Public Document Pack

Havering
LONDON BOROUGH

# HEALTH & WELLBEING BOARD
## AGENDA

| 1.00 pm | Wednesday, 20 December 2023 | Town Hall |
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Members: 18, Quorum: 6

**BOARD MEMBERS:**

| | |
|---|---|
| Elected Members: | Cllr Gillian Ford (Chairman), Cllr Oscar Ford, Cllr Keith Darvill and Cllr Paul McGeary |
| Officers of the Council: | Andrew Blake-Herbert, Mark Ansell, Barbara Nicholls, Tara Geere, Patrick Odling-Smee and Neil Stubbings |
| NEL CCG: | Narinderjit Kullar, Luke Burton and Emily Plane |
| Other Organisations: | Anne-Marie Dean, Ann Hepwroth, Carol White, Paul Rose and Sarita Symon |

**For information about the meeting please contact:**
**Luke Phimister 01708 434619 01708 434619**
**luke.phimister@onesource.co.uk**

***Under the Committee Procedure Rules within the Council's Constitution the Chairman of the meeting may exercise the powers conferred upon the Mayor in relation to the conduct of full Council meetings. As such, should any member of the public interrupt proceedings, the Chairman will warn the person concerned. If they continue to interrupt, the Chairman will order their removal from the meeting room and may adjourn the meeting while this takes place.***

***Excessive noise and talking should also be kept to a minimum whilst the meeting is in progress in order that the scheduled business may proceed as planned.***

**What is the Health and Wellbeing Board?**

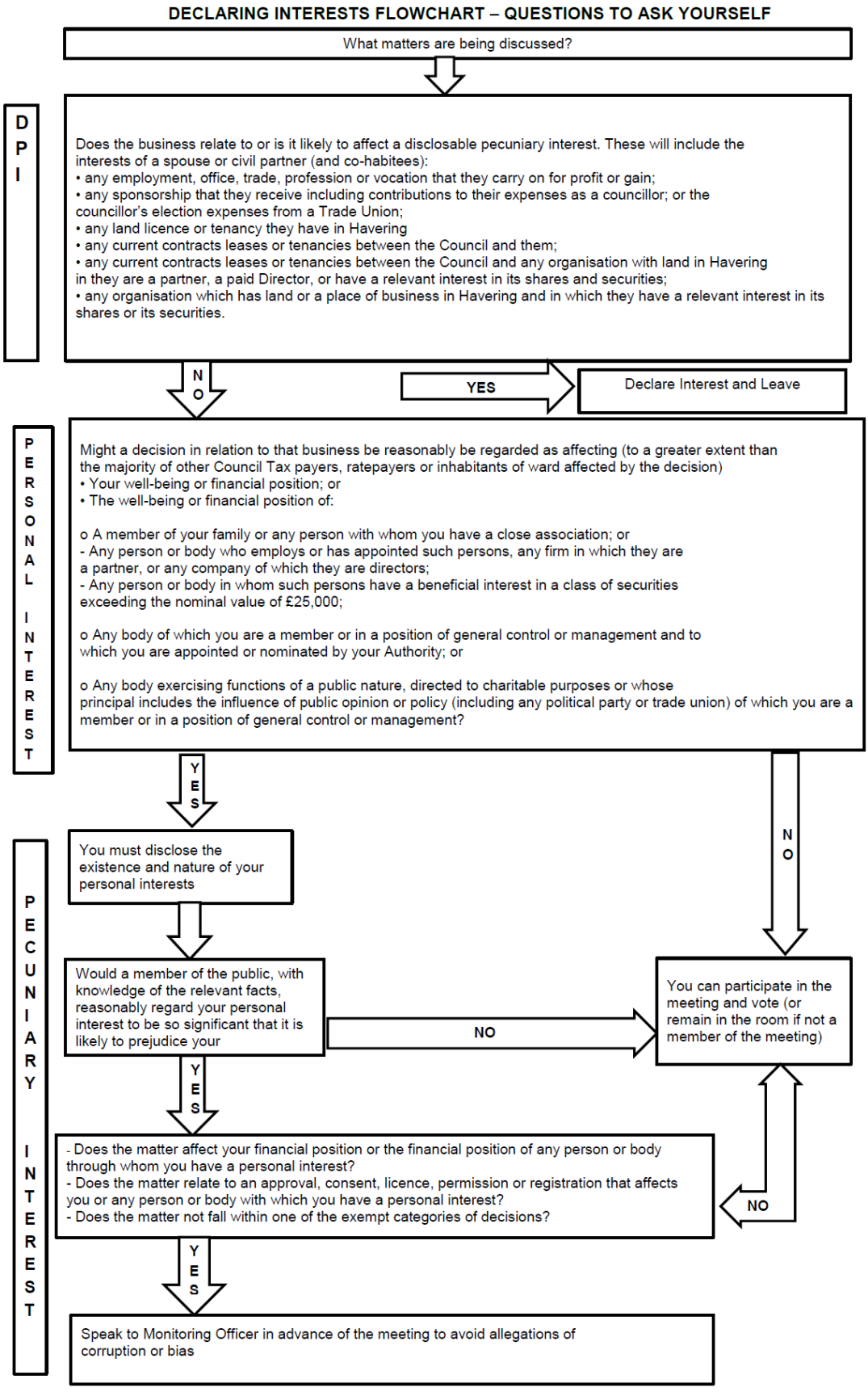
Havering's Health and Wellbeing Board (HWB) is a Committee of the Council on which both the Council and local NHS and other bodies are represented. The Board works towards ensuring people in Havering have services of the highest quality which promote their health and wellbeing and to narrow inequalities and improve outcomes for local residents. It will achieve this by coordinating the local NHS, social care, children's services and public health to develop greater integrated working to make the best use of resources collectively available.

**What does the Health and Wellbeing Board do?**

As of April 2013, Havering's HWB is responsible for the following key functions:

- Championing the local vision for health improvement, prevention / early intervention, integration and system reform
- Tackling health inequalities
- Using the Joint Strategic Needs Assessment (JSNA)and other evidence to determine priorities
- Developing a Joint Health and Wellbeing Strategy (JHWS)
- Ensuring patients, service users and the public are engaged in improving health and wellbeing
- Monitoring the impact of its work on the local community by considering annual reports and performance

information



## AGENDA ITEMS

**1 CHAIRMAN'S ANNOUNCEMENTS**

The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

**2 APOLOGIES FOR ABSENCE**

(If any) – receive

**3 DISCLOSURE OF INTERESTS**

Members are invited to disclose any interest in any of the items on the agenda at this point of the meeting.

*Members may still disclose any interest in any item at any time prior to the consideration of the matter.*

**4 MINUTES** (Pages 5 - 14)

To approve as a correct record the minutes of the Committee held on 25th October 2023 and to authorise the Chairman to sign them.

**5 MATTERS ARISING**

To consider the Board's Action Log

**6 FINDINGS OF #BEEWELL SURVEY** (Pages 15 - 20)

**7 GOVERNMENT FUNDING TO STOP SMOKING** (Pages 21 - 38)

**8 NEL JOINT FORWARD PLAN** (Pages 39 - 108)

**9 DATE OF NEXT MEETING**

To note the next meeting date of 27th March 2024.

**Zena Smith**
**Head of Committee and Election Services**

**MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD**
**Town Hall**
**25 October 2023 (1.00 - 2.45 pm)**

**Present:**

**Elected Members:** Councillors Gillian Ford (Chairman), Keith Darvill and Paul McGeary

**Officers of the Council:** Andrew Blake-Herbert (Chief Executive), Mark Ansell (Interim Director of Public Health), Barbara Nicholls (Director of Adult Services) and Tara Geere (Director, Starting Well)

**Havering Clinical Commissioning Group:**

Ann Hepworth - Director of Strategy & Partnerships BHRHUT
Dr Narinderjit Kullar, Clinical Director - Havering Place based Partnership

**Healthwatch:** Anne-Marie Dean (Chair)

**Other:** Paul Rose

**Also Present:**

Tha Han - Assistant Director of Public Health
Esosa Edosomwan
Elaine Greenway
Emily Plane - Head of Strategic Planning Havering Place based Partnership, NHS North East London
Luke Squires - Public Health Practitioner

11 **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman reminded Members of the action to be taken in an emergency.

12 **APOLOGIES FOR ABSENCE**

Apologies were received from Neil Stubbings and Nick Swift.

13 **DISCLOSURE OF INTERESTS**

Councillor Paul McGeary disclosed a non-pecuniary interest as an employee of the NELFT and the Cabinet Member for Housing.

## 14 MATTERS ARISING

There were no matters arising.

## 15 MINUTES

The minutes of the meeting held on 29 June 2023 were agreed as a correct record and signed by the Chairman.

## 16 SUBSTANCE MISUSE STRATEGY

The Assistant Director of Public Health Board presented a report on behalf of Havering Combating Drugs Partnership (Havering CDP) informing that Havering Council Public Health team launched a consultation on Havering Substance Misuse Strategy 2023-2028.

It was stated that Havering had a similar strategy called Drug and Alcohol Harm Reduction Strategy 2016- 19 but due to the Covid pandemic there has been a delay in the revision of the strategy. The Havering CDP strategy is in response to the national drugs strategy thereby renewing the previous Havering Strategy.

It was stated that a new 10- year national drugs strategy called “From harm to hope” plans to cut crime and save lives’ was published by the government in December 2021.

The Board noted that the national strategy was accompanied with a supplementary grant to increase capacity in local treatment system and the grant requires local partnerships to produce a new strategy.
This consultation was in response and the strategy is being developed to renew the previous Havering Strategy.

It was stated that the strategy covers all substances which have the potential for abuse and addiction except tobacco. It also aims to tackle the stigma around addiction to encourage individuals and families who are affected to get support and to minimise community violence towards those with substance-misuse problems.

The draft strategy describes some key findings from the needs assessment which estimated that 1 in 5 adults (around 41,000 people) in Havering drink excessive amount of alcohol and 14,000 16 to 74-year-olds use illicit drugs. Two workshops with local and regional partners and people with live experiences followed by direct communication with delivery partners informed the set of actions in the strategy.

It was noted that substance misuse and addiction affect more than just the person with dependency problems and affect the family and wider community in many ways. Substance misuse can lead to criminal behaviour

including domestic violence, assaults, antisocial behaviour, theft and burglaries, sexual exploitation, slavery and gang violence.

This Board was informed that partners in Havering will work together to:

- break drug supply chains;
- deliver a world-class treatment and recovery system;
- achieve a generational shift in the demand for drugs; and
- reduce risk and harm to individuals, families and communities.

There are plans to address the four key areas developed through working with all key stakeholders such as the National Health Service (NHS), drug and alcohol treatment services, voluntary care sector, schools, Police, trading standards, licensing, Department for Work and Pensions (DWP), children services, adult services.

The strategy will be implemented over a five-year period commencing from the date of publication and will be reviewed at least annually by the Havering Combating Drugs Partnership and amendments made where necessary.

The Board was informed that feedback from the consultation and engagement with service users will be incorporated into the final draft. The final draft will undergo an Equality Impact Assessment which will be added onto the final draft. Havering Combating Drugs Partnership will sign off the final draft before submission to Health and Wellbeing Board, Place-based Partnership and Cabinet for noting and approval.

During discussion, members of the board suggested that the consultation be extended to the Safer Neighbourhood Team and its Chairperson to make comments as there have been issue of drug abuse and antisocial behaviour in some areas.

The Director of Strategy & Partnerships Barking Havering and Redbridge University Hospitals NHS Trust responded that the Partnership will contribute to the consultation in as much that the NHS see the result of the issues. Officers were also extended an opportunity to make the presentation at an executive committee meeting and have a debate with the clinical teams.

The Board **noted**:

- the presentation content, responded to the consultation plan, suggesting any amendments to the strategy approach, and
- agreed that a final draft of the Strategy takes into account consultation responses be received by the Health and Wellbeing Board or the Chair for a final sign off in December
- to receive the consultation feedback following sign off.

## 17 ARNOLD'S FIELD HEALTH RISK ASSESSMENT

The Board received a presentation that summarised the health risk assessment being undertaken by the Council in response to recurrent fires at Arnolds Field off Launders Lane in Rainham.

It was explained that there was limited sampling undertaken suggesting there is a wide range of waste, including household, commercial / industrial (including wood, paper, glass, plastic, mattresses, furniture, cables and fabric materials) and construction waste deposits, several metres deep. There have been a number of significant fires in subsequent years which was likely caused by heat and methane generated by decomposition of organic matter

It was stated that the frequency of fires had increased in 2022. The London Fire Brigade (LFB) has attended for 12 LFB attendances for primary fires 52 attendances for damping down secondary fires and 70 attendances where residents think there is a fire. The LFB intend to use a drone with thermal imaging to determine if this is the case. In 2023, there have been 19 fires so far all of which occurred in the third quarter of the year.

It was noted that there has been an organised community action since the summer of 2022 following the complaints about smoke, dust and odour from the fires. Residents were also experiencing respiratory symptoms, sore throats and nosebleeds with links made to cases of cancer in the local community.
There have been public meetings organised by local residents with council officers participating. There is a Launders Lane crisis Facebook group with 1.6k members – sharing messages, fund raising, pushing for action on basis of perceived health risks.

There has been direct engagement with MP, elected members and Councils administration. Local residents have also engaged with the media to support their case with articles on local / regional media.

It was stated that before the 2022 public protection order that lead to a monitoring of Air Quality, there is a Air Quality monitor in Rainham about one kilometres from Launders Lane measuring Nitrogen Dioxide NO2 and other particulates. During the summer of 2022, analysis showed particulates were high during fires but the peaks are shortlived and did not exceed current UK limits which allow for multiple exceedances providing the annual mean level is met. It was stated that areas closer to or more often downwind of the site might exceed limits for specific pollutants.

The Board was informed that the Council Leader chairs a steering group since late summer of 2022 to oversee response to residents' concerns. The group also comprised Ward councillors, MPs, Environmental Authority, LFB, Chief Executive, Planning, Public Protection and Public Health.

It was stated that currently there is a health risk assessment on going led by Director of Public Health with the support of multiagency technical group.

A technical group was formed in September 22 to suggests approach to health risk assessment, reviews data generated, shares outputs with leadership group and residents. The Membership of the technical group comprised academic partners, LFB, TRL, Public Protection.

In terms of the Epidemiological findings, little progress has so far been achieved due to access to data. However, some progress is being made now to discuss the methodology for epidemiological analysis with colleagues from Imperial college and data will soon be made available by NHS partners.

The Board was informed of plans to appoint a provider to monitor ambient air quality between and during one or more fires, at one or more locations where residents are most likely to be affected by the smoke plume and to identify/quantify the precise products of combustion. This was in addition to Nitrogen Dioxide (NO2) and other particulate matter being measured by Imperial College Breathe London Sensors.

Officers stated that when there have been significant fires there were elevations in the amount of PM2.5 in monitoring locations close to Arnold's field site.
Officers agreed with residents that a solution to fires needed to be found and the landowner would be encouraged to find ways to resolve the problem.

During discussions, members of the board noted that monitoring was ongoing, it was suggested that available data be shared with residents. It was noted that there were drone images and that resident have also undertaken some drone surveillance. The Board was informed that the council was providing monthly report update on the site and information was available on the council website which can be accessible by residents.

The Board was assured that the council was meeting its statutory minimum requirement for monitoring general air quality.

The Board **noted** the presentation that summarised the health risk assessment being undertaken by the Council in response to recurrent fires at Arnolds Field off Launders Lane in Rainham and will receive the findings of the health risk assessment at a future date.

## 18 HEALTH PROTECTION FORUM ANNUAL REPORT

The Board received the Health Protection Forum Annual Report for 2022-2023. The Havering Health Protection Forum (HPF) supports Havering Director of Public Health (DPH) in discharging the DPH duty to protect health by supporting and challenging local health protection arrangements.

It was noted that the 2022-23 HPF Annual Report was the first since the Covid-19 pandemic was declared in 2020. The annual report summarised the work of the HPF during 2022-23 and outlines priorities for 2023-24.

The report outlined that in general, health protection arrangements in Havering are functioning effectively and there has been good recovery of services following lifting of Covid-19 regulations and accompanying restrictions. The report also summarised some areas where improvements could be made.

It was noted that each section of the report outlines how the health protection system works for the topic of focus, presents key data trends or a diagram demonstrating how the system works, a summary of current concerns or highlights and significant actions being taken.

The Board was informed that it is planned to take the report to the Borough Partnership for discussion on how to further strengthen health protection arrangements.

The Associate Director Public Health outlined the following key topic of focus for 2023/24 which include: Routine childhood and maternal immunization (MMR); Improving coverage of Positive Predictive value (PPV – for pneumonia in over 65's); Increase uptake of Flu vaccination; Screening for antenatal and new born (ANNB) with the aim to find health problems that may affect mother and new born; Focus on antimicrobial resistance which is a piece of work led by the East London Antimicrobial Resistant Strategy Group with a report to be presented in the future.

The Board **noted** the contents of the report, including the proposed key topics of focus for 2023/24 and that Health Protection Forum plans to present the report to the Borough Partnership.

## 19 PLACED BASED PARTNERSHIP INTERIM STRATEGY

The Board received from the Head of Strategic Planning, Havering Place based Partnership, NHS North East London a presentation on the Havering Place based Partnership Interim Health and Care Strategy.

The Havering Place based Partnership brings together the NHS, local government and providers of health and social care services, including the voluntary, community and social enterprise (VCSE) sector, Care sector, residents and communities. It is noted that the primary purpose of the Partnership is to review and respond to the needs of local people, and improve the delivery of care and support to them to meet these needs in a way that is meaningful to them.

It was stated that the Partnership has a formal Sub Committee with delegated authority from the NHS North East London Integrated Care Board

for certain key decisions on local budgets and local to Havering decisions on health and care. The formal sub committee and wider partnership will primarily focus on the key factors that influence health and care of local people, including key wider determinants of health such as lifestyle factors and housing.

The Partnership and Sub Committee will work alongside the Board driving the key needs of local people as set out in the Joint Strategic Needs Assessment (JSNA) which is currently undertaking a refresh.

It was noted that the Health and Wellbeing Board will have a slightly wider scope than the Partnership Board focusing alongside the JSNA and Health and Wellbeing Strategy on the wider elements of the council.

It was mentioned that a proposal is in development which will set out the relationship in more detail and will be presented to the Board.

It was stated that the partnership is in the early stages of development but has strong buy in from partners and is committed to better meet the needs of local people and in particular to reduce health inequalities.

The Board was informed that local 'neighbourhood' teams of health and care staff were being developed to work closely with the community and voluntary sector and primary care networks and GP practices working together in their areas to improve the way that care is delivered to local people.

The interim strategy highlighted the key priorities for the Havering Place based Partnership in 2023/24. NHS North East London is in the process of a restructure which includes the establishment of a new team at place for Havering structured around the life course approach set out within this strategy.

The Partners intend to integrate commissioning of health and care in Havering as much as possible to ensure that services are seamless. Services will be commissioned around the needs of local people including the wider determinants of health and deliver value for money. The service will be overseen in terms of impact by the Board who will ensure that the Local Health and Wellbeing strategy and the needs set out within the Havering Joint Strategic Needs Assessment are embedded in the Partnership work as part of a Population Health Management approach. It is envisaged that the Havering Place based Partnership will drive forward the changes needed and oversee their roll out.

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

It was mentioned that the strategy aligns with and compliments the NHS North East London priorities as set out in the Interim Strategy as well as the following cross cutting themes: Tackling Health Inequalities; a greater focus on Prevention; Holistic and Personalised Care; Co-production with local people; Creating a High Trust Environment that supports integration and

collaboration; and Operating as a Learning System driven by research and innovation.

The report outlined the following four main priorities for the Partnership:

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

Members of the Board congratulated the service for putting together a comprehensive report. The Board discussed how to effectively monitor the delivery of the strategy.

The Head of Strategic Planning responded that the priorities will enable Partners to deliver the aspirations detailed in the report for each life course. It was explained that data leads for both the NHS and Local Authority are working together to develop a dashboard which will help to monitor progress against the aspirations.

The Board **noted** and **endorsed** the Havering Place based Partnership Interim Health and Care Strategy in particularly the initial priorities for the Integrated Team at Place.

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

## 20 RELATIONSHIP BETWEEN HEALTH & WELLBEING BOARD AND PLACE BASED BOROUGH PARTNERSHIP

The Director of Public Health gave an update presentation on the role of the Health and Wellbeing Board and its relationship with the Havering Place Based Borough Partnership (HPBPB).

It was stated that a paper which developed the idea was shared with the Board in March 2023.

The paper explained the role and responsibilities of the two bodies within the context of integrated care systems.

The statutory duty for the Board to lead the development of the Joint Strategic Needs Assessment (JSNA) and use the resulting insight to set the strategic priorities for the borough regarding health and wellbeing, and health and care services in the Joint Local Health and Wellbeing Strategy (JLHWS) was outlined

It was explained that the HPBPB would develop plans to address these priorities and oversee their delivery and report to the HWB on progress periodically.

It was noted that there was considerable overlap between the membership of the HWB and HBPBP. It was suggested that a 'Committees in Common' arrangement might minimise the duplication of effort assuming the agendas of the two bodies could be sufficiently aligned.

As an alternative, it was suggested that the Board might wish to expand its membership to better address the wider determinants and create a more distinct but complementary agenda to that of the HPBPB.

The Board noted that the Executive of the HPBPBP met recently to consider its interim Strategy. The interim strategy demonstrates that the HBPBP is developing a comprehensive approach to addressing the health and care needs of local residents consistent with the priorities of the NEL ICB; informed by the Havering JSNA and engagement with local residents and professionals; and progressing towards a population health management approach whereby insight is used to facilitate more upstream preventative intervention.

The Executive of the HPBPBP also discussed its relationship with the Health and Wellbeing Board. Members considered the JSNA and endorsed continuation of the current approach, which considers population health outcomes as the product of the interaction between 4 drivers.

During discussion, members of the Board debated ways to minimise duplication with the HPBPBP and have a distinct agenda.

The Board the **agreed** the following proposal:

- to retain Health and Wellbeing Board
- to develop further ideas for the Board
- continue to undertake the joint strategic needs assessment (JSNA) and identify high level priorities for action in the Joint Local Health and Wellbeing Strategy (JLHWS)
- receive regular reports from the HPBPB on progress made with JLHWS priorities pertaining to health and care services and the residents benefitting from them
- consider how it might help progress issues escalated to it by the HBPBP

- take the lead on ensuring policy likely to impact on the wider determinants of health and environment gives due consideration to the potential impacts on the health of the population and health inequalities in the longer term

21 **DATE OF NEXT MEETING**

The date of the next meeting was noted.

**Chairman**

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# HEALTH & WELLBEING BOARD

| | |
|---|---|
| **Subject Heading:** | Havering Youth Wellbeing Census |
| **Board Lead:** | Mark Ansell, Director of Public Health |
| **Report Author and contact details:** | Lucy Goodfellow, Head of Insight |

**The subject matter of this report deals with the following themes of the Health and Wellbeing Strategy**

| | |
|---|---|
| ☐ | The wider determinants of health<br>• Increase employment of people with health problems or disabilities<br>• Develop the Council and NHS Trusts as anchor institutions that consciously seek to maximise the health and wellbeing benefit to residents of everything they do.<br>• Prevent homelessness and minimise the harm caused to those affected, particularly rough sleepers and consequent impacts on the health and social care system. |
| ☒ | Lifestyles and behaviours<br>• The prevention of obesity<br>• Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups<br>• **Strengthen early years providers, schools and colleges as health improving settings** |
| ☐ | The communities and places we live in<br>• Realising the benefits of regeneration for the health of local residents and the health and social care services available to them<br>• Targeted multidisciplinary working with people who, because of their life experiences, currently make frequent contact with a range of statutory services that are unable to fully resolve their underlying problem. |
| ☐ | Local health and social care services<br>• Development of integrated health, housing and social care services at locality level. |
| ☒ | BHR Integrated Care Partnership Board Transformation Board<br>• Older people and frailty and end of life<br>• Long term conditions<br>• **Children and young people**<br>• **Mental health**<br>• Planned Care<br>Cancer<br>Primary Care<br>Accident and Emergency Delivery Board<br>Transforming Care Programme Board |

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## SUMMARY

The Havering Youth Wellbeing Census is part of Havering Council's commitment to amplifying the voice of young people in the borough. The census was based on the #BeeWell survey and locally adapted by UCLPartners in collaboration with Havering Council.

The #BeeWell survey was originally developed as part of the #BeeWell programme, an initiative originating in Greater Manchester that combines academic expertise with youth-led change to make the wellbeing of young people everybody's business.

The Havering Youth Wellbeing Census used core questions from the #BeeWell survey, plus additional questions to meet locally identified needs as voiced by Havering's young people and the local organisations and services that support them.

10 schools took part in the Havering Youth Wellbeing Census during June and July 2023. This was a total of 2,287 students across year groups 8 and 10, representing 36% coverage of the target demographic.

The results of the survey will help us to understand the state of wellbeing across age groups and consider actions to support young people's mental wellbeing.

## RECOMMENDATIONS

A core principle of the original #BeeWell programme, and of our delivering the Havering Youth Wellbeing Census, is that young people's wellbeing is everybody's business.

It is recommended that:

- Health and Wellbeing Board notes the observations highlighted; and
- Board Members take time to explore the interactive neighbourhood dashboard and additional insight it provides that is relevant to the themes of the Health and Wellbeing Strategy.

## REPORT DETAIL

### Background

The 2021 Census results, released in June 2022, confirmed that the child population of Havering increased by 15.2% over the last decade. Havering now has a higher proportion of children aged 0-17 (22.3%) than 80% of local authorities in England.

Nationally there have been growing concerns about mental health and wellbeing in children and adolescents over the last few years. In 2017, one in nine children

aged five to 16 were identified as having a probable mental health problem. By July 2021, this figure had increased to one in six (or five children in every classroom).

Locally we have also seen an upward trend, exacerbated further by the Covid-19 pandemic and lockdowns. Contacts coming through the front door to Social Care (the Multi Agency Safeguarding Hub) concerning children's mental health increased by more than 50% when compared with pre-pandemic figures. Our data for Education, Health and Care Plans shows that proportionately, the greatest increase has been in plans for Social, Emotional and Mental Health (SEMH) needs.

The Havering Youth Wellbeing Census provides an opportunity to 'get upstream' and improve our understanding of wellbeing in young people.

**#BeeWell**

The #BeeWell survey was originally developed as part of the #BeeWell programme, an initiative originating in Greater Manchester that combines academic expertise with youth-led change to make the wellbeing of young people everybody's business. The programme is a collaboration between the Greater Manchester Combined Authority and #BeeWell national founding partners: University of Manchester, Anna Freud Centre for Children and Families and the Gregson Family Foundation.

More detail about #BeeWell in Greater Manchester can be found here: https://beewellprogramme.org

Designed by young people, the #BeeWell survey measures the wellbeing of young people and the results are used to deliver positive change. Survey themes include 'emotions', 'meaning, purpose and control' and 'understanding yourself', and what drives wellbeing (for example, health and routines, hobbies and entertainment, relationships).

**Survey adaptation for Havering**

The Havering Youth Wellbeing Census used core questions from #BeeWell, plus additional questions to meet locally identified needs as voiced by Havering's young people and the local organisations and services that support them.

A number of workshops were held with Havering pupils in four pathfinder schools, which included exploring what wellbeing meant to the young people. As part of this, pupils also looked at some of the results from a local survey completed in late 2022, 'SHOUT – we are listening'.

A Questionnaire Advisory Group, whose membership included a young person representative and local system stakeholders, was then responsible for agreeing the final measures to be included in the survey.

Questions added in Havering, based on local priorities, included:

- Climate change
- Vaping
- Crime
- Accessing support
- Travel to school
- Schoolwork related stress

**The response**

In total, 14 out of the 18 mainstream secondary schools in Havering engaged and of these, ten were able to deliver the census. The other four schools that initially engaged were unfortunately unable to deliver due to logistical challenges (scheduling time, access to IT suites and teacher strikes).

The 2,287 pupils that participated across academic years 8 and 10 represent 36% of all on roll.

Survey responses have been combined with data held by the Local Authority such as free school meal eligibility and special educational needs status, which allows the breakdown of survey responses according to different groupings. 2,236 responses were combined in this way, with the remaining responses not combined due to incomplete information.

**School level results**

Participating schools have each received an interactive report which allows them to compare the results for their school to those of all schools.

Schools were invited to a webinar in November 2023 to help them understand the results and how to navigate their report.

Schools have also been offered a 1 to 1 meeting with a consultant from the Child Outcomes Research Consortium to further support them in understanding their report and beginning to prioritise and plan next steps.

**Neighbourhood dashboard**

The neighbourhood dashboard has been published on the Havering Data Intelligence Hub. It allows people to view the results across Havering as a whole and split up by our three health localities (North, South and Central).

The intention is that the data will be used to inspire a place-based response to young people's wellbeing. This will require collective action across communities, businesses, the voluntary sector, the health sector, government and schools.

The dashboard was designed by UCLPartners alongside Havering's Insight team. The dashboard includes intuitive data visualisations and the ability to explore the data at different levels (e.g. year group, gender, free school meal eligibility, special educational needs status).

The following points should be useful in understanding and navigating the dashboard:

- The census contained more than 100 questions and whilst the school reports provide detailed results against all of these, due to its different intended audience, the neighbourhood dashboard presents a mix of specific questions and high level scores.

- At the top of each page is an explanation of the question and the response categories that the visualisation represents. Underneath each category, the number of responses is shown (n = ).

- The dashboard will continue to evolve and further questions / results may be added. A later phase of analysis will include the ability to combine variables and bring in additional relevant contextual data (e.g. indices of deprivation).

- Where possible, comparisons with the #BeeWell survey (2021) in Greater Manchester have been provided. In some cases this is not possible due to differences in the way GM summarised their data, or where questions were added locally in Havering.

- Care should be taken when comparing areas, particularly where comparisons with Greater Manchester are available. There are likely to be greater differences in population characteristics between Havering and Greater Manchester than between the three Havering localities. Also, the Greater Manchester results shown were collected in Autumn term 2021 while the Havering data was collected in the Summer term 2023.

- The visualisations on the left hand side of each page show the results for each locality, all localities combined, and young people who attend school in Havering but live outside the borough.

- The visualisations on the right hand side of each page show the results broken down by four demographics: Free School Meal eligibility, Year Group, Special Educational Needs status and Gender.

- The two way interactivity allows users to:

  - Click on a locality and see the differences between all the different demographic groups for that area alone; and
  - Click on one particular demographic and see the locality level results for that group alone.

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## IMPLICATIONS AND RISKS

The results from Havering's Youth Wellbeing Census and the additional data the results have been combined with provide a useful starting point for discussions about the needs of young people. Data should help with the identification of strengths, as well as priority areas for development and improvement.

A core principle of the original #BeeWell programme, and of our delivering the Havering Youth Wellbeing Census, is that *young people's wellbeing is everybody's business*. That means every section of society has a responsibility towards our young people and it is critical that local partners come together in a response.

A meeting of the Babies, Children and Young People Work stream of our Place Based Partnership took place on 4 December 2023, which was the first opportunity for partners to consider the results and begin to think about how we might respond as individual agencies and collectively.

Some of the observations from that meeting will be highlighted in the presentation. These should not be considered an agreed set of headline messages. A key principle of the Havering Youth Wellbeing Census (and #BeeWell) is that the response should be youth-led, therefore an agreed summary can only be produced with input from young people, who will also be involved in identifying and prioritising the issues that most require a response.

## BACKGROUND PAPERS

https://www.haveringdata.net/youth-wellbeing-census/

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# HEALTH & WELLBEING BOARD

| | |
|---|---|
| **Subject Heading:** | Proposed spending plan with additional government funding for stop smoking services |
| **Board Lead:** | Councillor Gillian Ford |
| **Report Author and contact details:** | Kate-Ezeoke-Griffiths Assistant Director/Public Health Consultant Kate.Ezeoke-Griffiths@havering.gov.uk |

**The subject matter of this report deals with the following themes of the Health and Wellbeing Strategy**

| | |
|---|---|
| ☐ | The wider determinants of health<br>• Increase employment of people with health problems or disabilities<br>• Develop the Council and NHS Trusts as anchor institutions that consciously seek to maximise the health and wellbeing benefit to residents of everything they do.<br>• Prevent homelessness and minimise the harm caused to those affected, particularly rough sleepers and consequent impacts on the health and social care system. |
| ☒ | Lifestyles and behaviours<br>• The prevention of obesity<br>• Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups<br>• Strengthen early years providers, schools and colleges as health improving settings |
| ☐ | The communities and places we live in<br>• Realising the benefits of regeneration for the health of local residents and the health and social care services available to them<br>• Targeted multidisciplinary working with people who, because of their life experiences, currently make frequent contact with a range of statutory services that are unable to fully resolve their underlying problem. |
| ☐ | Local health and social care services<br>• Development of integrated health, housing and social care services at locality level. |
| ☐ | BHR Integrated Care Partnership Board Transformation Board<br>• Older people and frailty and end of life<br>• Long term conditions<br>• Children and young people<br>• Mental health<br>• Planned Care<br>Cancer<br>Primary Care<br>Accident and Emergency Delivery Board<br>Transforming Care Programme Board |

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| SUMMARY |
| --- |
| This is a presentation outlining the spending proposal with additional Government funding for stop smoking services for 2024/25 in line with national guidance |
| **RECOMMENDATIONS** |
| To agree the spending proposal |
| **REPORT DETAIL** |
| The attached presentation |
| **IMPLICATIONS AND RISKS** |
| Additional government funding will support local plan to reduce the harm caused by tobacco and vapes whilst minimising the risk to health and well-being caused by smoking. |
| **BACKGROUND PAPERS** |
| Not applicable |

# Overview

# Additional Government funding for stop smoking services

Kate-Ezeoke-Griffiths

Assistant Director/Public Health Consultant



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# Measures Announced

1. **Create 1st smoke free generation** – legislate to raise age of sale of tobacco one year every year to ensure children born on or after 1st January 2009 unable to legally buy tobacco products

2. **Strengthen support to quit smoking** by

- increasing funding to LAs stop smoking services
- additional funding for marketing campaigns
- Swap to Stop - one million smokers to swap cigarettes for vapes
- Pregnancy Voucher Incentive
- Mandatory cigarette pack inserts

3. **Tackle Youth Vaping** - crackdown on Illicit vapes sales – to stop children, young people, non-smokers take up smoking

# Funding to Local Authorities Stop Smoking Services

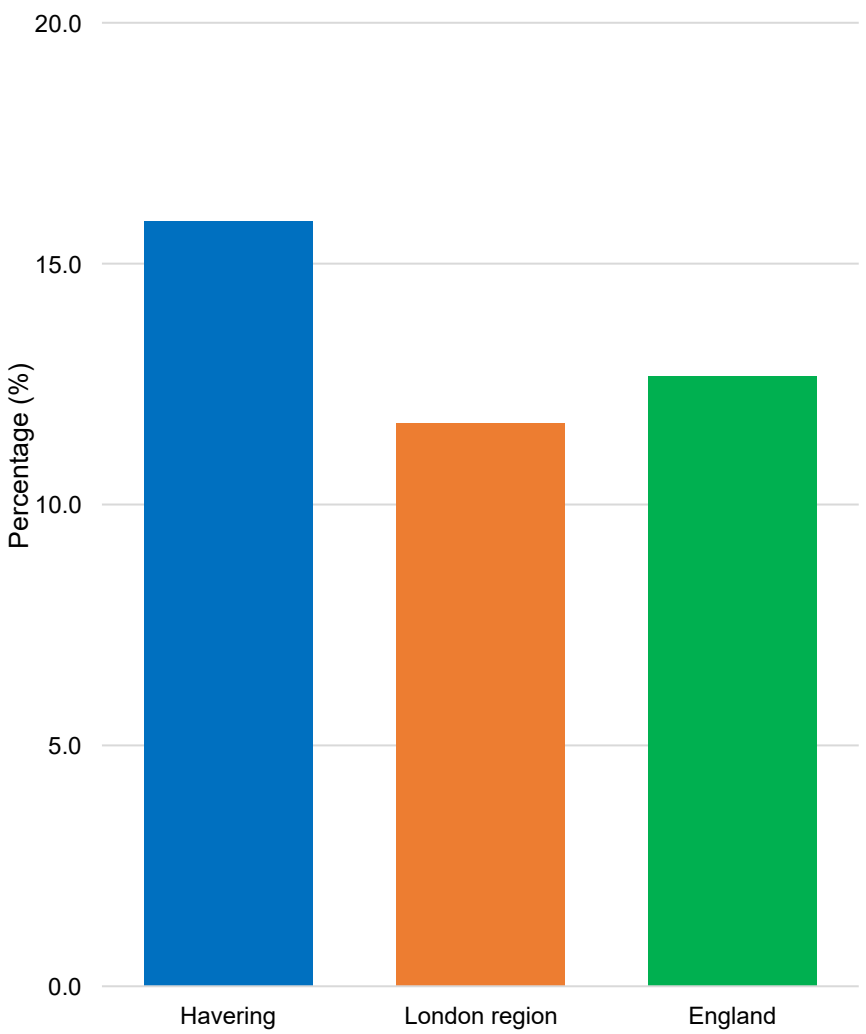
- Aim- to help more people quit smoking
- Funding over 5 financial years - 24/25 to 28/29
- Targets local areas with highest smoking rates
- Funding annually, ring fenced and to be spent
- Havering allocation for 2024-25: £307, 542.61



Funding Criteria: LAs must:

- Maintain existing spend on stop smoking services
- Maintain the level of funding throughout grant period
- Comply with the quarterly reporting requirements to NHS England

# Smoking in Havering




Source: OHID Fingertips – APS 2022

## Adult Smokers -18+

**15.9%** Annual Population Survey (APS), 2022

**13.4% (28,300) adult smokers**

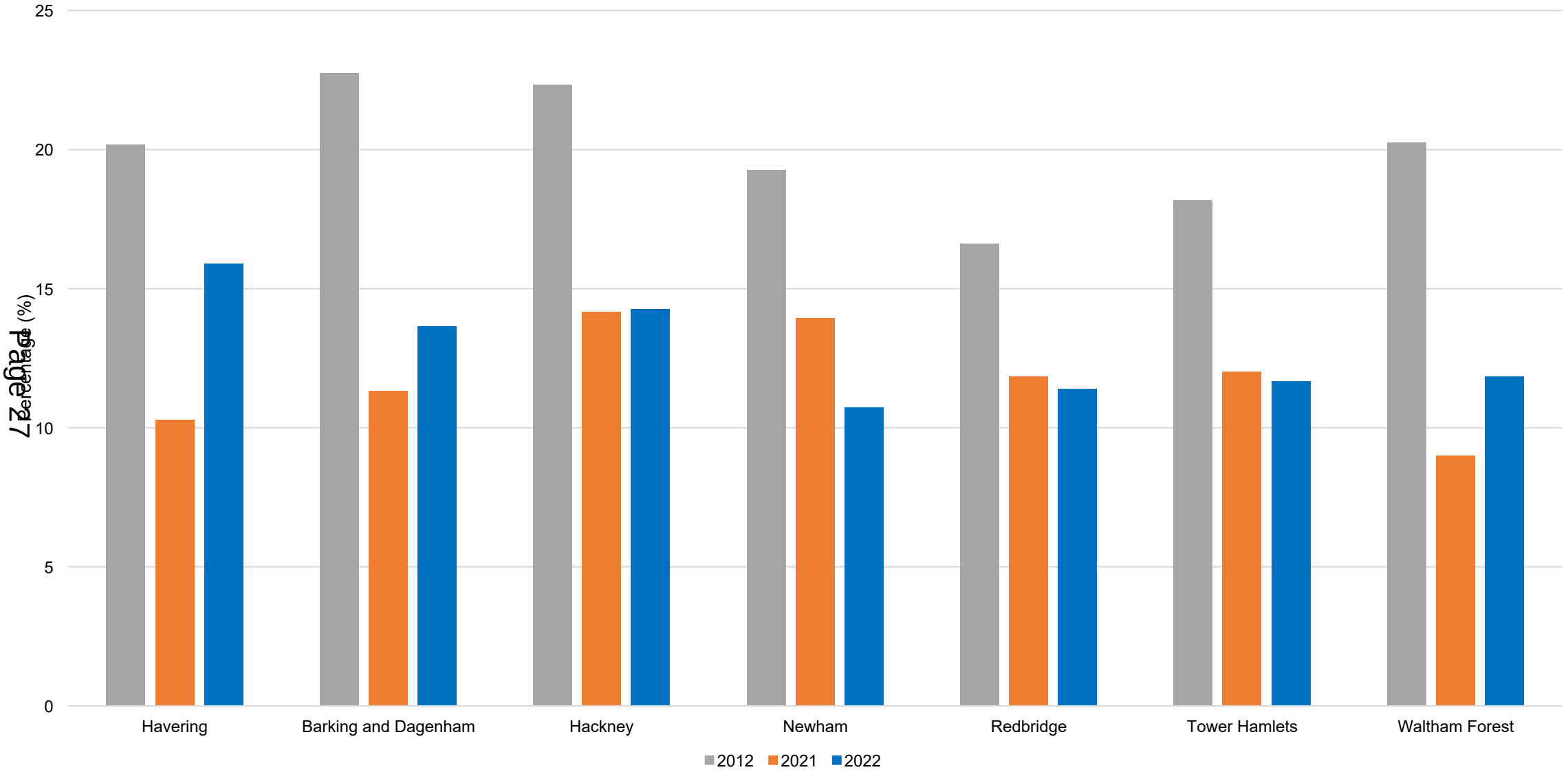
NEL ICB GP data, September 2023

## Smoking by Gender

**22.5% males** **8.5% females**

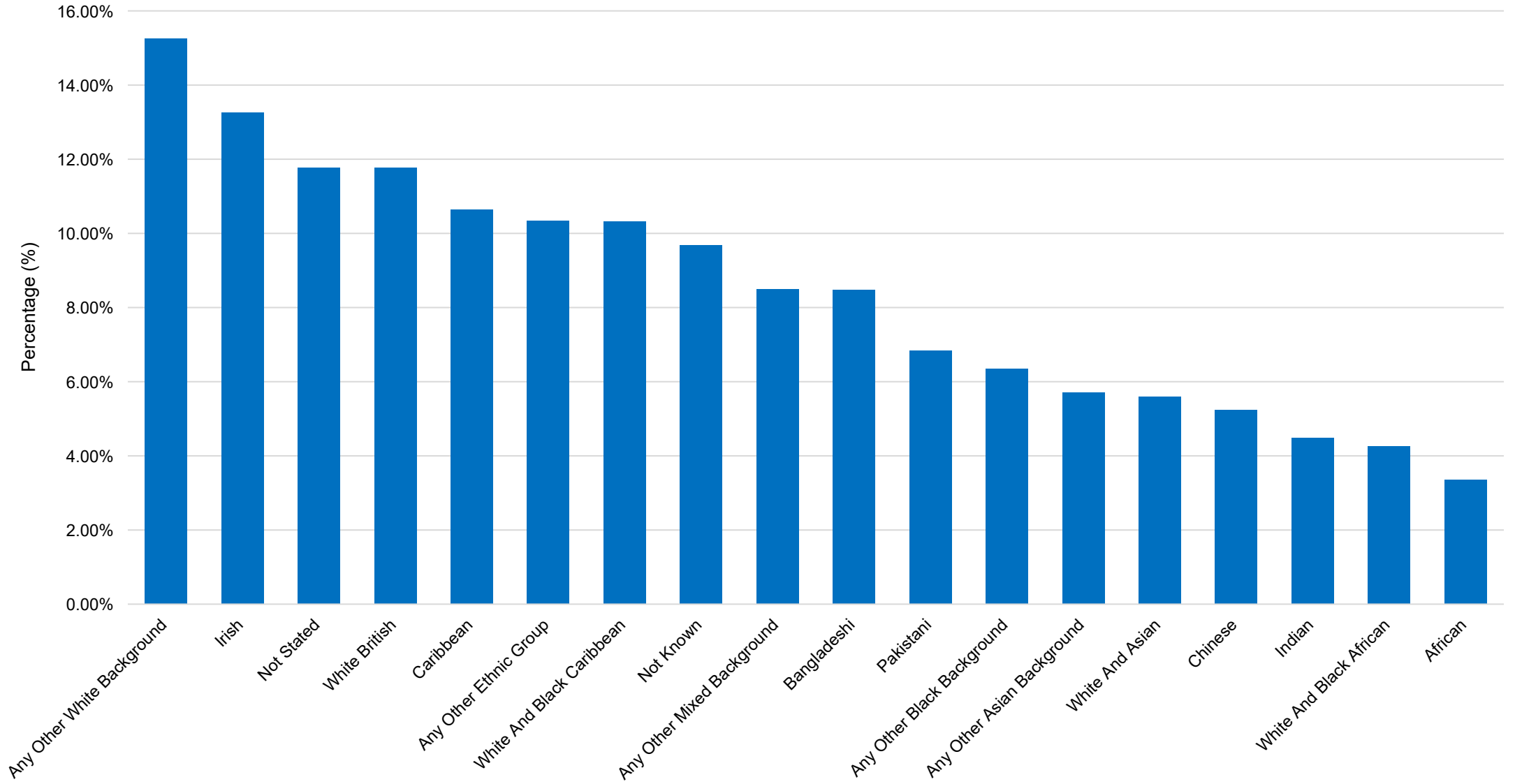
Source: OHID Fingertips – APS 2022

# Time series of smoking across NEL



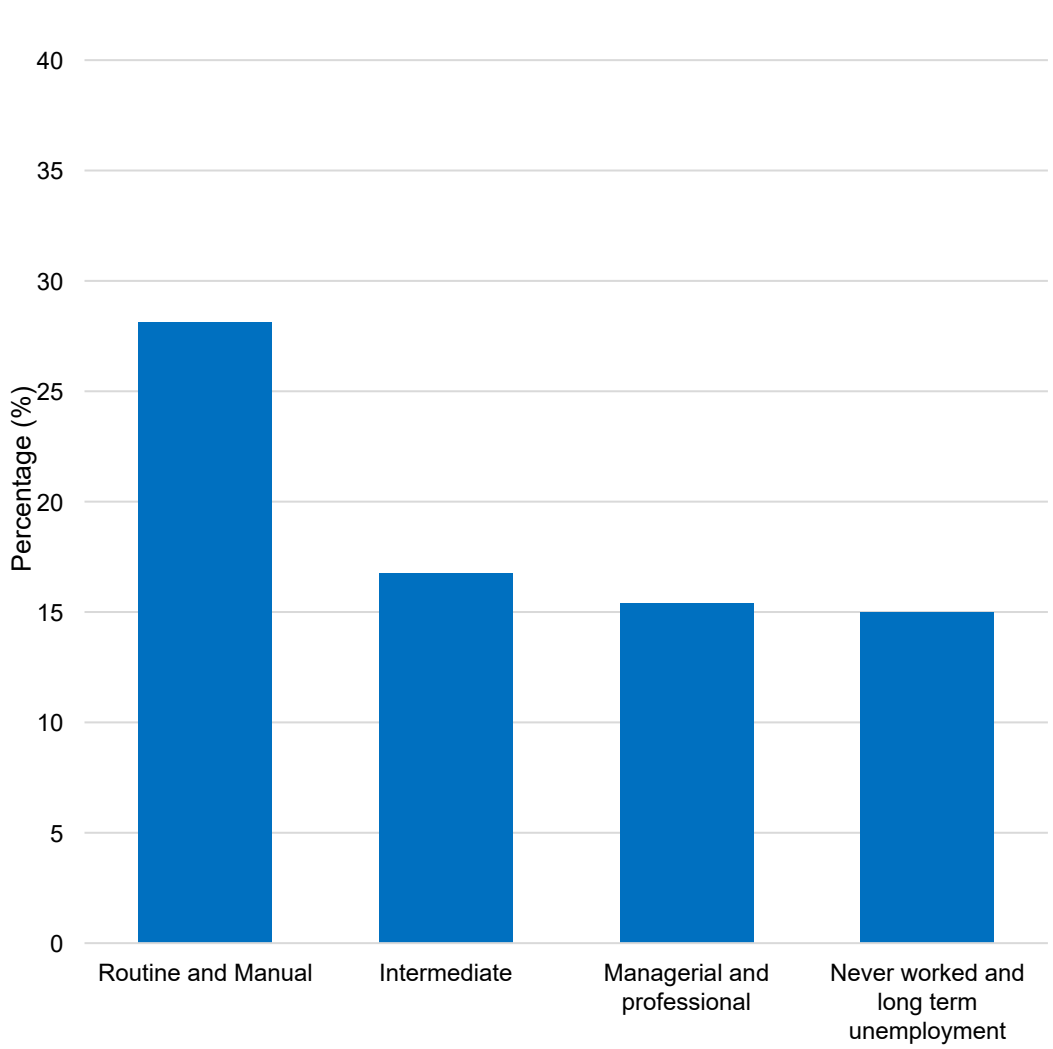

Source: OHID Fingertips – APS 2022

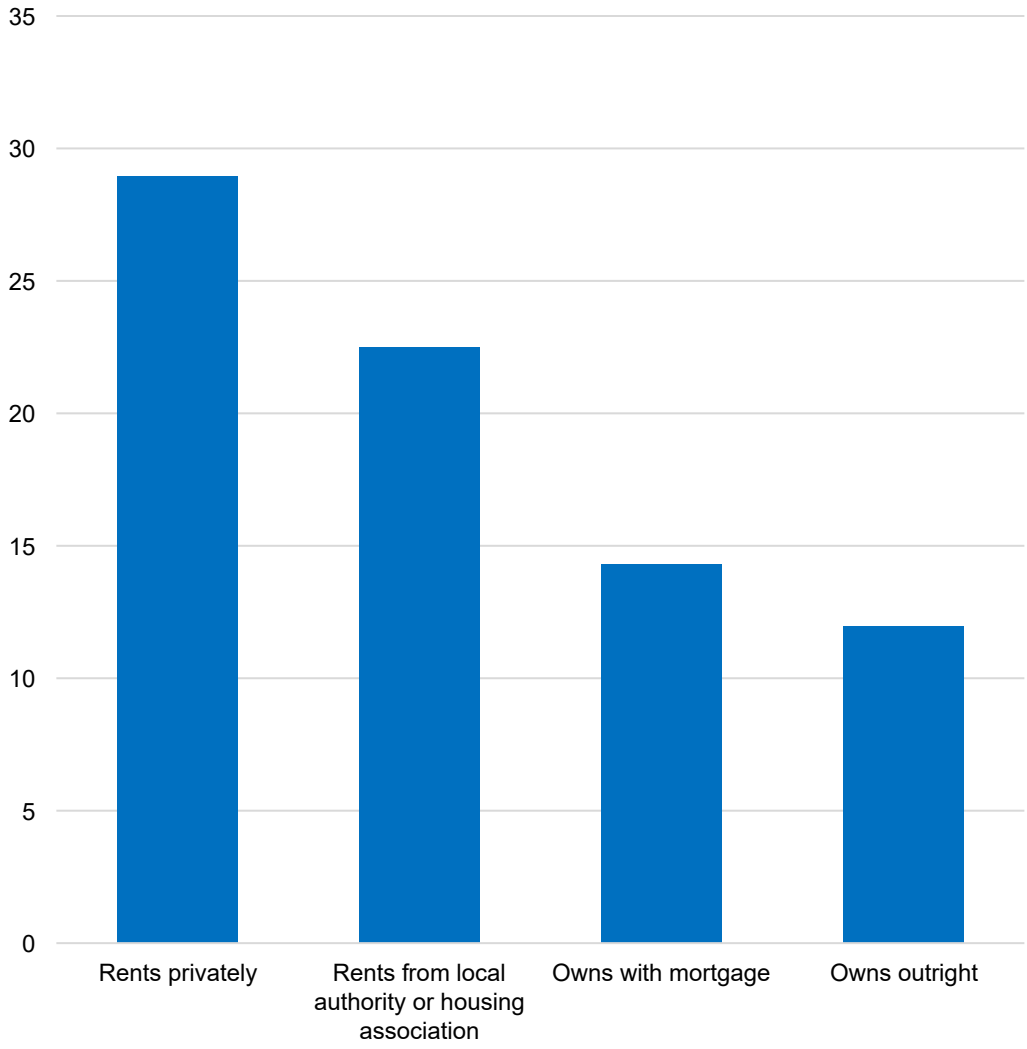
# Smoking by Ethnicity in Havering



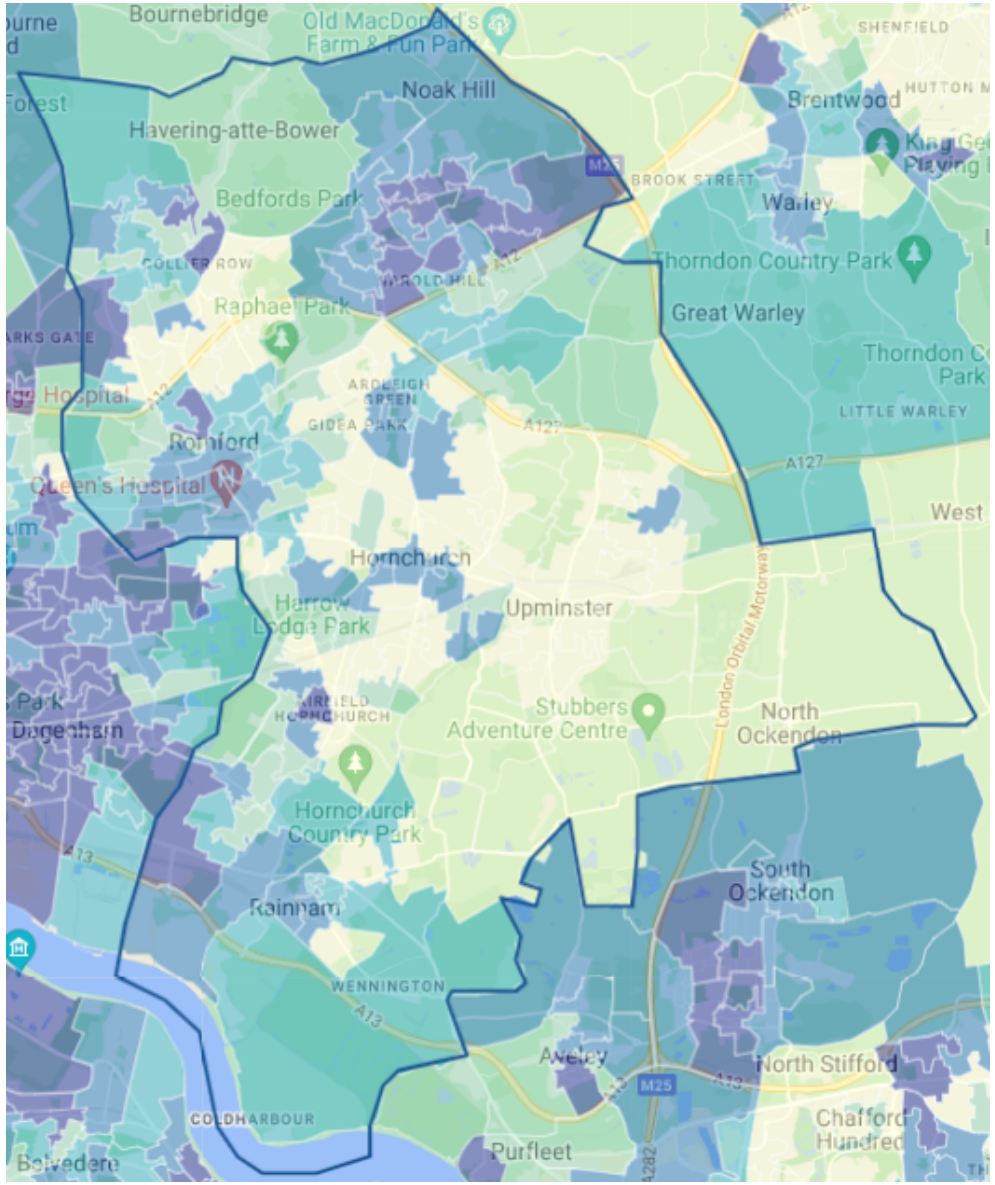

Source: NEL ICB GP data, September 2023

# Adult Smokers by Occupation and Housing,

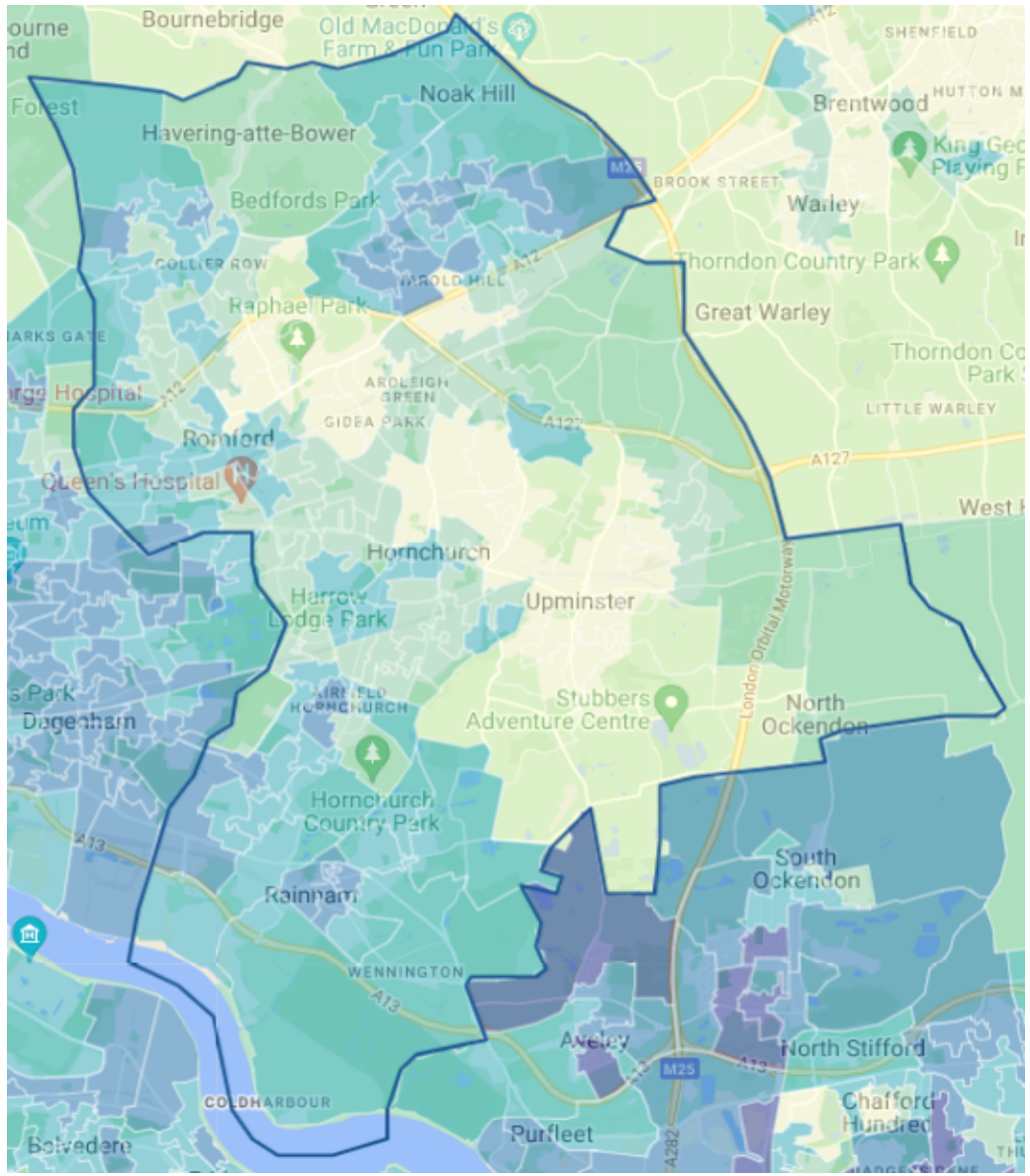



Source: OHID Fingertips – APS 2022




Social rented housing (Census 2021)




Routine Occupations (Census 2021)

Source: Havering Local Insight

**51%** Homeless are smoke

**33%** with Severe Mental Illness (SMI) are smoke

**7-7.9%** Learning Disability smoke

Source: NEL ICB GP data, September 2023



**4.5%** women smoked at time of delivery

**33.7%** adults admitted for alcohol misuse treatment are smokers

**60%** admitted for alcohol & non opiate misuse are smokers

Source: OHID Fingertips – APS 2022

## Smoking and children

**10,200** children in Havering estimated to live in smoking households.

Around **480** children each year estimated to start smoking in Havering

Source: ASH Inequalities Dashboard 15/11/2023 (accessed on 02/12/2023)

# Key impacts of smoking

- **901** deaths attributable to smoking
- **1,452** number of hospital admissions (2019/20)
- **363.0** rate of emergency hospital admissions for COPD/ 100,000 people (2019/20)

Source: OHID Tobacco Control Dashboard (Power BI)

- **£266.8m** estimated economic cost

Source: ASH ready reckoner 15/11/2023 (accessed on 02/12/2023)

# Highlight on Vaping

- Legal Vapes are safer than smoking, can be useful aid to stop smoking but long term effects are unknown
- Vaping increasing among people who have never smoked
- Increasing vaping among young people a large concern
- Vapes being marketed at young people using flavours and colours to appeal
- Illegal vapes are a large concern, with varying levels of nicotine and toxic chemicals
- Disposable vapes have implications for the environment

## Enforcement Issues

- 87 premises in Havering selling vapes
- 3 raids undertaken - 1 raid was of two shops – taking:
  - 2500 vapes
  - 58,000 cigarettes
  - 223 packets of HRT (hand rolling tobacco)
  - Estimated value of £69,000
- Economic costs = £2 billion/yr nationally
- **Insufficient resources in Trading Standards to enforce illegal tobacco & vape sale**

# Guidance on use of funding

**Guidance**

- Sets out how extra funding is to be used.
- Funding is ring fenced for stop smoking support and services  but
- Allows for additional activities which are effective.

**Proposed key areas of investment with additional funding based on**

- Needs assessment
- Gaps in current provision
- Actions likely to yield maximum outcome
- National guidance



Local stop smoking services and support: guidance for local authorities - GOV.UK (www.gov.uk)

# Use of funding-local stop smoking support & services

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| Building capacity | Building demand |
|---|---|
| **Increase Leadership, co-ordination and commissioning capacity** to expand offers to support smokers to quit.<br><br>**Increase local resources to help people quit** and widen availability of stop smoking aids by:<br>• Recruiting dedicated specialist staff to provide smoking cessation interventions and support others<br>• Improving knowledge and skills of non-specialist staff – e.g. nurses via training<br>• Access to specialist and non-specialist advisers in locations routinely attended by smokers- GP surgeries etc<br>• Increasing spend for stop smoking aids making available full range of products to support quit<br>• Enhancing overall service infrastructure, including: digital and remote support, and outreach | **Improve the referral pathways and number of referrals** into local stop smoking services and support, using the 'very brief advice'.<br>**Working jointly with key partner agencies and frontline services to increase demand through:**<br>• routine identification of smokers<br>• providing advice on effective methods to quit<br>• making active referrals to provide swift access to behavioural support referral (not signposting)<br>• increased referrals from partner agencies including: primary care/NHS talking therapies/ employers, Drugs & Alcohol services<br>• **Increased promotion of local SSS**<br>• **Working together to fund services-** over a greater geographical area/through integrated care partnership |

# Proposed Actions

| Action | Description | Target Groups |
|---|---|---|
| **1. Expand current local provision of stop smoking services:** | **a.** Scale up pharmacy service offer by recruiting 5 more pharmacies Consideration to those located near social housing estates, close to transport links, and in higher deprivation areas | Routine & manual workers/unemployed/long term sick |
| | **b.** Extend the consultation period and provide enhanced supply of quit aids including S2S vapes. | Ditto |
| | **c.** Establish Stop Smoking Advisor led SSS support through recruitment of 2 stop smoking advisors to provide support in specific community settings e.g. social housing, temporary accommodation/hostels, community hubs/pantry, foodbanks, YMCA, Colleges, Children's Centres | Ditto + young people/care leavers/homeless/those with drug & alcohol addiction |
| **2. SMI service** | Use allocation to Fund SMI service from 2024/25 | Residents with Severe Mental Illness discharged from acute setting and in the community. |
| **3. Training for front line health & social care staff** | Very Brief Advice training to improve knowledge and confidence around giving advice to stop smoking<br>be undertaken by | frontline/healthcare workers – Wellbeing Coaches, Health Visitors, Housing Officers |
| **4. Provide CO test kits** | Provide CO test kits to Health visitors & HWB coaches to use at appointment with pregnant women and new birth appointments to enable prompt Signposting/referring to SSS. | Pregnant women and families/new parents |

# Proposed Actions

| Actions | Description | Target Groups |
|---|---|---|
| **5. Communications campaigns to raise awareness of tobacco harm and the services available** | **Targeted campaign:** materials printed and displayed in housing estates, advertisements in key channels-newsletters, Community Hubs, Facebook/Instagram .<br><br>**Generic Annual Campaigns** (National No Smoking Day/New Year/Stoptober): widespread advertisement using JC Decaux boards, council boards /adverts in Living, website carousel/banner, internal advertising<br>**Promotion of services** | All residents 12+ that smoke |
| **6. Data management System to report stop smoking outcomes to DH** | Payment for Pharmoutcomes data license for all local stop smoking services | |
| **7. Evaluation of services** | Evaluation of stop smoking services to assess effectiveness and measure equality of uptake across various demographics | |

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# HEALTH & WELLBEING BOARD

| | |
|---|---|
| **Subject Heading:** | North East London Joint Forward Plan 2024-2025 Refresh |
| **Board Lead:** | |
| **Report Author and contact details:** | Anna Carratt |

**The subject matter of this report deals with the following themes of the Health and Wellbeing Strategy**

| | |
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| ☒ | The wider determinants of health<br>• Increase employment of people with health problems or disabilities<br>• Develop the Council and NHS Trusts as anchor institutions that consciously seek to maximise the health and wellbeing benefit to residents of everything they do.<br>• Prevent homelessness and minimise the harm caused to those affected, particularly rough sleepers and consequent impacts on the health and social care system. |
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## SUMMARY


1.1 The NEL Joint Forward Plan (NEL JFP) 2024-2025 Refresh draft document, attached, follows on from the first JFP 23/24 submitted in June this year. The expectation is that our system's five-year plan is refreshed yearly and submitted to NHSE by the end of March each year. It will therefore continue to describe how we will, as a system, deliver our Integrated Care Partnership Strategy as well as core NHS services.

1.2 As a partnership, we continue to work towards developing a cohesive and comprehensive delivery plan for meeting all the challenges we face. As part of these annual refreshes going forward we will work with local people, partners and stakeholders to iterate and improve the plan as we develop our partnership, to ensure it stays relevant and useful to partners across the system.

1.3 For next year's 2024/2025 refresh we have maintained much of the core information and headlines that are in the current iteration. Updating and amending statistics and information where relevant.

1.4 Key additions that will be made for next year's NEL JFP include dedicated slides for our Place-based Partnerships and the identified cross-cutting themes within our interim strategy, as well as all our system improvement portfolios.

1.5 At this stage it must be emphasised that this version of the JFP is draft with refinements taking place until 23rd February.

1.6 Havering Place-based Partnership have in their information indicated the vision and ambition to pool collective resources to develop person centred seamless care designed around the needs of the local population throughout their life course. Key programmes to support delivery of the ambition include:

- **Start Well**; Children and young people get the best start in life, are able to achieve the best opportunities and keep as healthy and well as possible throughout their lives
- **Live Well**; People enjoy and are able to maintain a sense of wellbeing and good health, supported by resilient communities. They can access care and information when needed.
- **Age Well**; People are able to live independently in their own homes with appropriate care and support to maintain and develop their social and community networks
- **Die Well**; People are supported to ensure the last stages of their life happen in the best possible circumstances, receiving the right help at the right time from the right people


## RECOMMENDATIONS

It is recommended that the HWBB:

- note why the JFP refresh is being undertaken and the approach being followed in order to deliver a refreshed NEL 24/25 JFP by March 2024

- note what has been collated thus far from all contributors (Appendix 1- Draft JFP 24/25)
- constructively make suggestions and comments

**REPORT DETAIL**

The NEL system planning cycle has been divided into three steps:
1) integrated care strategy,
2) delivery plan, and
3) operational planning.

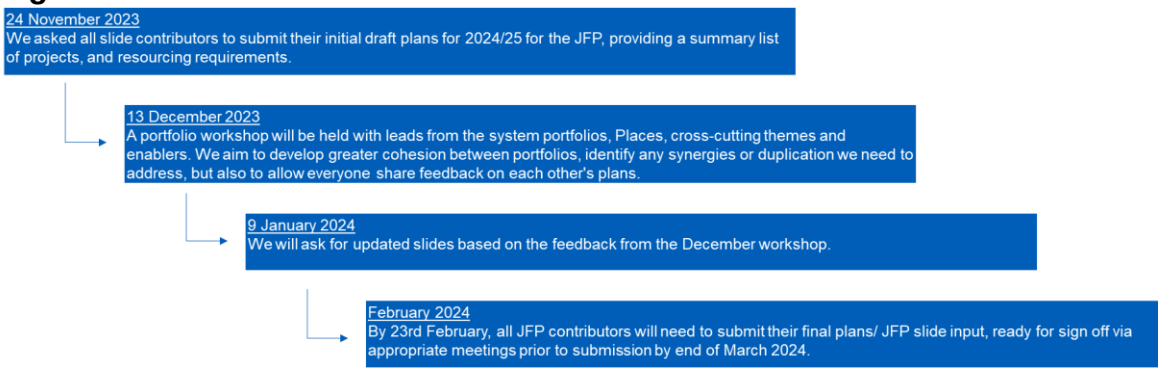
These are outlined below with related deliverables included below each step. These are not comprehensive but indicate some of the key activities underpinning each stage.


**Joint Forward Plan (JFP) Refresh for 24/ 25 next steps**
NEL ICB was formed on 1 July 2022 following the Health and Care Act 2022, and we published our interim Integrated Care Strategy in January 2023. This was followed by the Joint Forward Plan 23/24, our first five-year plan.

https://www.northeastlondonhcp.nhs.uk/ourplans/north-east-london-nel-joint-forward-plan/

Based on feedback and lessons learnt we are engaging with NEL System stakeholders earlier within the system planning cycle in order to ensure improved awareness and input to the 24/25 JFP. There will be annual refreshes of the JFP going forward in order to ensure that the document remains current. This JFP refresh continues to describe the challenges that we face as a system in meeting the health and care needs of our local people, but also the assets we hold within our partnership.

**High-level timeline**




**Main changes from the previous JFP**

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As we published our first JFP on 30 June 2023, we propose to keep the structure of the JFP, with some minor adjustments, as outlined below. Where references are made to figures, these will be updated to reflect the latest position.

Main additions:

- New slides to ensure we cover:
  - all our strategic system improvement portfolios in addition to our four strategic system priorities
  - our Place plans
  - our six cross-cutting themes and
  - our enables
- We have also included new slides outlining:
  - what is important to our residents and how it impacts our plans,
  - our successes to date, and
  - how we are developing a strategic outcomes framework to help us assess if we are having an impact.

**IMPLICATIONS AND RISKS**

Implication: The draft current version of the JFP 2024/ 2025 will have opportunities for further iteration leading up to the 23rd February.

**BACKGROUND PAPERS**

Appendix 1: Joint Forward Plan 24-25 - INITIAL DRAFT v1.0

The NEL Joint Forward Plan 2023/ 2024:
https://www.northeastlondonhcp.nhs.uk/ourplans/north-east-london-nel-joint-forward-plan/

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North East London Health & Care Partnership

NHS North East London



# North East London (NEL) Joint Forward Plan - Refresh

2024 - 2025

**DRAFT**

**ALL SLIDES WITHIN THIS PACK ARE DRAFT VERSIONS**

# 1. Introduction

# Introduction

- This Joint Forward Plan is north east London's second five-year plan since the establishment of NHS NEL. In this plan, we build upon the first, refreshing and updating the challenges that we face as a system in meeting the health and care needs of our local people, but also the assets we hold within our partnership.
- We know that the current model of health and care provision in north east London needs to adapt and improve to meet the needs of our growing and changing population and in this plan we describe the substantial portfolio of transformation programmes that are seeking to do just that. We have now also included new slides our cross cutting themes and each of our seven Place based partnerships.
- The plan sets out the range of actions we are taking as a system to address the urgent pressures currently facing our services, the work we are undertaking collaboratively to improve the health and care of our population and reduce inequalities, and how we are developing key enablers such as our estate and digital infrastructure as well as financial sustainability.
- Our Joint Forward Plan will be refreshed yearly to reflect that, as a partnership, we have continual work to do to develop a cohesive and complete action plan for meeting all the challenges we face together. We will work with local people, partners and stakeholders to update and improve the plan yearly as we develop our partnership, to ensure it stays relevant and useful to partners across the system.



**Highlighting the distinct challenges we face as we seek to create a sustainable health and care system serving the people of north east London**

In submitting our Joint Forward Plan, we are asking for greater recognition of three key strategic challenges that are beyond our direct control. The impact of these challenges is increasingly affecting our ability to improve population health and inequalities, and to sustain core services and our system over the coming years.

- **Poverty and deprivation** – which is more severe and widely spread compared with other parts of London and England, and further exacerbated by the pandemic and cost of living which have disproportionately impacted communities in north east London
- **Population growth** – significantly greater compared with London and England as well as being concentrated in some of our most deprived and 'underserved' areas
- **Inadequate investment** available for the growth needed in both clinical and care capacity and capital development to meet the needs of our growing population

# In January 2023, our integrated care partnership published our first strategy, setting the overall direction for our Joint Forward Plan

Partners in NEL have agreed a **collective ambition** underpinned by a set of **design principles** for improving health, wellbeing and equity.

To achieve our ambition, partners are clear that a radical new approach to how we work as a system is needed. Through broad engagement, including with our health and wellbeing boards, place based partnerships and provider collaboratives we have identified **six cross-cutting themes** which will be key to developing innovative and sustainable services with a greater focus upstream on population health and tackling inequalities.

We know that our people are key to delivering these new ways of working and the success of all aspects of this strategy. This is why supporting, developing and retaining our workforce, as well as increasing local employment opportunities, is one of our four system priorities identified for this strategy.

Stakeholders across the partnership have agreed to focus together on **four priorities as a system.** There are, of course, a range of other areas that we will continue to collaborate on, however, we will ensure there is a particular focus on our system priorities. We have been working with partners to consider how all parts of our system can support improvements in quality and outcomes and reduce health inequalities in these areas.

We recognise that a **well-functioning system** that is able to meet the challenges of today and of future years is built on **sound foundations.** Our strategy therefore also includes an outline of our plans for how we will transform our enabling infrastructure to support better outcomes and a more sustainable system. This includes some of the elements of our new financial strategy which will be fundamental to the delivery of greater value as well as a shift in focus 'upstream'.

Critically we are committed to a relentless focus on equity as a system, embedding it in all that we do.

Both the strategy and this Joint Forward Plan build upon the principles that we have agreed as London ICBs with the Mayor of London

**Our integrated care partnership's ambition** is to
"Work with and for all the people of north east London
to create meaningful improvements in health, wellbeing and equity."

| Improve quality and outcomes | Deepen collaboration | Create value | Secure greater equity |
|---|---|---|---|

**6 Crosscutting Themes underpinning our new ICS approach**

- Tackling **Health Inequalities**
- Greater focus on **Prevention**
- Holistic and **Personalised** Care
- **Co-production** with local people
- Creating a **High Trust Environment** that supports integration and collaboration
- Operating as a **Learning System** driven by research and innovation

**4 System Priorities for improving quality and outcomes, and tackling health inequalities**

- Babies, Children & Young People
- Long Term Conditions
- Mental Health
- Local employment and workforce

**Securing the foundations of our system**
Improving our **physical** and **digital infrastructure**
Maximising **value** through collective financial stewardship, investing in prevention and innovation, and improving sustainability
Embedding **equity**

# The delivery of our Integrated Care Strategy and Joint Forward Plan is the responsibility of a partnership of health and care organisations working collaboratively to serve the people of north east London

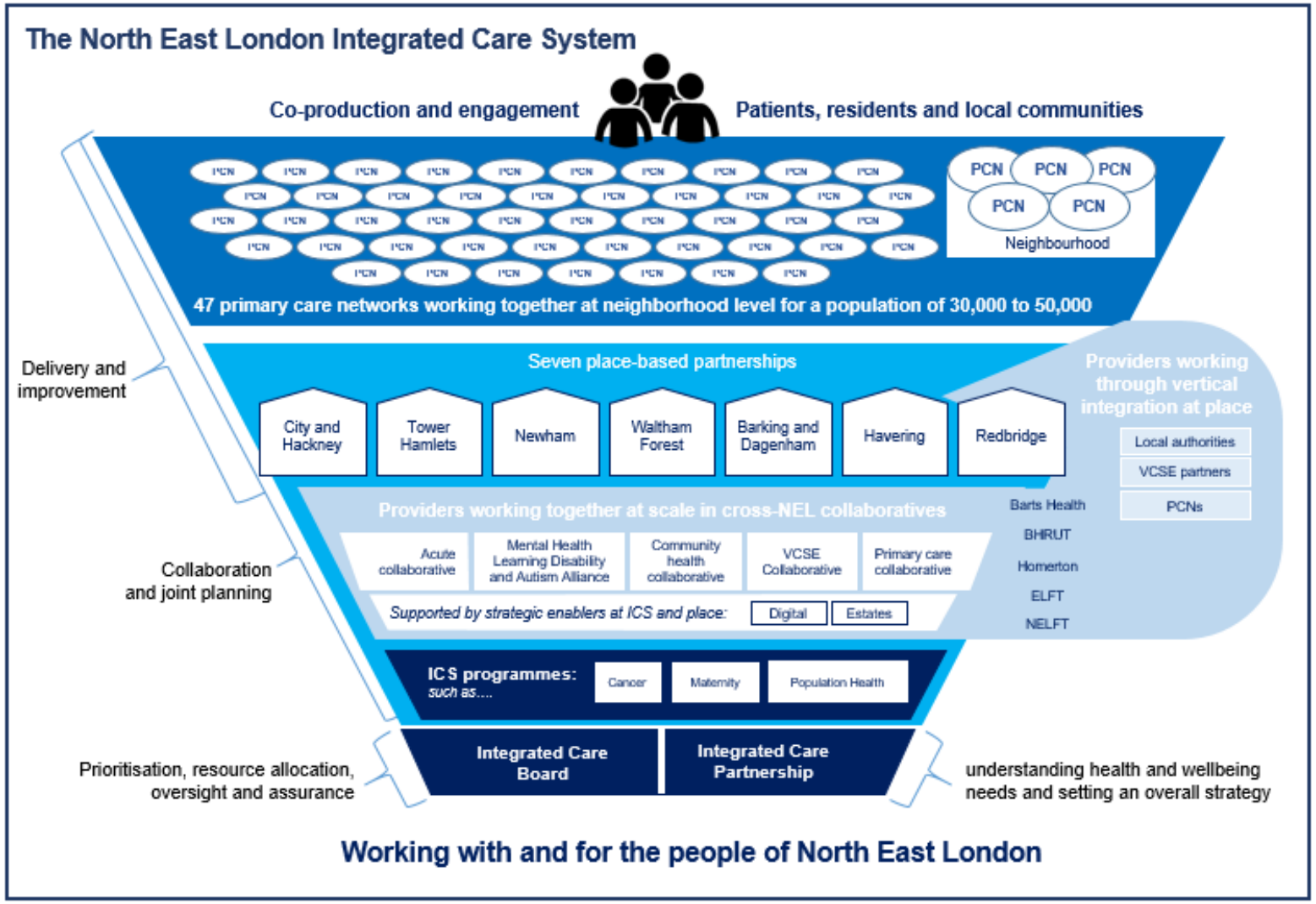
We are a broad partnership, brought together by a single purpose: **to improve health and wellbeing outcomes for the people of north east London**.

Each of our partners have positive impacts on the people of north east London – some providing care, others involved in planning services, and others impacting on wider determinants of health and care, such as housing and education. As we build upon and increase our collaboration and integrated ways of working the opportunity for greater impact will increase.

Our partnership between local people and communities, the NHS, local authorities and the voluntary and community sector, is uniquely positioned to improve all aspects of health and care including the wider determinants.

With hundreds of health and care organisations serving more than two million local people, we have to make sure that we are utilising each to the fullest and ensure that work is done, and decisions are made, at the most appropriate level.

Groups of partners coming together within partnerships are crucial building blocks for how we will deliver. Together they play critical roles in driving the improvement of health, wellbeing, and equality for all people living in north east London.



# 2. Our unique population

# Understanding our unique population is key to addressing our challenges and capitalising on opportunities

NEL is a diverse, vibrant and thriving part of London with a rapidly growing population of over two million people, living across seven boroughs and the City of London. It is rich in history, culture and deep-rooted connections with huge community assets, resilience and strengths. Despite this, local people experience significant health inequalities. An understanding of our population is a key part of addressing this.

### Rich diversity

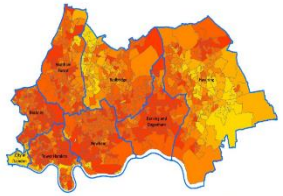
NEL is made up of many different communities and cultures. Just over half (53%) of our population are from ethnic minority backgrounds.

Our diversity means a 'one size fits all' approach will not work for local people and communities, but there is a huge opportunity to draw on a diverse range of community assets and strengths.

### Young, densely populated and growing rapidly

There are currently just over two million residents in NEL and an additional 300,000 will be living here by 2040.

We currently have a large working age population, with high rates of unemployment and self-employment. A third of our population has a long term condition. Growth projections suggest our population is changing, with large increases in older people over the coming decades.



### Poverty, deprivation and the wider determinants of health

Nearly a quarter of NEL people live in one of the most deprived 20% of areas in England. Many children in NEL are growing up in low income households (up to a quarter in several of our places).

Poverty and deprivation are key determinants of health and the current cost of living pressures are increasing the urgency of the challenge.

### Stark health inequalities

There are significant inequalities within and between our communities in NEL. Our population has worse health outcomes than the rest of the country across many key indicators. Health inequalities are linked to wider social and economic inequalities, including poverty and ethnicity.

Our population has been disproportionately impacted by the pandemic and recent cost of living increase.

# What is important to our residents and how it impacts our plans (Big Conversation themes)

**PLACE**

**HOLDER**

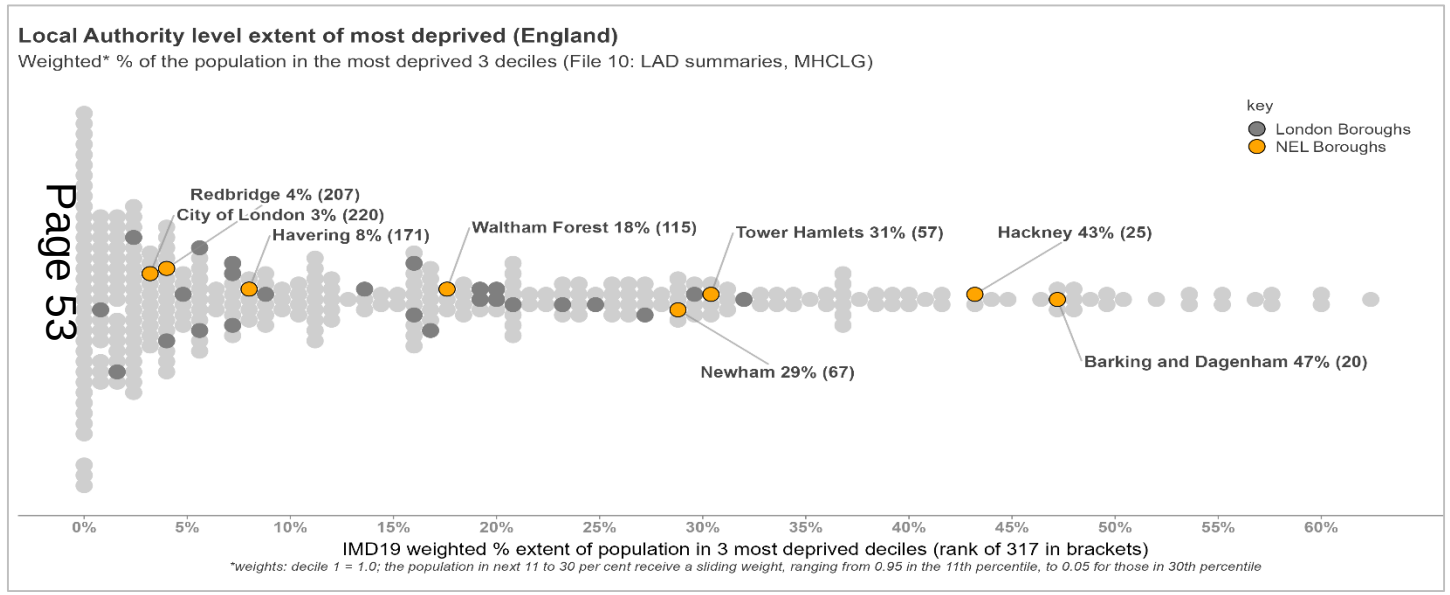
**SLIDE**

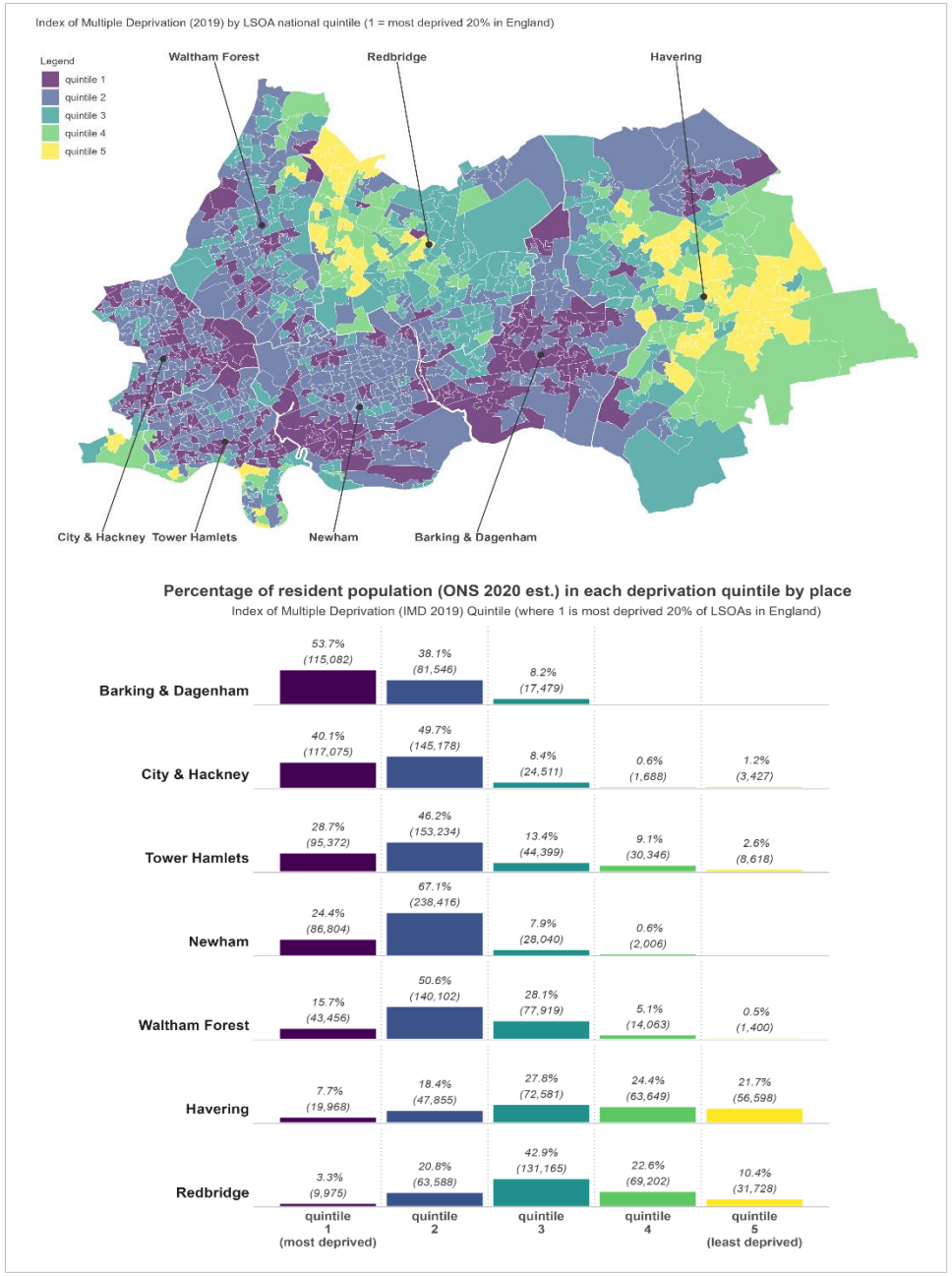
**<SLIDE IN DEVELOPMENT>**

# Key factors affecting the health of our population and driving inequalities - poverty, deprivation and ethnicity

Large proportions of our population live in some of the most deprived areas nationally. NEL has four of the top six most deprived Borough populations in London, and some of the highest in the country, with Hackney and Baking and Dagenham in the top twenty-five of 377 local authorities (chart below).

By deprivation quintile, Barking and Dagenham (54%), City and Hackney (40%), Newham (25%) and Tower Hamlets (29%), have between a quarter and more than half of their population living in the most deprived 20% of areas in England (map and chart right).




People living in deprived neighbourhoods, and from certain ethnic backgrounds, are more likely to have a long term condition and to suffer more severe symptoms. For example, the poorest people in our communities have a 60% higher prevalence of long term conditions than the wealthiest along with 30% higher severity of disease. People of South Asian ethnic origin are at greater risk of developing Type 2 Diabetes and cardiovascular disease, and people with an African or Caribbean family background are at greater risk of sickle cell disease.

# To meet the needs of our population we need a much greater focus on prevention, addressing unmet need and tackling health inequalities

### Child Obesity

Nearly 10% of year 6 children in Barking and Dagenham are severely obese. Nearly are third of children are obese (the highest prevalence rate in London).

NEL also has a higher proportion of adults who are physically inactive compared to London and England.

### Mental Health

It is estimated that nearly a quarter of adults in NEL suffer with depression or anxiety, yet QOF diagnosed prevalence is around 9%. Whilst the number of MH related attendances has decreased in 22/23, the number of A&E attendances with MH presentation waiting over 12 hours shows an increasing trend, increasing pressure on UEC services.

### Tobacco

One in 20 pregnant women smokes at time of delivery. Smoking prevalence, as identified by the GP survey, is higher than the England average in most NEL places. In the same survey, NEL has the lowest 'quit smoking' levels in England.

### Premature CVD mortality

In NEL there is a very clear association between premature mortality from CVD and levels of deprivation. The most deprived areas have more than twice the rate of premature deaths compared to the least deprived areas. 2021/22 figures showed for every 1 unit increase in deprivation, the premature mortality rate increases by approximately 11 deaths per 100,000 population.

### Vulnerable housing

NEL has higher numbers of vulnerably housed and homeless people, including refugee and asylum seekers, compared to both London and England. At the end of September 2022, 11,741 households in NEL were in council arranged temporary accommodation. This is a rate of 23 households per thousand compared to 16 per thousand in London and 4 per thousand in England as a whole.

### Homelessness

Shelter estimates in 2022 there were 42,399 homeless individuals in NEL inc. those in temp accommodation, hostels, rough sleeping and in social services accommodation. That's 1 in 47 people, compared to 1 in 208 people across England and 1 in 58 in London. People experiencing homeless have worse health outcomes & face extremely elevated disease and mortality risks which are eight to twelve times higher than the general population.

### Childhood Poverty

Five NEL boroughs have the highest proportion of children living in low income families in London. In 2020/21, 98,332 of NEL young people were living in low-income families, equating to 32% of London's young people living in low-income families. Since 2014 the proportion of children living in low income families is increasing faster in NEL than the England average.

### Childhood Vaccinations

The NEL average rate of uptake for ALL infant and early years vaccinations is lower than both the London and the England rates

There are particular challenges in some communities/parts within Hackney, Redbridge, Newham and B&D, where rates are very low with some small areas where coverage is less than 20% of the eligible population.

**There is clear indication of unmet need across our communities in NEL**

- For many conditions there are low recorded prevalence rates, while at the same time most NEL places have a higher Standardised Mortality Ratio for those under 75 (SMR<75) – a measure of premature deaths in a population – compared to the England average. Whilst some of this may be due to the age profile of our population, there may be significant unmet health and care need in our communities that is not being identified, or effectively met, by our current service offers.
- Analysis of DNAs (people not attending a booked health appointment) in NEL has shown these are more common among particular groups. For example, at Whipps Cross Hospital, DNAs are highest among people living in deprived areas and among young black men. Further work is now happening to understand how we can better support these groups and understand the barriers to people attending appointments across the system.

# Our population is not static – we expect it to grow by over 300,000 in the coming years, significantly increasing demand for local health and care services

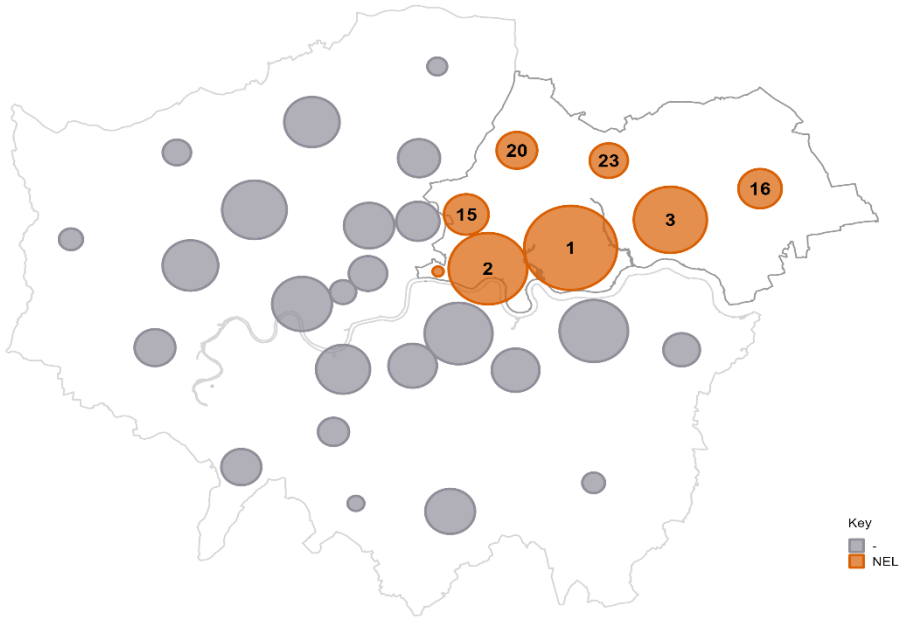
The population of north east London (currently just over 2 million) is projected to increase by almost 15% (or 300k people) between 2023 and 2040. This is equivalent to adding a whole new borough to the ICS, and is by far the largest population increase in London.

The majority of NEL's population growth during 2023-2040 will occur within three boroughs: Barking and Dagenham (27%), Newham (26.3%) and Tower Hamlets (20.3%), all of which are currently home to some of the most deprived communities in London/England.

| ICS | Increase in population 2023-2040 |
|---|---|
| NEL | +303,365 |
| SEL | +175,292 |
| NWL | +169,344 |
| NCL | +115,801 |
| SWL | +90,220 |

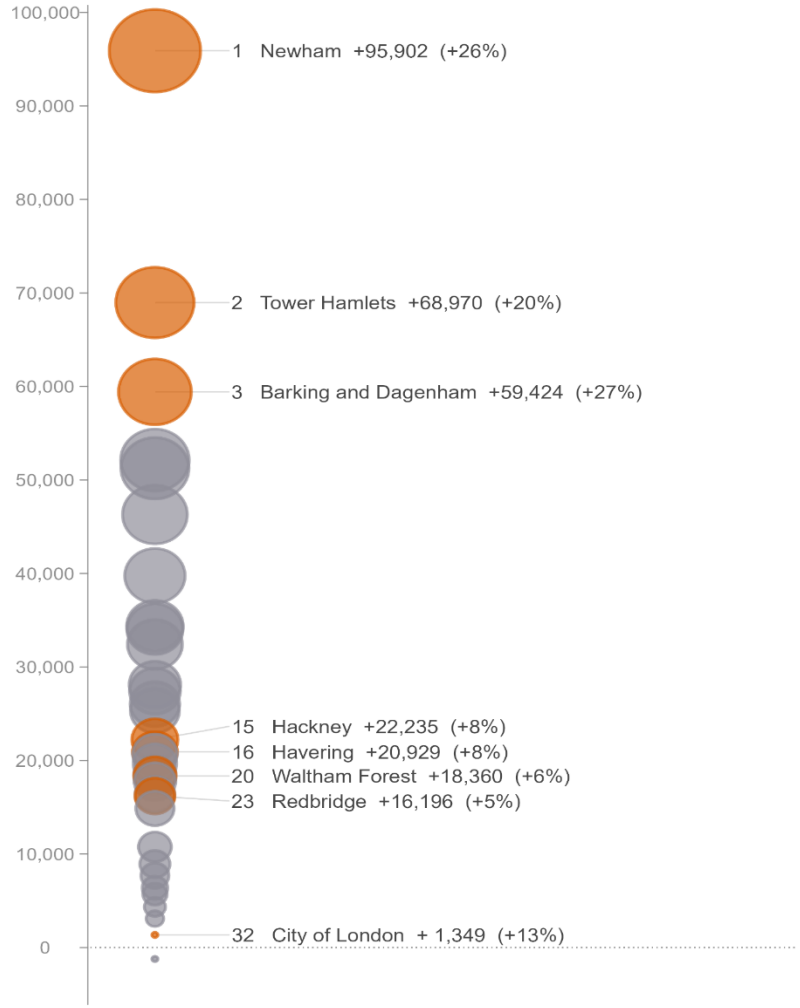
In addition, the age profile of our population is set to change in the coming years. Our population now is relatively young, however, some of our boroughs will see high increases in the number of older people as well as increasing complexity in overall health and care needs.

**London borough all age population increase 2023-2040**
Labelled circles = NEL Boroughs rank out of 33 in London




*GLA Identified Capacity Scenario, published September 2021, 2020 based*

**London borough all age population increase 2023-2040**
Labellled circles = NEL Boroughs rank out of 33 in London




*GLA Identified Capacity Scenario, published September 2021, 2020 based*



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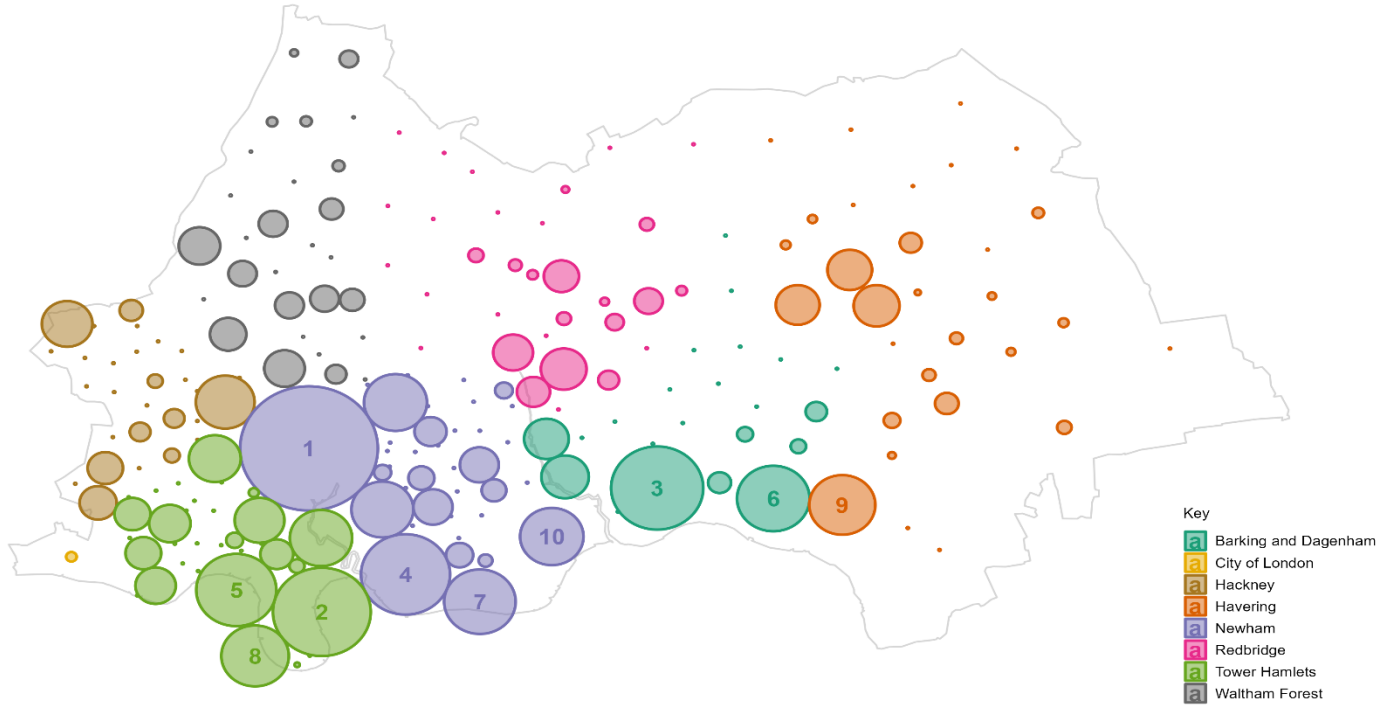
# We need to act urgently to improve population health and address the impact of population growth

Across NEL the population is expected to increase by 5% (or 100k people) over the five years of this plan (2023-2028). Our largest increases are in the south of the ICS, in areas with new housing developments such as the Olympic Park in Newham, around Canary Wharf on the Isle of Dogs, and Thames View in Barking and Dagenham.

Sustaining core services for our rapidly growing population will require a systematic focus on prevention and innovation as well as increased longer term investment in our health and care infrastructure.

**NEL neighbourhood (MSOA) all age population increase 2023-2028**

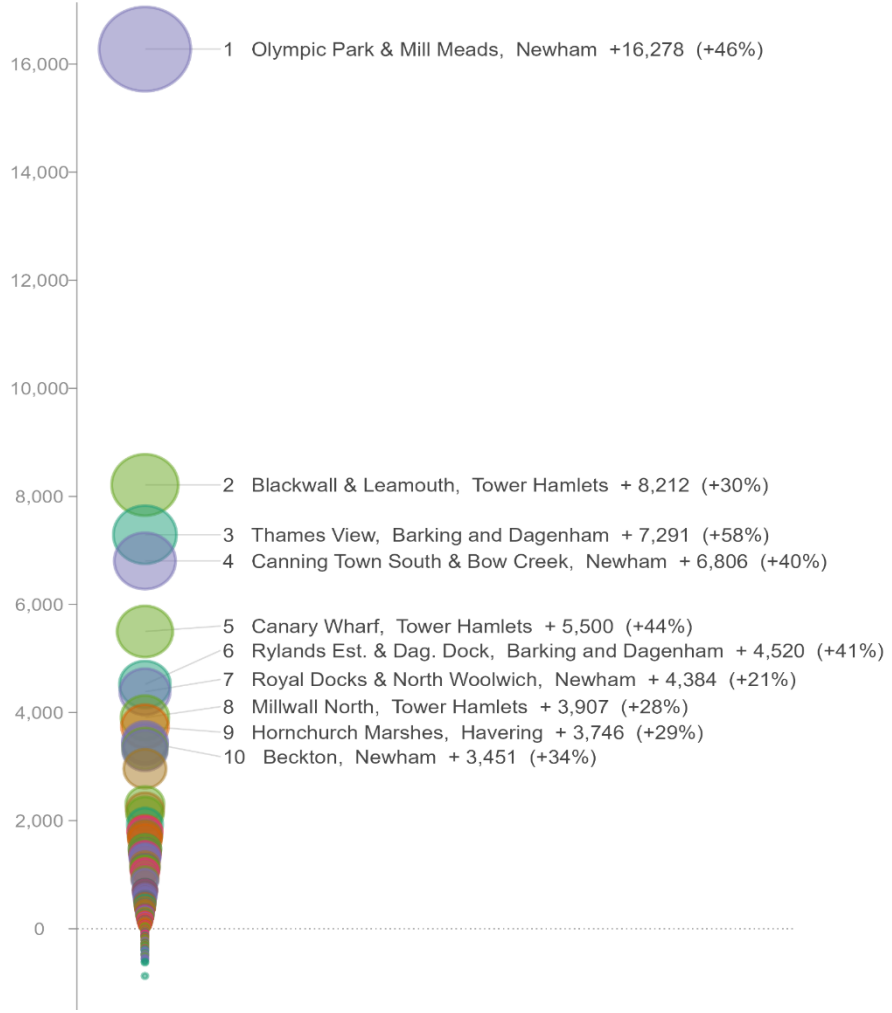
Smallest circles = MSOAs with zero increase or marginal decrease, labelled circles = top 10 NEL neighbourhoods by population increase (1=highest)




*GLA Identified Capacity Scenario, published September 2021, 2020 based*

**NEL neighbourhood (MSOA) all age population increase 2023-2028**

Labelled circles = top 10 NEL neighbourhoods by population increase



# 3. Our assets

# We have significant assets to draw on

North east London (NEL) has a growing population of over two million people and is a vibrant, diverse and distinctive area of London, steeped in history and culture. The 2012 Olympics were a catalyst for regeneration across Stratford and the surrounding area, bringing a new lease of life and enhancing the reputation of this exciting part of London. This has brought with it an increase in new housing developments and improved transport infrastructure and amenities. Additionally, the area is benefiting from investment in health and care facilities with a world class life sciences centre in development at Whitechapel. There are also plans for the Whipps Cross Hospital redevelopment and for a new health and wellbeing hub on the site of St George's Hospital in Havering, making it an exciting time to live and work in north east London.

**Our assets**

- **The people of north east London** – bring vibrancy and diversity, form the bedrock of our partnership, participating in our decisions and co-producing our work. They are also our workforce, provide billions of hours of care and support to each other and know best how to deliver services in ways which work for them.
- **Research and innovation** – continuously improving, learning from international best practice and undertaking from our own research and pilots, and our work with higher education and academia partners, to evidence what works for our diverse communities/groups. We want to build on this work, strengthen what we have learnt, to provide world-class services that will enhance our communities for the future.
- **Leadership** – our system benefits from a diverse and talented group of clinical and professional leaders who ensure we learn from, and implement, the best examples of how to do things, and innovate, using data and evidence in order to continually improve. Strong clinical leadership is essential to lead communities, to support us in considering the difficult decisions we need to make about how we use our limited resources, and help set priorities that everyone in NEL is aligned to. Overall our ICS will benefit from integrated leadership, spanning senior leaders to front line staff, who know how to make things happen, the CVS who bring invaluable perspectives from ground level, and local people who know best how to do things in a way which will have real impact on people.
- **Financial resources** – we spend nearly £4bn on health services in NEL. Across our public sector partners in north east London, including local authorities, schools and the police, there is around £3bn more. By thinking about how we use these resources together, in ways which most effectively support the objectives we want to achieve at all levels of the system, we can ensure they are spent more effectively, and in particular, in ways which improve outcomes and reduce inequality in a sustainable way.
- **Primary care** - is the bedrock of our health system and we will support primary care leaders to ensure we have a multi-disciplinary workforce, which is responsive and proactive to local population needs and focused on increasing quality, as well as supported by our partners to improve outcomes for local people.

# Our health and care workforce is our greatest asset

Our health and care workforce is the linchpin of our system and central to every aspect of our new Integrated Care Strategy and Joint Forward Plan. We want staff to work more closely across organisations, collaborating and learning from each other, so that all of our practice can meet the standards of the best. By working in multi-disciplinary teams, the needs of local people, not the way organisations work, will be key. Where necessary, our workforce will step outside organisational boundaries to deliver services closer to communities.

Our staff will be able to serve the population of NEL most effectively if they are treated fairly, and are representative of our local communities at all levels in our organisations. Many of our staff come from our places already and we want to increase this further.

Our workforce is critical to transforming and delivering the new models of care we will need to meet rising demand from a population that is growing rapidly, with ever more complex health and care needs. We must ensure that our workforce has access to the right support to develop the skills needed to deliver the health and care services of the future, and to adapt to new ways of working, and, potentially, new roles. AI and digitalisation will play a major role in determining our workforce needs over the next ten years.

Our ICS People and Culture Strategy will ensure there is a system wide plan to underpin the delivery of our new Integrated Care Strategy and Joint Forward Plan, through adopting a joined up 'One Workforce for NEL Health and Social Care' across the system that will work in new ways, across organisational boundaries and be seamlessly deployed for the delivery of health and care priorities. The strategy will focus on increasing support for our current and potential workforce through the implementation of inclusive retention and health and well-being strategies, and creating innovative, flexible and redesigned heath and care careers.

It will ensure right enablers at System, Place, Neighbourhood and in our provider collaboratives, to strengthen the behaviours and values that support greater integration, and collaboration across teams, organisations and sectors. It will contribute to the social and economic development of our local population through upskilling and employing under-represented groups from our local people, through creating innovative new roles, values-based recruitment and locally-tailored, inclusive supply and attraction strategies in collaboration with education providers.

There are almost one hundred thousand people working in health and care in NEL, and our employed workforce is growing every year.

Our workforce includes:

- Over 5,600 people working in general practice (Aug 23)
- 47,638 people working in our Trusts (Aug 23)
- 46,000 people working in adult social care including the independent sector (22/23)
- These are supported by a voluntary sector workforce roughly estimated at over 30,000

# There are opportunities to realise from closer working between health, social care and the voluntary and community sector

**Voluntary, Community, and Social Enterprise (VCSE) organisations** are essential to the planning of care and to supporting a greater shift towards prevention and self-care. They work closely with local communities and are key system transformation, innovation and integration partners.

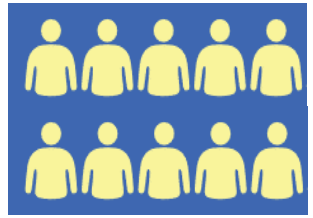
In NEL we are supporting the development of a VCSE Collaborative to create the enabling infrastructure and support sustainability of our rich and diverse VCSE in NEL, also ensuring that the contribution of the VCSE is valued equally.

**Social care plays a crucial role in improving the overall health and well-being of local people** including those who are service users and patients in north east London. Social care promotes people's wellbeing and supports them to live independently, staying well and safe, and it includes the provision of support and assistance to individuals who have difficulty carrying out their day-to-day activities due to physical, mental, or social limitations. It can therefore help to prevent hospital admissions and reduce the length of hospital stays. This is particularly important for elderly patients and those with chronic conditions, who may require long-term social care support to maintain their independence and quality of life.

**In north east London 75% of elective patients discharged to a care home have a length of stay that is over 20 days (this compares to 33% for the median London ICS).**

The **work of local authorities more broadly, including their public health teams,** as well as education, housing and economic development, work to address the wider determinants of health such as poverty, social isolation and poor housing conditions. As described above, these are significant challenges in north east London, critical to addressing health and wellbeing outcomes and inequalities.

In our strategy engagement we heard of the desire to accelerate integration across all parts of our system to support better access, experience and outcomes for local people. We heard about the opportunities to support greater multidisciplinary working and training, the practical arrangements that need to be in place to support greater integration, including access to shared data, and the importance of creating a high trust and value-based environment which encourages and supports collaboration and integration.



There are **more than 1,300 charities operating across north east London**, many either directly involved in health and care or in areas we know have a significant impact on the health and wellbeing of our local people, such as reducing social isolation and loneliness, which is particularly important for people who are vulnerable and/or elderly.

Thousands of informal carers play a pivotal role in our communities across NEL, supporting family and friends in their care, including enabling them to live independently.

# 4. Our challenges and opportunities

# The key challenges facing our health and care services

Partners in NEL are clear that we need a **radical new approach to how we work as an integrated care system** to tackle the challenges we face today as well as securing our sustainability for the future. Our Integrated Care Strategy highlights that a shift in focus upstream will be critical for improving the health of our population and tackling inequalities. The health of our population is at risk of worsening over time without more effective **prevention** and **closer working with partners** who directly or indirectly have a significant impact on healthcare and the health and wellbeing of local people, such as local authority partners and VCSE organisations.

Two of the most pressing and visible challenges our system faces today, which we must continue to focus on, are the long waits for accessing **same day urgent care;** and a large backlog of patients waiting for **planned care**. Provision of urgent care in NEL is more resource intensive and expensive than it needs to be and the backlog for planned care, which grew substantially during Covid, is not yet coming down, as productivity levels are only just returning to pre-pandemic levels. Both areas reflect pressures in other parts of the system, and have knock-on impacts.

The wider determinants of health are also key challenges that contribute to challenges. Most of our places we have seen unemployment rise during the pandemic, although this number is dropping, and we still have populations who remain unemployed or inactive.



We currently have a **blend of health and care provision for our population that is unaffordable**, with a significant underlying deficit across health and care providers (in excess of £100m going into 23/24). If we simply do more of the same, as our population grows, our financial position will worsen further and we will not be able to invest in the prevention we need to support sustainability of our system.

To address these challenges and enable a greater focus upstream, it is necessary to focus on **improving primary and community care services**, as these are the first points of contact for patients and can help to prevent hospital admissions and reduce the burden on acute care services. This means investing in resources and infrastructure to support primary care providers, including better technology, training and development for healthcare professionals, and better integration of primary care with community services. In addition, there is a need for better management and **support for those with long-term conditions** (almost a third of our population in NEL). People with LTCs are often high users of healthcare services and may require complex and ongoing care. This can include initiatives such as care coordination, case management, and self-management support, which can help to improve the quality of care, prevent acute exacerbation of a condition and reduce costs.

Achieving this will require our workforce to grow. This is a key challenge, with high numbers of vacancies across NEL, staff turnover of around 23% and staff reporting burnout, particularly since the COVID-19 pandemic.

***The following slides describe these core challenges and potential opportunities in more detail. Where possible we have taken a population health approach, considering how our population uses the many different parts of our health and care system and why. More work is required to build this fuller picture (including through a linked dataset) and this forms part of our development work as a system.***

# We face substantial pressures on same day urgent care

| *Key messages* | *Detail* |
|---|---|
| Demand for same day urgent care is growing rapidly as NEL's population grows | • Demographic and non-demographic changes to the NEL population are projected to increase demand for A&E attendance and unplanned admissions by 15-16% over the next 5 years |
| The status quo isn't viable. Doing more of the same will exacerbate existing pressures | • We have significant performance challenges across all three acute Trusts (e.g. average 60% on 4 hour A&E target)<br>• Growing demand for unplanned care within acute settings risks undermining efforts to reduce backlog of patients waiting for planned care |
| Improvements in care pathways, including a shift of system resource to out of hospital services (primary and community care), could help reduce demand for expensive unplanned acute care for some patients | • Rates of avoidable admissions (for conditions that ought to be manageable through better primary care) are high at a large number of primary care practices within NEL (between 37 and 46 depending on the type of avoidable admission)<br>• Mental Health patients are facing long waits in A&E (4,440 waited more than 12 hours during 22/23)<br>• Non-conveyance from ambulance calls to care homes vary considerably and represent a higher proportion than the London average<br>• Around 13% of A&E attendances leave without any significant investigation or treatment, suggesting they could have been better managed elsewhere in the system |
| Patients on waiting lists are causing pressures across other parts of the system | • A snapshot of the current elective waiting list indicates that 14% of the patients waiting for elective care have been responsible for 47,000 A&E attendances during their wait |
| There is an opportunity for improving UEC by better system working | • An analysis of NEL against other London ICSs indicates that moving to the median ICS performance for non-elective admissions would see a reduction of around 10%. This would be a substantial contribution to closing the projected gap created by growing demand and equates to around £65m per year |

# We have a large backlog of people waiting for planned care

| *Key messages* | *Detail* |
|---|---|
| Demand for elective care is growing, adding to a large existing backlog | • Demand for planned care is expected to grow by 19.7% between 2022/23 and 2027/28, or by around 4% per year.<br>• There are currently around 174,000 people waiting for elective care As of December 2022, 18 people had been waiting longer than 104 weeks, 843 longer than 78 weeks and 8,646 longer than 52 weeks. |
| Activity levels vary week on week for many reasons and we haven't yet seen consistent week on week improvements in the total waiting list size | • The 'breakeven' point for NEL's waiting list (neither increasing nor decreasing) requires an activity level of 4,281 per week*. This breakeven point is expected to increase by around 4% per year due to projected increases in demand.<br>• Activity levels vary throughout the year. For instance, in Sept-Dec 2022 trusts in NEL were reducing the overall number of waiters by 391 per week, whereas since then the overall number waiting has increased. |
| There are financial implications from over/under performance on elective care | • We have an opportunity to earn more income (from NHSE) by outperforming activity targets, thereby bringing more money into north east London. If the additional cost of performing that extra activity is below NHSPS unit prices then this also supports our overall financial position. |
| Tackling the elective backlog is a long-term goal and will require continuous improvements to be made | • A reasonably crude analysis of our elective activity suggests that delivering elective care at the rate of our peak system performance for last year (Sept-Dec 2022) would lead to no one waiting over 18 weeks by September 2027. This timescale would require an uplift in care delivery each year equivalent to expected demand increases (4% per year). |
| There may be opportunities for improvements in elective care, particularly around LOS | • An analysis of NEL against other London ICSs indicates that moving to the median LOS for elective admissions would reduce bed days by 13% and moving to the England median would reduce bed days by 31% (comparison excludes day cases). |





* Activity calculations are based on assessment of those on waiting list for more than 18 weeks, at end of Feb 2023

# We need to expand and improve primary care, including improving care and support for those with long term conditions

- North-east London currently has fewer GP appointments per 100,000 weighted population than other ICSs in England. The national median is around 8% greater than in NEL, suggesting part of the cause of pressure on other parts of the system, including greater than expected non-elective admissions at the acute providers, may be due to insufficient primary care capacity.
- Across NEL there is wide variation in the number of delivered appointments or average clinical care encounters per week. For 2022/23 this ranges from 93.56 per 1000 (weighted registered) patients in Tower Hamlets, to 68.01 per 1000 (weighted registered) patients in Havering. The NEL average is 77.78 per 1000 (weighted registered) patients.**
- Between March 2022 and March 2023, booked general practice appointments across NEL increased by around 32% to 11 million appointments. 56% of appointments were delivered by other professionals such as nurses and 43% of all appointments were seen on the same day as they were booked*. This figure includes both planned and reactive care. 57% of appointments were patient-initiated contacts, booked and seen on the same day.***
- We are developing a set of principles to streamline patient access to the most appropriate type of appointment and advice, with clear signposting, for health care professionals and local people to ensure they are directed to the full range of services available at Practice and Place, in and out of general practice hours.
- Without substantial increases in primary care staffing the GP to patient ratio will worsen as demand for primary care increases in line with projected population growth. There are pockets of workforce shortages with significant variation in approaches to training, education and recruitment. We are committed to focusing upon retention initiatives such as mentoring and portfolio careers having developed SPIN (specialised Portfolio innovation) which is the basis for the national fellowship programme which we are offering to GPs and other professional groups.
- There are opportunities to build on our best practice to further develop integrated neighbourhood teams, based on MDTs, social prescribing and use of community pharmacy consultation services, which will strengthen both our continuity of care of long term conditions and our ability to work preventatively.

## Long term conditions

- Across north east London, one in four (over 600 thousand people) have at least one long term condition, with significant variation between our places (in Havering the figure is 33%, vs 23% in Newham and Tower Hamlets).
- Age and deprivation are strong predictors of long term conditions, so while north east London has a relatively young population, significant areas of deprivation drive our numbers up (those in the poorest areas, the bottom deprivation quintile, can on average expect to get a long term condition around 10 years earlier than those in the best off, the top deprivation quintile)
- In 21/22 those with long term conditions accounted for 139,213 A&E attendances; 53,676 emergency admissions and 488,057 bed days.



 Source(s): *GPAD, **Discovery, ***Edenbridge APEX DRAFT

# Develop and build upon our community care resources

- Community care in north east London is currently fragmented, with four core provider trusts and over 65 other providers offering an array of community services.  More work is required to understand the impact this has on patient outcomes and variability across NEL's places, but we know that for pulmonary rehab, for example, there is variation in service inclusion criteria and the staffing models used, and that waiting times vary between 35 and 172 days, with completion rates between 36% and 72% across our places and services.

- There are significant opportunities and synergies to improve community pathways given the co dependencies with neighborhood teams, long term conditions, planned care , primary care and UEC. Community services are key to optimizing admission avoidance and discharge but a resource shift is required to enhance preventative and community pathways

- More children and young people are on community waiting lists in NEL than any other ICS (NEL is about average, across England, for the number of people on adult community waiting lists). Particular challenges are SALT, community pediatrics and neurodiversity pathways

- Our adult waiting lists are very pressured , particularly regarding MSK pathways, SALT, podiatry and dietetics

- Identifying and understanding the areas of greatest population and community need will provide a basis for community health care leads to support a joint planning approach. Allowing for agreement on priority areas under the context of service pressures. Approaching community health care in a targeted way and focusing on those areas of greatest need will also support reducing variance in services across the NEL system

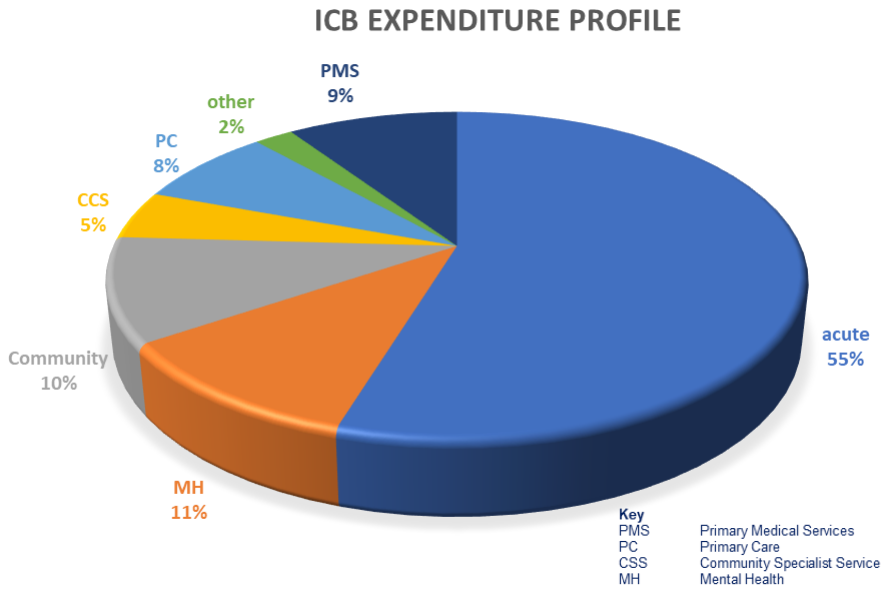
- There is a need for a clear and current overview of community health services across the system and places. Linked to also being able to monitor the outcomes for residents of those services and the resources utilized, this will ensure that the NEL system is able to make the most efficient use of those community health services for the population.

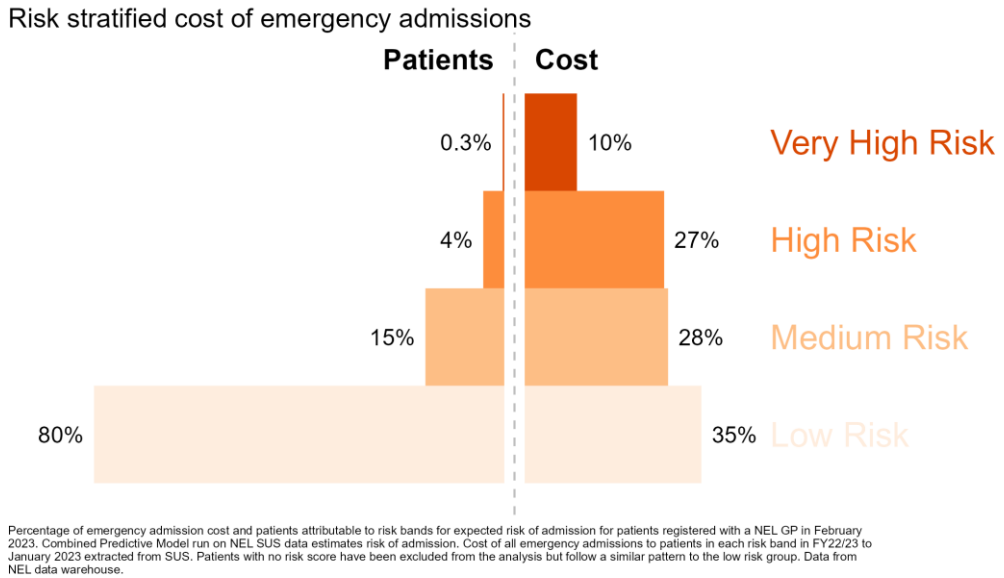
- Improvement networks give us an opportunity to bring together best practice, jointly work on solutions that are led by clinicians and subject matter experts, in partnership with our users and carers. This approach will ensure equitable and consistent pathways, that are delivered locally and tailored to meet local population needs.

# We need to move away from the current blend of care provision which is unaffordable

- The system has a significant underlying financial deficit, held within the Trusts and the ICB. Going into 2023/24 this is estimated to be in excess of £100m. This is due to a number of issues, including unfunded cost pressures.
- The system has therefore developed a financial recovery plan, which if delivered would result in a £31m deficit in 23/24.
- Current plans to improve the financial position, such as productivity/cost improvement programmes within the Trusts, are expected to close some of this financial gap and we know there are opportunities for reducing unnecessary costs, such as agency spend. The system is also looking at a range of further measures designed to improve the underlying run rate.
- In addition to a financial gap for the system overall, there are discrepancies between how much is spent (taking into account a needs-weighted population) across our places, in particular with regard to the proportion spent on out of hospital care.
- The system receives a very limited capital budget in 23/24 of £95m, significantly less than other London ICSs (which receive between £130m-£233m) and comparable to systems with populations half the size of NEL*. This puts significant pressure on the system and its ability to transform services, as well as maintain quality estate. In 24/25 the estimated budget is £86m.
- There is huge variation in the public health grant received by each of NEL's local authorities from central government. The variation is at odds with the government's intended formula (which is based on SMR<75) and is the result of grants largely being based on historical public health spend. This impacts on our ability to invest upstream in preventative services.
- As a system the majority of our spend is on more acute care and we know that this is driven by particular populations (0.3% of the population account for 10% of costs associated with emergency admissions; just under 20% account for 65%).






Percentage of emergency admission cost and patients attributable to risk bands for expected risk of admission for patients registered with a NEL GP in February 2023. Combined Predictive Model run on NEL SUS data estimates risk of admission. Cost of all emergency admissions to patients in each risk band in FY22/23 to January 2023 extracted from SUS. Patients with no risk score have been excluded from the analysis but follow a similar pattern to the low risk group. Data from NEL data warehouse.



* Capital figures are based on 2022/23. Norfolk and Waveney ICB received £98.5m capital in 22/23 and has a population of 1.1m people

# We are making progress – Our successes

**PLACE**

**HOLDER**

**SLIDE**

**<SLIDE IN DEVELOPMENT>**

# 5. How we are transforming the way we work

# Across the system we are transforming how we work, enhancing productivity and shifting to a greater focus on prevention and earlier intervention

- The previous section set out the challenges that the north east London health and care system needs to address to succeed in its mission to create meaningful improvements in health and wellbeing for all local people
- North east London's portfolio of transformation programmes has evolved organically over many years: rooted in the legacy CCGs and sub-systems, then across the system through the North East London Commissioning Alliance and the single CCG, and now supplemented by programmes being led by our place partnerships, provider collaboratives, and NHS NEL.
- It has never previously been shaped or managed as a single portfolio, aligned to a single system integrated care strategy.

As part of moving to this position, this section of the plan baselines the system portfolio with programmes set out according to common descriptors – providing a single view never previously available across the system, with the scale of the investment of money and staff time in transformation clearer than ever before.

This section sets out how partners across north east London are responding to the challenges described in the previous section. It describes how they are contributing to our system priorities by considering five categories of improvement

1. Our core objectives of high-quality care and a sustainable system
2. Our NEL strategic priorities
3. Our supporting infrastructure
4. Place based Partnerships priorities x7
5. Our cross-cutting programmes

# Urgent and emergency care

**Portfolio vision, mission and key drivers:**
The aim of our portfolio is to improve access to urgent and emergency care for local people that meets their needs and is aligned with the UEC national plan. The portfolio is structured around five strategic system goals: **Prevention** of conditions, **Management** of existing conditions and needs, **Timely intervention** for escalation of needs or new needs and conditions, **Timely and effective return** to community setting following escalation, underpinned by **data, governance, effective pathways and enablers.**
The national and local drivers focus on **increasing capacity**, **growing the workforce**, **speeding up discharge** from hospitals**, expanding new services in the community** and helping people access the **right care first time**.

**Key stakeholders:**
Place, PCNs, practices, pharmacy, Acute, Community and mental health collaboratives and Urgent and emergency care services. Healthwatch and patient groups.

**Key programmes of work that will deliver the vision and mission**
The work within the portfolio is mapped against our strategy goals and four outcomes. **1) strengthening provision and access to alternative pathways, 2) optimising flow through hospitals, 3) using population health management to keep people well in the community and 4) setting up governance and pathways to form system wide sustainable plans**.
There are a range of projects to deliver on these outcomes that have been divided into directly managed by UEC portfolio and those sitting in other portfolios.
UEC directly managed – 111 procurement and development, hospital flow, ambulance flow, system co-ordination centre, urgent treatment centres, virtual wards and winter planning.
Other delivery areas such as same day access, urgent community response, mental health pathways and planned care sit in other portfolios but will be monitored and reported to the UEC Board.
Additionally establishing the NEL UEC PMO and governance will provide infrastructure to deliver a measurable impact.

**Details of engagement with places, collaboratives and other ICB portfolios**
One to ones throughout the summer to understand local strategies and plans to build up the NEL UEC portfolio. Work underway to propose new ways of working and governance structures. Collaboration will be at the heart of the portfolio.

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**

April 2025:
- System co-ordination centre set up in line with specification
- Reduction in delayed discharges and improvements to A&E performance
- Elimination of ambulance handover waits over 45 minutes
- 111 provider working to a new specification following procurement process
- Expansion and coordination of virtual wards beds

April 2026:
-

April 2027:
-

**Engagement with the public:**
Engagement activities have taken plan at Place and Trust level which has informed plans and communications – to date there have been NEL UEC patient engagement activities

# Community Health Services

**Portfolio vision, mission and key drivers:**

- Develop a consistent community services offer across NEL
- Improving population health and outcomes, working closely with residents
- Supporting neighbourhoods and PLACEs to enable people to stay well and independent, for as long as possible, wherever they call home
- Creating wider system value by unlocking system productivity gains
- Using evidence to understand the totality of services, outcomes and resources across NEL, identifying opportunities for improved outcomes
- Create and facilitate collaborative partnerships with local authorities, primary care, health providers, and the independent voluntary and charitable sector
- Supporting wider system pressures by maximising CHS opportunities (i.e LAS call outs, UEC attendances, unplanned care, LA residential care pressures)

**Key stakeholders:**

- 7 PLACEs
- ELFT
- NELFT
- Homerton
- Barts
- 65 plus bespoke providers

**Key programmes of work that will deliver the vision and mission**

- Leading joint approach to Planning for the first time across NEL
- Coordinating finance discussions across NEL re pressures, risks and priorities
- Developing and evolving Improvement Networks, bringing together subject matter experts and creating a conducive environment to design best practice pathways and consistent offers across NEL
- BCYP Improvement network 15th November
- Rapid Response and Falls Network TBC January ’24
- RR and Falls likely to lead to Improvement Network re Community Nursing/integration opportunities across health and social care workforce
- Discussions re MSK pathway in train with Planned Care colleagues
- Aligning with Digital work , Proactive Care, Universal Care Plan, Fuller
- Maximising opportunities for CHS blueprint/integration via Whipps X (WF and RB), St Georges HWB Hub (Havering) and Porters Ave (LBBD)
- Comprehensive CHS Diagnostic planned (to procure Dec ‘23) giving a bottom up approach from a PLACE perspective, to gain NEL wide understanding of resource, quality outcomes, user and carer experience, cost, workforce across health, local authorities, primary care, VCS

**Details of engagement undertaken with places, collaboratives and other ICB portfolios**

- Joint planning sessions 1st Nov and 11th Dec (45+ people across PLACEs and providers)
- 121 discussions with Place Directors, core provider leads
- Engagement across collaboratives and programmes (UEC, LTC, BCYP, Planned Care)
- Joint meeting with Primary Care Collab Dec ‘23

**Co dependencies on other programmes**

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**

- Developing Consistent pathways and models for CHS, minimising variances in outcomes and experience
- Maximising opportunities to integrate and avoid duplication

**Engagement with the public:**

- Patient engagement at an early stage but conversations with Patient experience leads Nov ‘23 to utilise existing forums
- Well established carer and user infrastructure in BCYP

# Primary Care

**Portfolio vision, mission and key drivers:**
Our vision is for north east London to be a place where you can access consistent high-quality primary care, from a dedicated, motivated and multi-skilled workforce enabling local people to live their healthiest lives
The aim of our portfolio is to deliver on ambitious plans to transform primary care, offering patients with diverse needs a wider choice of personalised, digital-first health services through collaboration with partners across the health and social care and communities. National and local plans place a focus on improving access, prevention, personalisation, tackling inequalities and building trusting environments.
Our local challenges include population growth, deprivation, exacerbating poor physical and mental health and workforce retention and development and a financial challenge urging cost effectiveness and efficiency

**Key stakeholders:**
Place, PCNs, practices, pharmacy, Acute, Community and mental health collaboratives and Urgent and emergency care services. Healthwatch and patient groups.

**Key programmes of work that will deliver the vision and mission**
There are a range of programme that make up the primary care portfolio to ensure the delivery of our goals.
Empowering patients - supporting patients to manage own health, stay healthy and access services. Improving access - providing a range of services and assistance to respond to patient needs in a timely manner. Modernising primary care - developing new and digital tools to support highly responsive quality care. Building the workforce - staff recruitment, retainment and develop plans in place to improve job satisfaction and flexibility. Working smarter - reduced workload across primary/secondary services and improvements to sustainable and efficient ways of working. Optimising enablers - estate, workforce and communication plans to support the implementation of our goals.

Integrated Neighbourhood Teams (INT) are pivotal to transforming Primary Care and will be delivered through work responding to the Fuller recommendations. **A framework** will offer a streamlined approach for the delivery by integrating Primary Care, including Pharmacy, Optometry and Dentistry, alongside wider health care, social care and voluntary sector organisations. INTs will facilitate care, through 'teams of teams' approach enabling **continuity of care**. These teams will also be instrumental in broadening the availability of care, providing **extended in and out-of-hours services,** including urgent care. A **single point of contact through advanced cloud-based telephony systems** will streamline access to care, while **improved signage and navigation** will guide patients to the right services.

The Fuller initiatives are accompanied by other enabling programmes. **People**, will bolster the **capacity of the ARRS roles**, **establish training and development opportunities**, and **determine the ideal workforce** for INTs. Infrastructure, including, Estates and Data will align current plans to INT requirements, as well as **Digital First** which aims to improve digital access (including remote consultation), NHS App usage, improving practice efficiency and increasing competence to use digital tools.

Wider programmes which are fully or partly delivered through primary care providers, include, **Pharmacy,** enhancing the role of the community pharmacy to improve access and patient self-management, **Long Term Conditions (LTCs),** including a range of interventions such as case-finding, annual or post-exacerbation reviews for targeted patients, as well as programmes that sit in other collaboratives such as **Personalisation** and **Vaccinations**. Other transformational projects to improve dental and optometry services will be developed in the future as their provider groups mature.

**Details of engagement undertaken with places, collaboratives and other ICB portfolios**
A number on workshops with collaboratives, places and the UEC/ LTC / digital / workforce programmes.
The portfolio is overseen by a lead for UEC portfolio to strengthen interplay. Working in conjunction with other portfolios is a key improvement area following the deep dive in October
Webinars held for PCNs to promote digital tools

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**

April 2025:
- Same day handling of all calls to practices
- All practices transferred to cloud based telephony
- Improvements to NHS app and practices websites and e-Hubs
- All practices offering core and enhanced care for people with LTCs
- Additional services from community pharmacies
- All Places have INTs established for at least one patient cohort

April 2026:
- All practices will be CQC rated as GOOD or have action plans to achieve this further equalisation of enhanced services (IN DEVELOPMENT)

April 2028:
- Streamlined access to a universal same-day care offer, with the right intervention in the right setting and a responsive first point of contact

**Engagement with the public:** Enhanced access engagement exercise with practices in 2022. London wide digital tools engagement involved NEL residents. Fuller programme plans to engage on the SDA vision

# Planned Care

**Portfolio vision, mission and key drivers:**

- The aim of the programme is to reduce waiting times for elective care in line with the national recovery plan so that no one is waiting more than 52 weeks by March 2025
- This will be delivered through an integrated system approach to improving equity of access to planned care for the people of North East London by focusing on 3 primary drivers – managing demand, optimising capacity & creating new capacity.
- The portfolio of planned care recovery & transformation work spans the elective care pathway from pre-referral to treatment encompassing out of hospital services, outpatients, diagnostics and surgery.
- The planned care portfolio consists of three significant programmes of work – outpatient & out of hospital transformation; diagnostic recovery & transformation and surgical optimisation. The activities and interventions undertaken with these programmes are designed to improve the management of demand, optimise existing capacity and support and enable the creation of new capacity

**Key stakeholders:**

- Trusts
- APC
- ICB
- Place Based Partnerships
- Primary Care Collaborative including PCNs
- Community Care Collaborative
- Independent Sector Providers – acute and community
- Clinical and operational teams across all acute Trusts

**Key programmes of work that will deliver the vision and mission**

The portfolio of planned care recovery & transformation work spans the elective care pathway from pre-referral to treatment encompassing;

- **Outpatients and out of hospital services** - The aim of this programme is to optimise the use of our existing outpatient capacity whilst transforming how we work together across primary, community and secondary care to manage demand for services and create a sustainable outpatient & out of hospital system. Achieving this requires transformation across the whole pathway, as well as the way in which outpatient clinics are organised and delivered
- **Diagnostics -** The recovery and transformation of diagnostics includes a broad portfolio of work encompassing imaging, endoscopy, pathology and physiological measurement. The aim of the programme is to create resilient diagnostic services to support elective, including cancer, pathways
- **Surgical Optimisation** - The focus of this programme is to ensure we are using our available elective surgical capacity to increase volumes of activity and reduce waiting times. This includes Trusts improving the utilisation of their elective theatre capacity and optimising the use of NHS and ISP capacity to reduce waiting times. NEL has secured @ £33m investment from the target investment fund to open new theatres in Hackney, Newham and Redbridge, which are expected to operate as system assets.

**Details of engagement undertaken with places, collaboratives and other ICB portfolios**

The planned care recovery & transformation programme is an integrated system programme with system wide engagement at its heart. Priorities, governance and delivery structures have been created over the last 2 years with primary care, the ICB, PBP and acute providers.

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**

In NEL, this will mean delivering reduction in waiting times and reducing the variation in access that exists. Key benefits include;

- Reduce variation in service provision and improve equity of access
- Improve referral pathways. Enable patients to get the right service at the right time
- Improve patient accessibility to diagnostics, in order to; reduce pressures on primary and unplanned care, reduce waiting times, reduce steps in patient pathway, reduce follow-up activity; reduce non-admitted PTL, improved utilisation of imaging capacity
- Increase surgical activity at all sites, avoid wasted capacity, enable patients to be offered surgery at sites with shortest wait

**Engagement with the public:**

The national elective recovery plan has been developed with widespread public engagement. Our programme reflects these priorities, which are adapted to meet the needs of our local population.

# Cancer

**Portfolio vision, mission and key drivers:**

The North-East London Cancer Alliance is part of the North East London Integrated Care System and is committed to **improving cancer outcomes and reducing inequalities for local people.**

Our aim is that everyone has equal access to better cancer services so that we can help to:

- Prevent cancer
- Spot cancer sooner
- Provide the right treatment at the right time
- Support people and families affected by cancer

- **Drivers**
- Our work enables the ICB to achieve its objectives, as set out in the strategy, across the ICB's six cross-cutting themes:
- Tackling Health Inequalities
- Greater focus on Prevention
- Holistic and Personalised Care
- Co-production with local people
- Creating a High Trust Environment that supports integration and collaboration
- Operating as a Learning System driven by research and innovation

**Key stakeholders:**

Patient and Carers
Providers, Partners, PLACE
Cancer board
APC Board and National / Regional Cancer Board

**Key programmes of work that will deliver the vision and mission**

- The programme consists of projects to improve diagnosis, treatment and personalised care.
- Key milestones to be delivered by March 2025 and 2026 include:
  - Deliver BPTP milestones in suspected prostate, lower GI, skin and breast cancer pathways:
  - Delivering the operational plan agreed for 28d FDS, combined 31d treatment and 62d cancer standards.
  - Deliver 100% population coverage for Non-Specific Symptoms (NSS) pathways.
  - Ensure sustainable commissioning arrangements for NSS pathways are in place for 2024/25
  - TLHCs provided in 3 boroughs with an agreed plan for expansion for all boroughs by 2025.
  - Develop and deliver coproduced quality improvement action plans to improve experience of care.
  - Support the extension of the GRAIL interim implementation pilot into NEL.
  - Ensure all patients are offered the personalised care package with equal access to psychological support, pre-habilitation and rehabilitation services.
  - Personalised stratified pathways can reduce outpatient attendance and allow patients to be monitored remotely reducing the need to attend clinics.
  - Improve the quality of life and support patients need to live beyond cancer.

**Details of engagement undertaken with places, collaboratives and other ICB portfolios**

- Weekly APG Operational delivery meeting
- Tumour specific Experts Reference Group (ERG)
- Project Delivery Groups (PDG)
- Cancer board – internal assurance
- Programme Executive Board – NEL operational delivery
- APC Board, CAB and National / Regional Cancer Board

**Summary of the benefits/impact that North East London local people will experience by April 2025 and April 2027:**

**2025/26**:

- Access to Targeted Lung Health Check service for 40% of the eligible population
- Invitation for up to 45,000 people into the GRAIL pilot
- Continued mainstreaming as part of the Lynch Syndrome pathway
- Improved quality of life and experience of care.

- **2027/ 28:**
  - Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028.
  - Improved uptake of cancer screening
  - Every person in NEL receives personalised care and support from cancer diagnosis

**Engagement with the public:**

Patient Reference groups
Campaign workshops

# Maternity

**Portfolio vision, mission and key drivers:**

- Three year delivery plan for maternity and neonatal services: 2023-2026. . This has consolidated the improvement actions committed to in Better Births, the NHS Long Term Plan, the Neonatal Critical Care Review, and reports of the independent investigation at Shrewsbury and Telford Hospital NHS Trust and the independent investigation into maternity and neonatal services in East Kent. The expectations on Local Maternity and Neonatal Systems are that they focus on the following areas;
- ➢ Listening to, and working with, women and families with compassion
- ➢ Growing, retaining, and supporting our workforce
- ➢ Developing a Culture of safety, learning and support
- ➢ Standards and structures that underpin safer, more personalised and more equitable care

**Key stakeholders:**

All LMNS and APC board Stakeholders (PBC, LA, Trusts, MNVPs- service users, Third sector organisations) Regional Maternity Transformation Team, Chief Midwife Office, ICB BCYP, Public Health.

**Key programmes of work that will deliver the vision and mission**

- Pelvic Health Service: All women experiencing urinary incontinence to be able to access postnatal physiotherapy up to 1 year post delivery
- Increased breastfeeding rates, especially amongst babies born to women from black and minority ethnic groups or those living in the most deprived areas.
- Midwifery Continuity Care, prioritising the provision to women from Black and minority ethnic (BAME) groups who will benefit from enhanced models of care.
- Perinatal Optimisation Programme:
- Develop pathways to manage abnormally invasive placenta across NEL
- Workforce and Development Projects

**Details of engagement undertaken with places, collaboratives and other ICB portfolios**

All LMNS and APC board Stakeholders (PBC, LA, Trusts, MNVPs- service users, Third sector organisations) Regional Maternity Transformation Team, Chief Midwife Office, ICB BCYP, Public Health.

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**

- By reducing stillbirth, maternal mortality, neonatal mortality, and serious brain injury in women and babies from BAME groups and women from deprived areas. National ambition to reduce by 50% by 2025
- By closely aligning maternity and neonatal care to deliver the best outcomes for women and their babies who need specialised care by achieving <27 weeks IUT.
- By improving personalised care for women with heightened risk of pre-term birth, including for younger mothers and those from BAME groups and deprived backgrounds
- By ensuring that all providers have full baby-friendly accreditation and that support is available to those who are from BAME groups and/or living in deprived areas who wish to breastfeed their babies
- Ensuring local maternity and neonatal voice partnerships (MNVPs) have the infrastructure they need to be successful and put service user voices at the heart of service improvement. This includes funding MNVP workplans and providing appropriate training, and administrative and IT support.

**Engagement with the public:**
MNVPs, Third Sector organisations and communities identified in the E&E LMNS report.

# Babies, children and young people

**Portfolio vision, mission and key drivers:**

**Vision:** To provide the best start in life for the babies, children and young people of North East London.

**Mission:** The BCYP Programme aims to reduce unwarranted variation and inequality in health and care outcomes, increase access to services and improve the experience of babies, children, young people, families and carers and strengthen system resilience.

Through strong working relationships across health and social care partners, we will increase collaboration, enhance partnership working and innovation, share best clinical and professional practices with each other and deliver high quality services.

**Drivers**: NEL Integrated Care Strategy, NHS Priorities and Operational Planning Guidance, NHS Long Term Plan, Ongoing impact of COVID-19 pandemic, Royal College of Paediatrics and Child Health – State of Child Health, Academy of Medical Royal Colleges – Prevention is better than cure and NHS England (London Region) Children and Young People's mandated requirements.

**Key stakeholders:**

ICB Executive, BCYP SRO, Place Directors; Collaborative/ Programme Directors; Provider Directors; GP CYP Clinical Leads;
Directors of Children's Social Care; Designated Clinical/Medical Officers; NHSE (London) CYP Team; North Thames Paediatric Network; Safeguarding Team; Parent Forums

**Key programmes of work that will deliver the vision and mission**

Acute care - priorities are CYP elective care recovery, diabetes, allergy and addressing urgent and emergency care priorities for BCYP.
Community-based care -priorities are local integrated care child health pilots, increasing capacity (including 7 day access to children's community nursing and hospital@home), improving children's community service waiting times;
National/regional mandated priorities including long term conditions;
Primary care – priorities are BCYP unregistered with a GP, YP access to integrated health hubs; 'You're Welcome standards and Child Health training curriculum;
Special Education Needs and Disabilities (SEND) - SEND Inspection Readiness Group to ensure Places and ICB are prepared for new Ofsted Inspection framework and are meeting NHSE requirements. Focus Areas – Autism and Diagnostic pathways and Pre and Post offers of support for families.
Special cohorts including Child Sexual Abuse (CSA) hub, looked after children and care experienced young people.

**Details of engagement undertaken with places, collaboratives and other ICB portfolios**

Acute, community, mental health/learning disabilities and autism and primary care collaboratives. LTC and UEC Programmes. Places via NEL BCYP Delivery Group

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**

Care is delivered closer to home as our children, young people, their families and carers have requested;
Enhanced quality of care for BCYP with asthma, diabetes and epilepsy;
Improved access to primary and integrated care for BCYP via integrated health hubs;
CYP with SEND will receive integrated support across education, health and care and reduced waiting times for SLT and autism;
Prescription poverty for our care leavers will be tackled.
Reduce the impact of child sexual abuse through improved prevention and better response.

**Engagement with the public:**

Via Providers.
SEND Parent's Forum
National Voices

# Long Term Conditions

**Portfolio vision, mission and key drivers:**

**Our vision -** To support everyone living with a long-term condition in North East London to live a longer, healthier life and to work to prevent conditions occurring for other members of our community, and support communities to prevent LTC onset or progression

**Mission -** Listening to communities to understand how we can support patients in managing their own conditions

- Reduce working in silos and embed a holistic approach to LTCs
- Reduce unwarranted variation and inequality in health and care outcomes
- Increase access to services and improve the experience
- Working partners to prevent residents from developing more than one LTC through early identification of risk factors
- To ensure there are appropriate interventions and services that support a patient in preventing or managing an exacerbation of their condition
- Keep hospital stay short and only when needed
- To ensure we effectively plan and provide services that are value for money

**Key drivers –**

Long-term conditions have a national and regional focus as a core component of the Long Term Plan, with attention on Cardiovascular disease, stroke, diabetes, and respiratory. Furthermore, LTCs are entwined with us to address inequalities, and we support projects such as Core25Plus and Innovation for Healthcare Inequalities Programme

Long-term conditions (LTCs) is 1 of NEL's 4 System Priorities for improving quality and outcomes and tackling health inequalities. This is reflected in Place-based priorities which all have identified one or more LTCs

- Across NEL, one in four (over 600 thousand people) have at least one long-term condition, with significant variation between our places (in Havering, the figure is 33%, vs 23% in Newham and Tower Hamlets)
- NEL is the highest performing ICB in England for many outcomes related to CVD, stroke, and renal, but local social demographics put the system at risk of continued growth in demand
- Nationally, long-term conditions account for half of GP appointments, 64 percent of all outpatient appointments, and over 70 percent of all inpatient bed days.
- The most deprived areas, people acquired three or more conditions (complex multimorbidity) when they were 7 years younger, compared with the least deprived.

**Key stakeholders:**

- Residents and communities
- Place based teams
- Regional and National colleagues
- Organisation Delivery Networks
- Voluntary organisations
- Specialised Services
- Pharmacy and Medicine Optimisation
- Primary care
- Babies, Children and Young People
- Communities services
- Community collaborative
- Planned care
- Acute Provider Collaborative
- Mental health programme and collaborative
- Urgent Care programme
- BI and insights
- Communication and engagement
- Contracting and finance

**Key programmes of work that will deliver the vision and mission**

**Primary LTC prevention & Early identification**

**Social determinants of health (SDOH) impact 80% of health outcomes from chronic disorders** and across NEL we have areas of significant deprivation which is linked with increased prevalence of long-term health conditions and lower life expectancy

We want to work with our local population to empowering and enabling people to manage their own health and engage in healthy behaviours across their lives, so they don't develop a LTC.

**Secondary prevention and avoiding complication**

DH data has demonstrated that **9 out of 10 strokes** could be prevented and u**p to 80% of premature CVD deaths are preventable**, if risk factors could be controlled. Working with social communities, and ensuring we provided person focused early identification, secondary care and avoiding complication enables us to improve outcome and reduce exacerbation of an LTC

**Co-ordinated care and equability of service**

Across NEL, **one in four (over 600 thousand people) have at least one long-term condition**, with significant variation between our places. The feedback from the Big Conversation reflects the need to join-up care and move forwards person focused approach. Working with colleagues at place we aim to continue to review current provision and reduce unwarranted variation in care across the pathway, with an aim of improving health outcomes

**Enabling people to live well with a LTC and tertiary prevention**

The effective support and management of LTC will increasingly require the management of complexity, and moving away from a single condition approach. In NEL 3 in 5 patients with a diagnosed long term condition have only one condition, the other **2 in 5 have multiple co-morbidities, of which diabetes and hypertension were most common**

**Details of engagement undertaken with places, collaboratives and other ICB portfolios**

Places – working with Heads of Live well across the 7 places who are responsible for LTCs

Clinical/improvement Networks – wider engagement with trusts, community providers, pharmacy, primary care and place

Organisation Delivery Networks (renal and CVD/cardiology)

Other programme directors including specialised service, community, mental health, BYCP.

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**

Work toward national targets including:

- Improve detection of atrial fibrillation and ensure appropriate stroke risk reduction through anticoagulation - by 2029 85% of expected numbers with AF are detected, and 90% of patients with AF and high risk of a stroke on anticoagulation.
- Improve detection of undiagnosed hypertension and ensure those with hypertension are controlled to target – by 2029 80% of expected numbers with hypertension are detected and 80% of people with high blood pressure are treated to target
- Improve access to and uptake of Cardiac Rehabilitation (CR) – by 2029 85% of eligible patients are accessing CR
- Reduction of type 2 diagnoses / delayed onset in residents developing Type 2 (T2) diabetes delivered through an increase the number of people referred and starting the National Diabetes Prevention Programme (DPP) 45% of eligible populations).
- nting with symptoms of Transient Ischaemic Attack will have access 7 days a week to stroke professionals who can provide specialist assessment and treatment within 24 hours of symptom onset thus preventing long term disability

**Engagement with the public:**

The big conversation which consists of 56 focus groups, 430 attendees of key community events and local survey focused on LTCs and the outputs are incorporated into priorisation for 24/25.

Furthermore, we have incorporated feedback at service level such PR and diabetes

# Mental Health

**Portfolio vision, mission and key drivers:** the aim of the Mental Health, Learning Disability and Autism Collaborative is to work together to improve outcomes, quality, value and equity for people with, or at risk of, mental health problems and/or learning disability and autism in North East London. We do this by putting what matters to service users and their families front and centre of everything we do.

The service user and carer priorities that represent our key drivers include:

- Improving peoples' experience of accessing mental health services, including their first contact with services, and ensuring equity of access
- Children and young people can access different support from different people, including those with lived experience, when and where they need it
- People with a learning disability have the support they need and a good experience of care, no matter where they live

**Key stakeholders:** NHS North East London, East London NHS Foundation Trust, North East London NHS Foundation Trust, local authorities, primary care, voluntary, community and social enterprise sector organisations, service users, carers & residents

**Key programmes of work that will deliver the vision and mission**

1. Investing in and developing lived experience leadership across the MHLDA Collaborative so that experts by experience are active and equal partners in leading improvement and innovation across mental health, learning disability and neuro-developmental services
2. Continuing the work led by our children and young peoples' mental health improvement network to reduce unwarranted variation across boroughs, and to do more of what works to reduce self-harm and improve outcomes for young people
3. Accelerate the work of our talking therapies improvement network to improve access, and continue to transform and improve community mental health services, with a particular focus on improving equity of access for minoritised groups and people with neurodevelopmental needs
4. Continue our focus on improving mental health crisis services and alternatives to admission - while also working to ensure that quality inpatient services are available for those who need them - making sure that people get the right support, at the right time, and in the right place
5. Working to develop core standards for community learning disability services, with a view to reducing unwarranted variation between boroughs, and sharing good practice to support our specialist workforce better

**Details of engagement undertaken with places, collaboratives and other ICB portfolios:** Place based priorities for mental health are the cornerstone of our plans. We also connect closely with the Acute Provider Collaborative on mental health support in emergency departments and form part of their programme governance on UEC. We also have strong links into the BCYP programme and community health.

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**

- Improved access, outcomes and experience of NHS Talking Therapies for minoritised communities and other under-served populations
- Improved system-wide response to children and young people presenting with self-harm through the introduction of new evidence-based interventions, including better support to teachers, GPs and parents
- Improved offer of pre-diagnostic, diagnostic and post-diagnostic support for people with neurodevelopmental support needs
- Greater equity in the community learning disability support offer across boroughs
- Improved inpatient services with lower lengths of stay, and better options of high-quality supported housing / residential care for those who need it
- Widespread adoption of personalised and person-centred care planning processes with an emphasis on continuity of care and biopsychosocial assessment

**Engagement with the public:** Our Lived Experience Leadership arrangements ensure we are continually engaging with children and young people, adults with mental health needs and people with learning disabilities and their families, and coproducing our work with service users

# Employment and workforce

**Portfolio vision, mission and key drivers:**
- Our vision is to create a transformational and flexible “One Workforce for NEL Health and Social Care” that reflects the diverse NEL communities and meets our system priorities.
- The mission focuses on developing a sustainable and motivated workforce, equipped with the right skills, competencies, and values, to improve the overall socio-economic outcomes of our NEL populations.
- The key drivers are responding to population growth and increasing demand, and developing meaningful and rewarding careers within health and social care services for local residents.

**Key stakeholders:**
- Provider CPOs
- People Board
- Place Directors
- Staff
- Local Authorities
- Care Sector

**Key programmes of work that will deliver the vision and mission**
- **System Workforce Productivity:** Continuing to address NEL’s difficult financial position through urgent investigation of workforce productivity drivers and implementation of productivity improvement initiatives.
- **System Strategic Workforce Planning:** Development of a strategic workforce planning function with the capacity, capability and digital enablers to provide the enable evidence-based decisions to ensure the long-term sustainability of the NEL Health and Social Care workforce. With the ultimate aim of developing of a system-wide health and social care workforce database and an integrated workforce planning system.
- **System Anti Racist Programme:** Embedding inclusive, anti-racist and empowering cultures across the system.
- **System wide scaling up and corporate services:** Identification of corporate services with scope for rationalisation. Streamlining operations, improving efficiency, standardising approach and reducing costs.
- **NEL Health Hub Project Programme:** Connecting local health and social care employers with colleges for employment opportunities. . Healthcare part is in partnership with Newham College and London Ambulance service and funded by GLA until March 2024. Social Care part is led by Care Provider Voice, aiming for 150 to outcomes, and funded until March 2025.
- These programmes are subject to approval by the People Board, Exec Committee, CPOS, Place, and collaboratives, aligning with the goal of enhancing socio-economic status in NEL through workforce development.

**Details of engagement undertaken with places, collaboratives and other ICB portfolios**
- Engaged with a broad spectrum of Health and Social Care partners through workshops and sessions.
- Involved Local Authorities, Voluntary and independent Care Sectors, Primary Care, NHS Trusts, Provider collaboratives, and Education Providers.
- More engagement is required.

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**
- **Integrated Health and Social Care Services:** Enhanced workforce development will lead to more integrated and effective health and social care services, improving overall care delivery.
- **Workforce Expansion and Skilling:** Initiatives like the NEL Health Hub and Social Care Hub are set to expand the healthcare workforce, providing training and development opportunities, leading to better staffed and skilled services.
- **Healthcare System Sustainability:** Focus on financial stewardship and innovation will contribute to a more sustainable healthcare system, ensuring long-term service delivery and effectiveness.
- **Equity in Healthcare Employment:** Targeted employment opportunities for under-represented groups in health and social care sectors will enhance workforce diversity, contributing to more inclusive and equitable healthcare services.
- **Enhanced Health and Well-being Services:** Programs like the Keeping Well Nel programme, funded until June 2024, will enhance health and well-being services, directly benefiting the ICS, workforce, and indirectly impacting local population health.

**Engagement with the public:**
- Actively engaged ICS staff via hackathons and NEL residents through community events and job fairs.
- Utilized feedback from the Big Conversation for inclusive strategy development.
- More engagement is required.

# Specialist Commissioning

**Portfolio vision, mission and key drivers:**

**Our vision:**

- is to ensure that the population of north east London have good access to high quality specialist care that wraps around the individual, and ensures the best possible outcomes

**Our mission and drivers:**

- We are responsible for planning and commissioning of delegated specialised health services across north east London. We are responsible for specialised spend, performance and outcomes, and ensuring all parts of the local health system work effectively together to deliver exemplary specialist care
- We are responsible for integrating pathways of care from early intervention and prevention of LTC through to specialist provision, ensuring end to end pathways to improve outcomes and manage future demand of costly specialist care.
- We set priorities for specialised services and work with our local ICS, multi ICB partners and London regional partners to deliver world class specialised services to benefit patients within north east London, North London or London ensuring access to the right level of care.
- We will do this by working together with health partners, specialist providers, local authorities and the voluntary community and social enterprise (VCSE) sector, with residents, patients and service users to improve how we plan and deliver specialised services.

**Key programmes of work that will deliver the vision and mission**

From 2024/25, ICBs will have budget allocated to them on a population basis, and from April 25 this will be allocated on a needs based allocation basis. The specialised allocation will follow a similar formula to that of other nonspecialised services that ICBs hold, and **so can be considered and contracted for alongside the rest of the pathways we commission**. Delegation of specialised services and transformation of specialised services allows us to consider the totality of resources for our population, making it easier to ensure investment in the most optimal way to improve quality and outcomes, reduce health inequalities and improve value.

The key programmes of work are to:

1. Ensure safe delegation of specialised services working alongside the NHSE regional team
2. Joint work with NHSE, London ICBS and locally in NEL focussed on specialised transformation: sickle cell disease (Haemoglobinopathies), HIV and Hepatitis (including liver disease), Renal disease, Neurosciences, Cardiology, complex urogynaecology and specialist paediatrics
3. Working alongside other portfolios will deliver this mission, mainly LTC to ensure a whole pathway approach routed in place, cancer, planned care, critical care, BCYP and mental health

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**

**HIV**

- People living with HIV will have improved follow up care with investment in a community led peer programme with an aim to reduce by 70% the number of eligible patients that are lost to care/failed by care. This follow up care will include regular testing, counselling, mentoring, group support, assurance and information and advice.

**Renal**

- Working towards maximise patient dialysing at home - 496 patients on home therapies by 31/32 (target of 28% of patients on home therapies by 2032).
- Working towards maximise patients being transplanted - 280 transplant operations completed in 31/32

**Sickle Cell**

- Local people with sickle cell will receive appropriate analgesia and other pain management measures (ideally within 30 minutes) when attending any acute A&E in NEL
- Residents will have timely access to multi-disciplinary team to support delivery of trauma-informed care based on the principles of safety, trust, choice, collaboration, empowerment and cultural competence.

**Hepatitis and HIV**

- To achieve micro elimination of HCV across NEL (2025).
- Improved access to diagnostics and increase local prevention programmes by aligning with the British Liver Trust optimal pathway. This will support the reduction in the growth rate of liver disease (currently 20%).

**Neurosciences**

- 10% of eligible stroke admissions will have consistent 24/7 access to mechanical thrombectomy to reduce the impact of stroke
- Improve detection of atrial fibrillation and ensure appropriate stroke risk reduction through anticoagulation - by 2029 85% of expected numbers with AF are detected, and 90% of patients with AF and high risk of a stroke on anticoagulation.

**Cardiology**

- Shorter waiting times and reduced elective and non-elective
- HF 30 day readmission rates have recently risen to more than 20%. We aim to reduce this to reduce this <15% with roll out of dedicated HF pharmacist to review and titrate patients post discharge

**Key stakeholders:**

- NHS London Region and London ICB partners
- NEL Provider Trusts
- North London ICB Programme Board partners (NCL/NWL)
- ODNs, mandatory and local clinical networks
- EoE Region
- Local authorities
- VCSE

**Details of engagement undertaken with places, collaboratives and other ICB portfolios:**

- APC Executive
- APC Joint Committee
- NEL Executive leads
- Close working with other ICB portfolios: LTC, Cancer, Planned Care, Critical Care, CYP, mental health

**Engagement with the public:**

- Engagement via regional and local clinical networks including Renal service users to inform dialysis provision
- Cardiac ODN: women, family
- HIV work with charities

# Digital

**Portfolio vision, mission and key drivers:** There are four key elements to the ICS digital strategy; patient access, population health, shared record access and provision of core infrastructure:

- **Patient Access** gives residents the ability to view their records and interact digitally with health and care providers. This is and will be provided through expanding use of the NHSApp, Online and Video consultation tools, online registration and the patient held record system, Patients Know Best
- **Population Health** utilises a variety of data sources to build a picture of care needs at various levels, primarily identifying specific cohorts of patients requiring intervention but also providing overviews at population level, allowing providers to alter service provision
- **Shared Records** is the mechanism for ensuring that clinicians and other care professionals have as full a picture as possible to allow them to provide the most appropriate care to individual patients / residents. This was pioneered in NEL and is now used across London and beyond
- **Core infrastructure** is the fundamental basis for all digital activity; the foundational work done at each provider that allows them to operate effectively and puts them on a sure footing to be able to contribute to and receive data from systems external to themselves

**Key stakeholders:**
All ICS health and care providers including NHS trusts, local authorities, GPs, community pharmacists, care home providers, third sector health and care providers, NHS England

**Key programmes of work that will deliver the vision and mission**
The largest investment currently taking place is the replacement of the core electronic patient record (EPR) system in BHRUT. This is being replaced by extending the existing Oracle Millennium system in use at Barts Health. Planning is underway, with the system expected to be live by March 2025. Other significant investments in Trusts include:

- The expansion of the functionality available via the NHSApp to include the ability to manage hospital and community appointments, and the ability for patients and clinicians to interact digitally where appropriate, thus improving the experience for digitally enabled patients and freeing up resource to support those wishing to use traditional methods. This is enabled by the PHR programme
- Use of artificial intelligence and robotic process automation to support diagnostics and faster completion of administrative tasks such as clinic management within trusts, thus improving patient experience and reducing the administrative burden on trusts
- All acute trusts using the same imaging platform to store and view x-rays, scans, etc., reducing the requirement for repeat diagnostic procedures and making them available to any clinician that needs access. ICS-wide cyber security plans are in place with funding having been secured
- Introduction of remote monitoring equipment to support expansion of virtual wards

**Details of engagement undertaken with places, collaboratives and other ICB portfolios**
Members of the digital team attend portfolio and collaboratives' meetings. A meeting has taken place with place directors but further meetings are needed.

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**

- Residents can choose to interact with health and care professionals via the use of the NHSApp, Patient Held Record, online consultation and video consultation tools, which will smooth their interaction with the NHS and free up capacity to deal with people choosing to use other routes
- Patient level and aggregated information is provided to clinicians, managers and researchers, subject to a strict approval process. This helps change the planning and delivery of healthcare provision
- NEL hosted data is used across London and neighbouring ICS's, breaking down barriers by facilitating the sharing of information and good practice
- Information is provided to individual clinicians and other professionals from within their main system, giving access to information held by most London Trusts, which enables them to provide
- Key strategic programmes are co-ordinated by the ICS team, including Community Diagnostic Centres, Frontline Digitisation, Virtual wards, Care Sector, secondary care Appointment Systems and Primary Care Digital First, working with health, social care and third sector partners

**Engagement with the public:**
The One London programme has held various consultation meetings with patients across London, the results of which inform the strategies of each of the ICS' across London. Further engagement has been requested through further 'Big Conversations' planned in NEL

# Finance

**The benefits that north east London local people will experience by April 2024 and April 2026:**

- Improving quality and outcomes for local people of north east London
- Securing greater equity for our residents
- Maximising value for money
- Deepening collaboration between partners

**How this transformation programme reduces inequalities between north east London's local people and communities:**

- Incentivising transformation and innovation in clinical practice and the delivery of services to improve the outcomes of local people
- Supporting delivery of care closer to patients' homes, including investing in programmes that take place outside the hospital environment
- Refocus how the money is spent to focus on population health, including proactive measures that keep people healthier and to level up investment to address historical anomalies of funding
- Increasing investment in prevention, primary care, earlier intervention and the wider determinents of health, including environmental sustainability

**Key programme features and milestones:**

- Supporting our providers to reduce transactional costs, improve efficiency and reduce waste and duplication
- Support the financial stability of our system providers and underpinning a medium to long term trajectory to financial balance for all partners
- Recognising existing challenges, including that NEL is, as a SOF 3 ICS, financially challenged with a growing population and an acute provider (BHRUT) in SOF 4 for financial performance.
- Ensuring we do not create unnecessary additional financial risk, especially in the acute sector
- ICS investment pool to fund programs designed to reduce acute demand
- Finance development programme to agree overall budgets and develop place based budgets and budgetary delegation to place
- Effective integration of specialised commissioning, community pharmacy, dental and primary care ophthalmology services

**Further transformation to be planned in this area:**

- Supporting the integration of health and social care for people living with long term conditions who currently receive care from multiple agencies
- Ensuring that all partners are able to understand and influence the total amount of ICB resources being invested in the care of local people.

**Programme funding:**

- ICB plan submitted with a total budget of £4,218m in 23/24
- Specific transformation budgets, including health inequalities, virtual wards, physical, demand and capacity funding

**Leadership and governance arrangements:**

- Reporting to the ICB Board and Place Partnership Boards
- Finance, Performance and Investment Committee
- Audit and Risk Committee
- CFO lead monitoring of monthly and forecast performance

**Key delivery risks currently being mitigated:**

- Risk to delivery of a balanced financial position. Mitigated by delivery of efficiencies, delay of planned investments

# Physical infrastructure

Capital pipeline work to be completed Jan. Review in January 2024

**The benefits that north east London local people will experience by April 2024 and April 2026:**

- Across NEL ICS organisations, there are 332 estates projects in our pipeline over the next 5 /10 years, with a total value of c. £2.9 billion
- These include the redevelopment of Whipps Cross hospital and a new centre on the site of St George's, Hornchurch
- Formal opening of new St George Health and Wellbeing Hub – **Spring 2024**

**How this transformation programme reduces inequalities between north east London's local people and communities:**

- Infrastructure transformation is clinically led across the footprint whilst also achieving the infrastructure based targets set by NHSE.
- Our vision is to drive and support the provision of fit for purpose estate, acting as an enabler to deliver transformed services for the local population. This is driven through robust system wide Infrastructure planning aligned to clinical strategies, which is providing the overarching vision of a fit for purpose, sustainable and affordable estate.

**Key programme features and milestones:**

- Acute reconfiguration £1.2bn (includes estimated total for Whipps Cross Redevelopment of c. £755m)
- Mental Health, £110m
- Primary and Community Care, £250m
- IT systems and connectivity, £623m (inc. NEL Strategic digital investment framework c.£360m)
- Medical Devices replacement, £256m
- Backlog Maintenance, £315m
- Routine Maintenance inc PFI, £160m

**Further transformation to be planned in this area:**

- Construction will be undertaken where possible using modern methods in order to reduce time and cost and will be net carbon zero.
- Consider use of void spaces and transferred ownership of leases to optimise opportunity to meet demand and contain costs.
- Support back-office consolidation

**Programme funding:**

- Over the next 10 years there is expected to be a c£2.9bn capital ask from programmes across NEL

**Leadership and governance arrangements:**

- System-wide estates strategy and centralised capital pipeline
- Capital overseen by Finance, Performance and Investment Committee of NHS NEL.

**Key delivery risks currently being mitigated:**

- Recent hyperinflation has pushed up the cost of many schemes by as much as 30%. Currently exploring how to mitigate this risk, including reprioritisation
- Exploring opportunities for investment and development with One Public Estate, with potential shared premises with Councils

# Barking & Dagenham

**Portfolio vision, mission and key drivers:**

**Vision**

By 2028, residents in Barking and Dagenham will have improved physical and mental health and wellbeing, with a reduction in the gap in health inequalities between Barking and Dagenham resident and people living elsewhere. Our strategic aims are to:

- Enable babies, children and young people to get the best start in life
- Ensure that residents live well and when they need help they can access the right support at the right time in a way that works for them
- Enable residents to live healthier for longer and be able to manage their health, have increased opportunities to have an early diagnosis of health conditions and be provided with appropriate care to manage a condition before it becomes more serious

**Interdependent ICB programmes**

- Babies, Children and Young People; Maternity programme; Fuller programme; Population Health programme; Long Term Conditions programme; Urgent & Emergency Care programme; Estates

**Interdependent Collaborative programmes**

- Acute; Community Health; Mental Health, Learning Disability and Autism; Primary Care; VCSE

**Key programmes of work that will deliver the vision and mission**

- **Improving outcomes for CYP with SEND** with a focus on therapy support, ASD diagnosis and pre-and post-diagnostic support, mental health in schools
- **Tackling childhood obesity** leveraging the opportunities through family and community hubs for prevention
- **Development of Integrated Locality Health and Social Care Teams** (physical and mental health)
- **Developing a proactive and prevention approach to delivery of services** with targeted prevention approaches for falls prevention, dementia diagnosis and early support; long-term conditions identification and support and health outcomes for people who are homeless
- **Optimising outcomes and experience for pathways - d**eveloping a 24/7 Community End of Life Care Model; integrated Rehab and Reablement services; high Intensity User Services; demand and capacity management of high risk pathways (waiting list management)
- **Improving the physical health of people with SMI**

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**

- BCYP get the best start, are healthy, happy and achieve, thrive in inclusive communities, are safe and secure and grow up to be successful young adults
- Providing accessible services and support for residents to prevent the development of health conditions wrapped around local communities
- Improving physical and mental health and wellbeing for residents, particularly those with long term conditions
- Reduced reliance on acute and crisis services
- Improved physical health outcomes for those with a serious mental illness

**Key stakeholders:**

NELFT
Primary care/PCNS
BHRUT/Barts
VCSE
Healtwatch
Local Authority- childrens and adults services; public health
Estates and housing teams

**Engagement with the public:**

Best Chance Strategy for CYP and families; Just Say Parent Forum, engagement in Adults and Community strategy (ongoing)

# Havering

**Havering Place based Partnership vision, mission and key drivers:**
A Healthier Havering where everyone is supported to thrive; The vision of the Havering Partnership is to pool our collective resources to create person centred, seamless care and support designed around the needs of local people throughout their life course, with a strong focus on prevention, addressing inequalities and the wider determinants of health. This compliments Havering Council's vision for the 'Havering that you want to be a part of', with a strong focus on people, place and resources. We will do this by; Tackling inequalities and deprivation to reduce the impact that this has to access to services, and outcomes; Improving Mental and Emotional Support, Tackling Havering's biggest killers; Improving earlier care and support; coordinating and joining up care; working with people to build resilient communities and supporting them to live independent, healthy lives.

**Interdependent ICB programmes**
- Mental Health
- Long Term Conditions
- Urgent and Emergency Care
- Workforce and other enablers such as digital
- Planned Care
- Carers work and other cross place programmes

**Interdependent Collaborative programmes**
- Acute Provider Collaborative
- Community Provider Collaborative
- VCSE Provider Collaborative
- Mental Health Provider Collaborative
- Primary Care Collaborative
- North East London Cancer Alliance

**Key programmes of work that will deliver the vision and mission**
- **Start Well**; Children and young people get the best start in life, are able to achieve the best opportunities and keep as healthy and well as possible throughout their lives
- **Live Well**; People enjoy and are able to maintain a sense of wellbeing and good health, supported by resilient communities. They can access care and information when needed.
- **Age Well**; People are able to live independently in their own homes with appropriate care and support to maintain and develop their social and community networks
- **Die Well**; People are supported to ensure the last stages of their life happen in the best possible circumstances, receiving the right help at the right time from the right people
- **Building community resilience programme and other key enablers**; including improvements to Primary Care and delivery of the recommendations in the Fuller review, roll out of the Joy App as our single database of services and referral mechanism for social prescribing, making better use of our estate and delivery of new models of care such as the St Georges project, improvements to urgent and emergency care, imbedding a prevention approach, addressing our key workforce challenges by working together, creating the enabling framework for place including information sharing agreements between partners to enable decisions and service improvement to be driven by joined up data.
- Built on a foundation of a **joint health and care team**, bringing together the Havering Place NHS team with the Local Authority Joint Commissioning Unit to deliver improved outcomes for local people and better value for money in our commissioned services

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**

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

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

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

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

*Full details of the benefits are captured in the Havering Place based Partnership interim strategy*

DRAFT

**Key stakeholders:**
- Local People
- Staff
- VCSE
- London Borough of Havering and their staff, who are coming together with the NHS Place team to form a joint team
- NELFT
- BHRUT
- Healthwatch
- Care Providers Voice (including Home Care and Care Home providers)
- PELC
- Primary Care including the GP Federation and PCNs
- NHS North East London partners
- Police and other community partners
- Wider NHS partners
- Wider Community partners and groups

**Local People are at the heart of all of the work of the Place based Partnership**

**Engagement with the public:**
**A significant engagement programme has been underway with local people, VCSE groups, and stakeholders since the inception of the partnership. We are building an ongoing relationship with local people, and developing case studies to embed their experiences to drive improvements locally.**

# Redbridge

**Place vision, mission and key drivers:**

**VISION:** The Redbridge Partnership will relentlessly focus on improving the outcomes for the people of Redbridge and seek always to make a positive difference to people's lives. Together, we will build on what we have already achieved and use our combined resources to create person-centred, responsive care to build services around the needs of our communities within Redbridge. We will have a strong focus on prevention, addressing inequalities and the wider determinants of health**.**

**KEY PRIORITIES: Babies,Children & Young People (BCYP)-**Childhood Immunisations, **Housing & overcrowding, Multi-Disciplinary Team working(MDT)-** service integration, **Mental Health (MH)**– Access & wellbeing

**DRIVERS:** Good governance and accountability, a focus on the patient/resident's voice, a focus on Organisational Development, Commitment to working in partnership and beyond organisational boundaries, reliable data to inform impacts and adequate resourcing

**Interdependent ICB portfolios**

Long Term Conditions (LTC), Learning Disabilities (LD)/Mental Health (MH), Planned Care (PC), Health Inequalities (HI), Babies, Children and Young People (BCYP), Urgent and Emergency Care (UEC)

**Interdependent Provider Collaboratives**

Community Collaborative, Acute Provider Collaborative, Cancer, Collaborative, Primary Care Collaborative, Mental Health Collaborative

**Key programmes of work that will deliver the vision and mission.** (PLEASE NOTE THE PRIORTIES ARE PLANNED TO BE FORMALLY SIGNED OFF AT THE JANUARY 24 PARTNERSHIP BOARD.)

**Start Well**: Hospital at Home, Paediatric Integrated Nursing Service (PINs), Learning Disability Key workers, Integrated child health hubs, Special Education Needs & Disability (SEND), Children & Young People Asthma one stop shop

**Live Well:** Long Term Conditions Prevention/diagnosis, A Cardio renal and cardio vadcular programme, Increase health checks for residents with Serious Mental Illness (SMI) , Mental Health & Learning Disability, Review of Commissioning overlaps between organisations, Improve quality of life for residents of Redbridge.

**Urgent & Emergency Care/Ageing Well**: Keeping people well at home, Same day access to urgent care, Hospital flow-length of stay in hospital, Discharge from Hospital, End of Life Care, Avoidance of unnecessary attendance and admissions to hospital.

**Primary Care:** Fuller Programme ( Integrated Multi-Disciplinary Care, Staying well for longer, Access to care & advice), Direct Enhanced Services, Local Incentive Schemes, Same Day Access and extended hours care, Asylum Seekers services, Homeless Services, Spirometry

**Health Inequalities:** Various schemes addressing Core 20+5

**Ilford Exchange Health Centre:** To develop and deliver a new health centre in Ilford town centre following an extensive public consultation in September 2022. The consultation was over 6 weeks and included a range of engagement tools and events such as public surveys, information stands, 4 public engagement events and 1 event with a local charity One Place East.

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**

**By April 2025 and 2027 the Redbridge Place Based Partnership will:**

- Significantly reduce the variation in undiagnosed Long Term Condition diagnosis rates and improve early treatment intervention.
- Significantly improve the uptake of childhood immunisations
- Improve the rate of Healthchecks for residents with Serious Mental Illness.
- Reduce the number of Children & Young People patients attending A&E through the hospital at homes programme
- Significantly reduce health inequalities underpin by the Core20+
- Improve same day access for residents across both health and care
- Have a new integrated health centre operational in the Ilford Exchange by 2025.

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**Key stakeholders:**

- London Borough of Redbridge (LBR)
- Redbridge Community Volunteer Service (RCVS)
- Healthwatch
- Healthbridge (GP Federation),
- The Primary Care Networks (PCNs) in Redbridge
- North East London NHS Foundation Trust (NELFT),
- NHS NEL ICB
- Barking Havering & Redbridge University Hospitals NHS Trust (BHRUT)
- Barts Health NHS Trust (specifically Whipps Cross),
- Provider Collaboratives
- Care Provider Voice CPV)
- PELC
- LMC
- BHR CEPN

**Engagement with the public:**

The RBP will engage with local communities and organisations to create a strategic priorities programme that is informed by the views of local people. In particular we plan to have engagement workshops once the key priorities are signed off in January 2024, to shape the work programmes.
We will also have resident rep's on each Steering Group which are sub-committees of the Partnership Board.

# Tower Hamlets

**Portfolio vision, mission and key drivers:**

- Tower Hamlets residents, whatever their backgrounds and needs, are supported to self-care, thrive and achieve their health and life goals
- Health and social care services in Tower Hamlets are accessible, high quality, good value and designed around people's needs, across physical and mental health and throughout primary, secondary and social care
- Service users, carers and residents and children are active and equal partners in health and care and equipped to work collaboratively with THT partners to plan, deliver and strengthen local services
- All residents - no matter their ethnicity, religion, gender, age, sexuality, disability or health needs - experience equitable access to and experience of services, and are supported to achieve positive health outcomes

**Interdependent ICB programmes**

- ICB anti-racism workstream
- ICB CYP workstream
- ICB long term conditions workstream
- ICB MH workstream
- Primary Care Access
- ICB Fuller workstream
- ICB urgent care review
- Access to data & insights

**Interdependent Collaborative programmes**

- Community collaborative model for health and care
- Primary care collaborative
- Supporting out of borough NEL discharges
- Mental Health collaborative
- Planned Care workstream

**Key programmes of work that will deliver the vision and mission**

- Improving access to primary and urgent care
- Building resilience and self-care to prevent and manage long term conditions
- Implementing a localities and neighbourhoods model
- Facilitating a smooth and rapid process for hospital discharge into community care
- Being an anti-racist and equity driven health and care system
- Ensuring that Babies, Children and Young People are supported to get the best start in life
- Providing integrated Mental Health services and interventions

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**

- Ensuring residents can equally access high quality primary and urgent care services when and where they need them
- Better prevention of long term conditions and management of existing conditions
- Ensuring that every resident can access the health and care services they need to support their continued health and wellbeing within their local area or neighbourhood, including GP, pharmacy, dental and leisure facilities
- A smooth and rapid process for discharging residents from hospital to suitable community-based care settings when they are ready for this transition
- Ensuring our health and care system and services are achieving equitable outcomes for all residents and addressing inequalities that exist, e.g. access, experience, representation and outcomes
- Ensuring babies, children and young people (and their families) are supported to get the best start in life, especially where they have additional needs
- Providing integrated services and interventions to promote and improve the mental wellbeing of our residents

**Key stakeholders:**

LBTH
NEL ICB
Barts Health Trust
TH GP Care group
ELFT
Healthwatch
TH CVS

Tower Hamlets residents and service users

**Engagement with the public:**

The workstreams and the THT Board include VCS and resident stakeholders who input into the design of the programme.

# Newham

**Portfolio vision, mission and key drivers:**
Working with our diverse communities of all ages to maximise their health, wellbeing and independence. Supported by a health and care system that enables easy access to quality services, in your neighbourhood, delivered by people who are proud to work for Newham.

**Interdependent ICB programmes**
- Babies, Children and Young People
- Fuller
- Long Term Conditions
- Maternity
- Population Health
- Urgent & Emergency Care

**Interdependent Collaborative programmes**
- Acute
- Community Health
- Mental Health, Learning Disability and Autism
- Planned Care
- Primary Care
- VCSE

**Key programmes of work that will deliver the vision and mission**
- Joint Planning Groups (JPGs) for Babies, Children and Young People; Mental Health; Learning Disabilities and Autism; Ageing Well; Primary Care; and Urgent Care
- Additional JPG for Long Term Conditions being explored
- Local Authority-led programmes across Health Equity and Well Newham (prevention)
- Population growth programme

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**
- Reduce the prevalence and impact of long-term conditions on residents' lives
- Enable people to stay well in their own homes by proactively organising and managing their care & support
- Improve the mental wellbeing of residents and ensure people have access to mental health support when and how they need it
- Involve, engage and co-produce all our plans with residents
- Ensure people stay in hospital for the optimum time and are supported to rehabilitate and recover
- Ensure when people need urgent help they can access it quickly and as close to home as possible
- Develop and integrate children's services to ensure children have the best start in life
- Prepare for significant population growth in Newham and North East London and strengthen prevention initiatives

**Key stakeholders:**
ELFT
Healthwatch
LBN
NEL ICB
NUH
Primary Care
Residents
VCFS

**Engagement with the public:**
Residents and People & Participation Leads attend Partnership Board, JPGs and project groups

# Waltham Forest

**Portfolio vision, mission and key drivers:**

**Our aim** is for the population of Waltham Forest to have healthier lives by enabling them to **start well, live well, stay well and age well**, supporting each individual through to the end of their lives. We will do this by working together, as partner organisations and with our residents, **to improve health outcomes and reduce health inequalities.**

- We will engage and involve our residents to coproduce our interventions and services
- We will focus on supporting all residents to stay well and thrive throughout their lives
- We will use population health management approaches to understand the needs of our residents and target our resources to improve equity
- We will ensure when people need help, they can access high quality, good value services quickly and easily and are enabled to stay in their homes or return home as soon as possible.

**Key stakeholders:**

**Interdependent ICB programmes**

- ICB anti-racism workstream
- ICB UEC workstream
- ICB CYP workstream
- ICB long term conditions workstream
- ICB MH workstream
- Primary Care Access
- ICB Fuller workstream
- ICB Digital workstream

**Interdependent Collaborative programmes**

- Whipps Cross redevelopment programme
- MH Collaborative
- Community Collaborative
- Primary care Collaborative
- Planned care workstream

**Key programmes of work that will deliver the vision and mission**

- Delivery of a programme of locality **prevention, wellbeing and self-care** to intervene earlier with residents to improve health outcomes dentification for intervention and support for residents with **LTCs.**
- Delivery of proactive anticipatory care through delivery of **Care Closer to Home** transformation programme and establishing **Integrated Neighbourhood teams and hubs.**
- Deliver alternative to unplanned attendances and admissions to acute hospital and improve discharge pathways through the delivery of the **Home First programme** of transformation and improving **same day access to primary care.**
- To publish a **children's health strategy** , improve access to **therapies** and reduce the need for children to attend hospital.
- To transform **EOL** services in Waltham Forest to ensure residents have the support to die in their choice of place.
- Publishing a strategy for **children's health**, improving access to children's therapies, and developing services to reduce the need for children to attend Whipps Cross Hospital in an emergency.
- Improving access to **Mental Health** support in community for all ages and promoting positive well-being for all.

**Engagement with the public:**

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**

# City & Hackney

## Portfolio vision, mission and key drivers:

**City & Hackney PbP Vision**: Working together with our residents to improve health and care outcomes, address health inequalities and make City and Hackney thrive, by focussing on 3 key areas:

1. **Giving every child the best start in life (often by recognising the role of families)**
2. **Improving mental health and preventing mental ill-health**
3. **Preventing, and improving outcomes for people with long-term health and care needs**

Supporting our population health priority outcome areas (above), we are implementing 6 cross cutting approaches: Increasing social connection, ensuring healthy places, supporting greater financial wellbeing, joining up our local health and care services around resident's and families' needs, taking effective action to address racism and other discrimination, and supporting the health and care workforce. City and Hackney Neighbourhoods programme is about fostering community connections.
Our aim is to improve quality of care (clinical cost effectiveness, experience and safety) including access and waiting times for all our residents particularly those experiencing Health inequalities. We apply the principles of right time, right place, right support.
We acknowledge that the solution lies at "whole-system" level and requires detailed collaboration with wider system partners including local authorities, public health and our voluntary sector partners and strengthening partnership working and synergies to maximise benefits in terms of outcomes and system sustainability. Residents and Families are at the heart of everything we do.
**Key drivers**: - national and regional policy frameworks, local needs, and addressing areas in C&H where we have poor outcomes and evidence of inequalities (as articulated in JSNAs, Population Health data, and more)

## Interdependent ICB programmes

**Start Well –**BCYP programme priorities on Community Capacity (waiting lists, insights), Primary Care (new models, better integration) Acute care (capacity i.e.. diabetes, allergy)
**Live Well** - LTC and Specialised Commissioning; Planned Care; Urgent and Emergency Care; Personalised Care
**Age Well** - Palliative & End of Life Care; NEL Care Home / Care Provider Forum / Network; Continuing Healthcare: NEL Carers Network
**Mental Health** - Children (C&H); Unplanned / Crisis Care (C&H); Community Care (C&H); NEL MH Delivery Group

## Interdependent Collaborative programmes

**Start Well –** APC, Community Collaborative (Waiting lists, SLT), Mental health collaborative, C&H CAMHS Alliance, Primary Care Collaboratives
**Live Well –** APC; Community Collaborative
**Age Well -** Mental Health Alliance; Primary Care Collaboratives
**Mental Health -** Mental Health Integration Committee (MHIC); C&H Children's Emotional Health and Wellbeing Partnership; C&H Psychological Therapies and Wellbeing Alliance (PTWA); C&H CAMHS Alliance; C&H Dementia Alliance; C&H Primary Care Alliance; Hackney SIG



## Key programmes of work that will deliver the vision and mission

**Start Well –** CAMHS / Improving wellbeing and MH (ACEs), improving outcomes for CYP with SEND, complex health needs, ASD and LD, increasing immunisations and vaccinations, reducing maternity inequalities and improving perinatal mental health
**Live Well** - Neighbourhoods (Proactive Care, Community Navigation); Better Care Fund Partnership; Primary / Secondary Care Interface; Long Term Conditions Management
**Age Well** - Discharge Improvement Programme; Integrated Urgent Care - NEL Same Day Access Programme, Enhanced Community Response (Virtual Wards and Urgent Community Response), Frailty / Proactive Care
**Mental Health** - ADHD / ASD Assessment and Aftercare (All ages) – Backlog and Waiting times; Adult Talking Therapies – Integrated Pathways. Quality Improvement. Demand / Capacity and Waiting Times; Community Transformation / Continued Improvement with Neighbourhoods offer – aligning existing provision; Neurodevelopmental Pathways Review (CYP); Crisis / T3.5 Pathways Review (Including ICCS, Surge and IST); Whole System Approach (iThrive) – CYP Emotional Health and Wellbeing
Continue to enhance THRIVE working with Schools (WAMHS / MHSTs integration) / Youth Hubs (Super Youth Hub); SMI Pathway Improvement
Improving and optimising 117 Aftercare;

## Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

All our work is aimed at improving the health and wellbeing of our local residents and reducing inequalities

**Start Well**

- Reductions in crisis mental health presentations to ED for CYP and Improvements in mental health and wellbeing outcomes for specific communities
- An increase % of children achieving good level of development - Improved health and educational outcomes for those at risk of exclusion and those with complex needs, SEND and autism and LAC
- Increase immunisation coverage
- A reduction in infant mortality rate, and in the rate of neonatal mortality and stillbirths, including a reduction in inequalities in maternity and birth outcomes for children and families. Improvements in patient experience.

**Live Well and Age Well**

- Patients will feel safe and supported with any ongoing care needs following a hospital admission
- Patients will know about services are available and have increased confidence in them to meet their needs
- Patients feel supported to access the care they need
- Patients will have more care being provided outside hospital, closer to their home, where appropriate

**Mental Health**

- ***Improved experience, waiting times and overall quality of care*** - Neurodevelopmental assessment (CAMHS and Adults); Psychological therapies intervention (CAMHS and Adults); 117 Aftercare; Wellbeing in School and Youth Hubs; Crisis Care including Crisis prevention and wellbeing
- ***Better meeting the needs of residents who experience greater health inequalities*** - Protected characteristics - Equalities act; Social deprivation; Serious mental illness; Neurodevelopmental (ASD / ADHD / LD); Looked After Children / Care Leavers].

## Key stakeholders:

- Residents / Carers
- Local Authorities and the CoL (ASC; PH; MH; LD&A)
- Voluntary& Community Sector;
- Homerton Hospital
- ELFT
- LBH / CoL – Adult Social Care
- LBH CoL – Children Social Care
- Hackney Education
- ELFT – CAMHS / Adults
- HUH CAMHS / Adults / Acute / Paediatrics
- C&H Public Health
- Primary Care / GP Confed
- VSO Partners / SIG

## Engagement with the public:

- Healthwatch
- Programme / Project Service-user reps
- Engagement with the public
- Advocacy Project (MHIC)
- Alliance coproduction and Participation
- Maternity voices partnership
- SEND parent carer forum

# Health Inequalities

**Portfolio vision, mission and key drivers:**
Health inequalities exist between NEL and the rest of the country – for example we have particularly high rates of children with excess weight and poor vaccination and screening uptake – but they also exist between our places and communities. These inequalities are avoidable and unfair and drive poorer outcomes for our population. We want to improve equity in access, experience and outcomes across NEL. To do this we have made reducing health inequalities a cross-cutting theme that is embedded within all of our programmes and services within places and across NEL – everyone has a role to play.

**Key stakeholders:**
Public health teams
Local authority departments
Voluntary and community sector
Primary care
NHS trusts
NHS E and TPHC
ICB

**Key programmes of work that will deliver the vision and mission**
- Dedicated health inequalities funding has been provided to each place-based partnership to lead locally determined programmes to reduce health inequalities within their local communities. These projects will be evaluated and the learning shared and showcased.
- Development of a NEL Health Equity Academy to support all people and organisations working in health and care in NEL to be equipped with the knowledge, skills and confidence to reduce health inequalities for the benefit of local people
- Implementation of a community pharmacy scheme to provide targeted pharmacist advice and free over the counter medicines for people on low incomes and experiencing social vulnerability across NEL, to support our communities in the context of cost of living pressures.
- Taking a Population Health Management (PHM) approach, led by places and neighbourhoods, will support frontline teams to identify high risk groups and identify unmet need. A PHM Roadmap has been developed for NEL and is being implemented.
- Embedding the NEL Anchor Charter, working with system partners to ensure we are measuring and creating the opportunities that being an anchor institution affords are leveraged for our local population, to address structural inequalities such as ensuring the NHS in NEL is a London Living Wage accredited employer, embedding social value in procurement process and better utilising our infrastructure to support community activation and supporting a greener, healthier future.
- Delivering our ICS Green Plan including developing an Air Quality Programme, ICS wide net zero training programme, and embedding net zero into our procurement processes to support our aim of reducing our collective carbon footprint by 80% by 2028 and to net zero by 2040.
- Improving access to primary care for health inclusion groups (homeless and refugee and asylum seekers) through safe surgery programme, supported discharge for homeless through the out of hospital care programme, supporting families in temp accommodation to access support out of borough, commissioning a NEL wide initial health assessment for those seeking sanctuary housed in contingency accommodation, and commissioning a needs assessment for health inclusion in NEL to identify needs for other underserved groups that require focus.

**Details of engagement undertaken with Places, collaboratives and other ICB portfolios**
- NEL Population Health and Inequalities Steering Group is made up of representatives from places and collaboratives, and leads from across the ICS.
- Significant engagement across the system on what is useful from a Health Equity Academy
- Engagement from across the system on Anchors, Net-zero and health inclusion around homelessness and refugee and asylum seeker programmes

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**
- Reduced differences in health care access, experience and outcomes between communities within NEL, particularly for people from ethnic minority communities, people with learning disabilities and autism, people who are homeless, people living in poverty, and for carers.
- Improved health life expectancy for all communities across NEL, irrespective of who you are or where you live.
- Our population receives more inclusive, culturally competent and trusted services, underpinned by robust equity data.

**Engagement with the public:**
Engagement on specific topics, and in depth at place level.

# Prevention

**PLACE**

**HOLDER**

**SLIDE**

**<SLIDE IN DEVELOPMENT>**

# Personalised Care

PLACE

HOLDER

SLIDE

<SLIDE IN DEVELOPMENT>

# Learning System

**Portfolio vision, mission and key drivers:**

The transition to an Integrated Care System has provided an opportunity to work in a different way in how we deliver and approach change to services within north east London. In order to improve the care we provide our residents, it is crucial to embed the improvement process of learning from the current delivery. As such the ICB needs provide an environment that facilitates the ability to deliver a systematic approach to iterative data-driven improvement

To ensure an effective learning system, the organisational culture must support a strong learning approach. The three stage learning cycle (learning before, during and after) describes how staff can interact with the learning system to inform their work. Each stage is informed by the following principles:

- We are well-informed – before we act, we fully consider the impact of our decisions on individual, community and system outcomes and equity.
- We are responsive – we are effectively monitoring our interventions and taking action in a timely manner
- We reciprocate –we work together sharing knowledge openly and valuing collaboration over competition

**Key stakeholders:**
Quality and safety
Complaints
Strategy
Programme Management Office
Place-based directors

**Key programmes of work that will deliver the vision and mission**

Initial scoping still to be concluded and so no programme of work has been developed/

**Details of engagement undertaken with Places, collaboratives and other ICB portfolios**

First discussion meeting yet to take place and so as yet no engagement has taken place

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**

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- Participation in evidence-informed decision making, promoting legitimacy
- Development of a localised evidence-base, helping us to make decisions most suitable to our context and populations
- Reduction in duplication, improving productivity and sustainability
- Proportionate approaches to transformation, improvement and innovation, not driven by whim or external pressures

**Engagement with the public:**

First discussion meeting yet to take place and so as yet no engagement has taken place with Places, collaboratives and other ICB protfolios

# Co-Production

**PLACE**

**HOLDER**

**SLIDE**

**<SLIDE IN DEVELOPMENT>**

# High Trust Environment

**PLACE**

**HOLDER**

**SLIDE**

**<SLIDE IN DEVELOPMENT>**

# 6. Implications and next steps

# Lessons Learnt (in development)

**PLACE**

**HOLDER**

**SLIDE**

**<SLIDE IN DEVELOPMENT>**

**('Early lessons from work to develop this plan' - slide being amended)**

# How will we know we have succeeded - NEL Outcomes Framework

- The interim North East London Integrated Care Strategy was published and adopted by the Integrated Care Board in January 2023.
- The strategy highlights our four system priorities for improving quality and outcomes and address health inequalities as well as our six crosscutting themes which are part of the new approach for working together across NEL.
- The strategy was developed in conjunction with system partners, along with a set of 61 success measures, which aimed to measure delivery against the priorities and crosscutting themes.
- This slide deck outlines the steps we are proposing to develop an outcomes framework.

**What do we mean by an outcomes framework?**

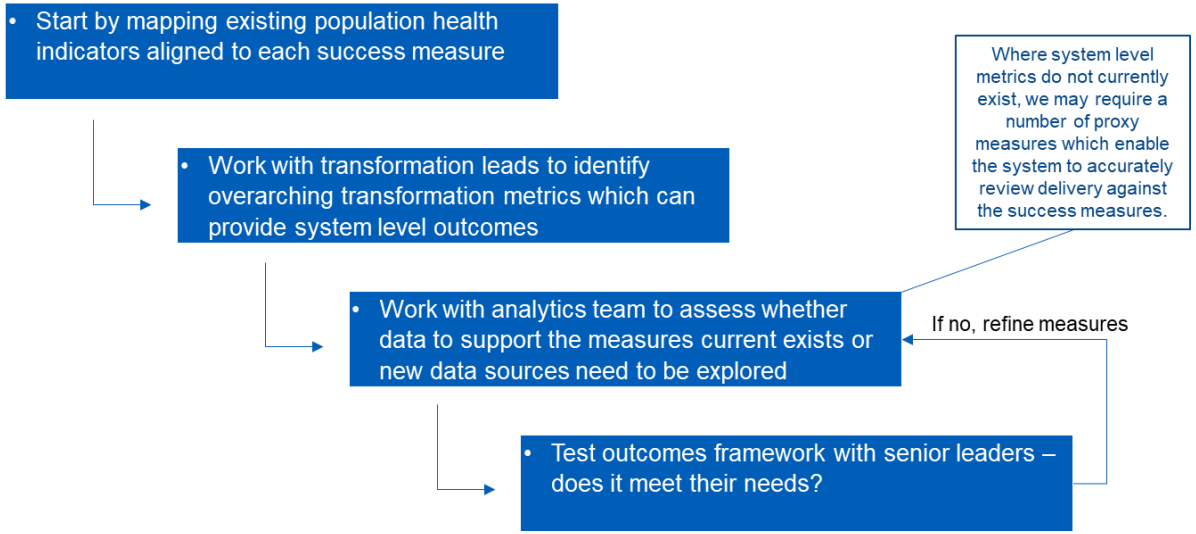
- An outcomes framework is a way for us to measure the effectiveness of our ICS strategy by focusing on the outcomes that are achieved, rather than just the activities that are carried out. That way we can assess whether our strategy is making a positive difference in people's lives.



In order to support the development of the outcomes framework, the below principles have been drafted to shape the design and implementation:

- **Assess delivery against ICS strategic themes and objectives**
- **Demonstrate current delivery on priority areas**
- **Develop outcome measures in conjunction with transformation leads, provider collaboratives, and ICS partner organizations**
- **Avoid developing an outcomes framework in the model of a performance framework**
- **Importance of recognising that outcomes are often long-term goals**
- **Assess wider population health measures rather than focus on statutory or mandated targets**
- **Make the system responsible for delivering metrics**

**The NEL approach**



# Next steps for our transformation programmes

- As the early analysis shows, all programmes within the portfolio can demonstrate alignment with elements of the integrated care strategy and operating plan requirements. The extent to which the portfolio responds to the more specific challenges described in the first half of this plan is more variable.
- Our shared task now is to prioritise (and therefore deprioritise) work within the current portfolio according to alignment with the integrated care strategy, operating plan requirements, and additional specific local challenges.
- This task is especially urgent in light of the highly constrained financial environment that the system faces, along with the upcoming significant reduction in the workforce within NHS North East London available to deliver transformation.
- The work required to achieve this is two-fold – part technical and part engagement – and will be carried out in parallel, with the technical work providing a progressively richer basis for engagement across all system partners and with local people.

**Technical work**

Tightening descriptions of the current programmes of work as the basis to inform prioritisation, especially:

- the **quantifiable beneficial impact** on local people, beyond the broad increases or decreases in certain measures currently signalled;
- the definition of **firm milestones** on the way to delivering these benefits;
- the **financial investment** in each programme and the anticipated returns on this investment; and
- quantifying the **staff resource** going into all programmes, and from all system partners.

**Engagement**

There is an important cross-system conversation needed, that enables us to create a portfolio calibrated to the competing pressures on it. Principle pressures to explore through engagement include:

- achieving early results that relieve current system pressures *and* creating the resources to focus on achieving longevity of impact from transformation around prevention;
- implementing transformation with a wide range of benefits across access, experience, and outcomes *and* ensuring, in the current financial climate, that we achieve the necessary short-term financial benefits;
- focussing on north east London's own local priorities *and* being open to additional regional or national opportunities, especially where new funding is attached;
- focussing on fewer large-impact transformation programmes *and* achieving a breadth that reflects the diversity of need and plurality of ambition across north east London; and
- ensuring that benefits are realised from transformation work already in train *and* pivoting to implementing programmes explicitly in line with current priorities.

# We will continue to evolve as a system

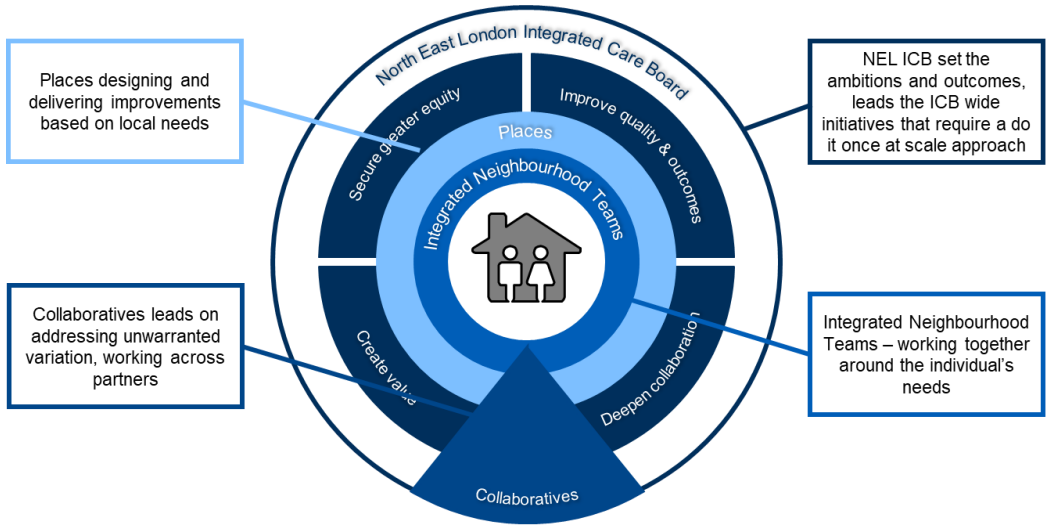
Our system has been changing rapidly over recent years, including the inception of provider collaboratives, the launch of seven place based partnerships, the merger of seven CCGs followed by the creation of the statutory integrated care board and integrated care partnership in July 2022.

Since becoming an ICS we have designed our way of working around teams operating:

- At **Place** delivering services and improvement for Neighbourhoods and Place;
- In **Collaboratives** reducing unwarranted variation, driving efficiency and building greater equity;
- For **NEL** sharing best practice, implementing NEL solutions for NEL work, providing programmatic support and oversight, and delivering enabling functions to our organisation and ICS through a business partner model.

Coordination between our Places, Collaboratives and NEL wide programmes is critical so that we:

- Operate as a learning system and spread best practice
- Ensure that activity, transformation and engagement happens at the most appropriate level, duplication is reduced and tensions are identified and resolved
- Identify where there is NEL work which should be done once for NEL
- Deliver value for money
- Deliver beneficial and sustained impact for the health and wellbeing of local people.




We are now looking to work with our partners to further develop how we work together, underpinned by our ambition to create a **High Trust Environment** that supports integration and collaboration and to operate as a **Learning System** driven by research and innovation.

Designing together *how* we want to work will be as critical as agreeing *what* we want to deliver.

This will help us get greater clarity on the responsibilities of different parts of the system, and critically how we want each part of the system to interact with another to enable integration and continuous improvement.

NHS
North East London

## Joint Forward Plan 24/25 Refresh:

# Havering
# Health & Well Being Board



20th December 2023

DRAFT

# Introduction: Overview of system planning deliverables

The NEL system planning cycle has been divided into three steps: 1) integrated care strategy, 2) delivery plan, and 3) operational planning. These are outlined below with related deliverables included below each step. These are not comprehensive but indicate some of the key activities underpinning each stage.

Steps

Deliverables

**Integrated Care Strategy:** Sets the strategic direction for the ICS

**Delivery Plan:** Sets out our plans to deliver on our strategic priorities and NHS requirements

**Operational planning:** Describes how we use collective resources to deliver the plan

**Annual review of our strategic context including national policy and local JSNAs potentially leading to changes**

**Development of a strategic outcomes framework measuring impact of the ICS strategy**

**Creation of a Future Forum for horizon scanning and looking forward**

**Resident / clinical / care professional engagement approach**

**Population modelling and scenario planning**

**Process review to inform future ways of planning**

**Annual refresh of Joint Forward Plan**

**Review of transformation programmes to ensure strategic alignment and impact**

**- clear programmes**

**- agreed milestones**

**- agreed impact metrics that delivers the NEL ICS strategy and national standards, aims and ambitions***

**- costed and funding source proposed**

**Evaluation plans**

*reflect the NHS planning guidance and other NHSE guidance

**Prioritised pipeline for how & where resources will be allocated – NEL, places, provider collaboratives, providers**

**Funding matched and agreed against pipeline and operating plan**

**System driven Operating Plan (updated yearly – 2 year plan) with a narrative related to national priorities, with triangulated activity, workforce, and finance numbers**

**Improving outcomes, experience and access for our local people and addressing inequalities**

**Sustainability of our system**

# Joint Forward Plan (JFP) Refresh for 24/ 25 next steps

NEL ICB was formed on 1 July 2022 following the Health and Care Act 2022, and we published our interim Integrated Care Strategy in January 2023. This was followed by the Joint Forward Plan 23/24, our first five-year plan.

https://www.northeastlondonhcp.nhs.uk/ourplans/north-east-london-nel-joint-forward-plan/

Based on feedback and lessons learnt we are engaging with NEL System stakeholders earlier within the system planning cycle in order to ensure improved awareness and input to the 24/25 JFP. There will be annual refreshes of the JFP going forward in order to ensure that the document remains current. This JFP refresh continues to describe the challenges that we face as a system in meeting the health and care needs of our local people, but also the assets we hold within our partnership.

**High-level timeline**

24 November 2023
We asked all slide contributors to submit their initial draft plans for 2024/25 for the JFP, providing a summary list of projects, and resourcing requirements.

13 December 2023
A portfolio workshop will be held with leads from the system portfolios, Places, cross-cutting themes and enablers. We aim to develop greater cohesion between portfolios, identify any synergies or duplication we need to address, but also to allow everyone share feedback on each other's plans.

9 January 2024
We will ask for updated slides based on the feedback from the December workshop.

February 2024
By 23rd February, all JFP contributors will need to submit their final plans/ JFP slide input, ready for sign off via appropriate meetings prior to submission by end of March 2024.

# Main changes from the previous JFP

As we published our first JFP on 30 June 2023, we propose to keep the structure of the JFP, with some minor adjustments, as outlined below. Where references are made to figures, these will be updated to reflect the latest position.

**Main additions:**

- New slides to ensure we cover:
  - all our strategic system improvement portfolios in addition to our four strategic system priorities
  - our Place plans
  - our six cross-cutting themes and
  - our enables
- We have also included new slides outlining:
  - what is important to our residents and how it impacts our plans,
  - our successes to date, and
  - how we are developing a strategic outcomes framework to help us assess if we are having an impact.

# Ask from Havering HWBB

**Considerations for the HWBB membership:**

Within the context of our interim integrated care strategy, HWBBs are asked to

1) note why the JFP refresh is being undertaken and the approach being followed in order to deliver a refreshed NEL 24/25 JFP by March 2024

2) note what has been collated thus far from all contributors (Appendix 1- Draft JFP 24/25)

3) constructively make suggestions and comments

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