalisation, and we believe My Community ePurse is a key component of our strategy.

My Community ePurse (MyCeP)

My Community ePurse is a personal budget and support planning tool that enables service users to receive personal budgets and purchase services all in one place. They will therefore not need to set up bank accounts or keep paper records related to their personal budgets. The system, when fully optimised, enables interfacing with other Council systems including SAP and Framework-i.

The overarching aim of the MyCeP is to help us embed Personalisation. It is ground breaking because it can facilitate change to all of our commissioning activity. The system also provides opportunity to address many of the forthcoming changes required as a result of the Care Bill by developing the existing system. With this in mind, there are many benefits we aim to deliver to service users, communities, providers and the local authority alike. These include:

- **Removing the barriers to personalisation** i.e. no need for bank accounts; enables a culture shift within Adult Social Service teams and a shift from commissioning to direct purchasing between service user and provider
- **Enables local authorities to have a shared directory** based on registration of local providers in each borough. For providers, this enables them to maintain their service/product information in one place.
- **Providers benefit from service user contributions** available at point of purchase and easy drawn down of payments
- **Greater transparency and enhanced safeguarding and quality assurance** in line with Audit Commission's requirements for managing Personal Budgets
- **Council can monitor transactions** leading to reduced fraud and improved safeguarding
- **Achieving financial savings** based on reducing the cost of care
- **Will evolve to meet the future requirements of the Care Bill** with 'add on' solutions to continue providing value to its users.
- **Providers can offer preferential rates** because prompt payment, and reduced administrations costs including non-invoicing of clients and recovery unpaid contributions
- **No need to outsource brokerage services** as 'self-brokering' becomes the norm
- **Provides business intelligence about supply and demand** enabling market shaping based on co-production/co-design of services

My Community ePurse is an opportunity for us to deliver real benefits to service users, carers, communities, providers and staff alike. The challenges and opportunities that await us include:

- Fully integrating MyCeP with other Council systems including SAP and Framework-i (or care management system).
- Developing software enhancements that help address some of the requirements of the Care Bill
- Adapting our ways of working to ensure that the end-to-end process for Personalisation using MyCeP leads to increased quality and efficiency

We are responding directly to the needs of Harrow's residents. By listening closely to what people tell us about the ways in which we can increase their control, improve their wellbeing and reduce their isolation, we have raised the bar. There is no upper ceiling to our concept of quality. So, guided by the principles of personalisation, innovations like My Community ePurse take us another step closer to meeting the diverse needs of our diverse community.

More information our new tool is available from Chris Greenway, Head of Safeguarding Assurance at chris.greenway@harrow.gov.uk .