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JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE AGENDA

4.00 pm	Tuesday 14 January 2025	Council Chamber - Havering Town Hall, Romford

COUNCILLORS: **Quorum: 4**

Councillor Muhib Chowdhury	London Borough of Barking & Dagenham
Councillor Donna Lumsden	London Borough of Barking & Dagenham
Councillor Paul Robinson	London Borough of Barking & Dagenham
Councillor Christine Smith	London Borough of Havering
Councillor Julie Wilkes	London Borough of Havering
Councillor Sunny Brar	London Borough of Redbridge
Councillor Beverley Brewer (Chairman)	London Borough of Redbridge
Councillor Bert Jones	London Borough of Redbridge
Councillor Catherine Deakin	London Borough of Waltham Forest
Councillor Richard Sweden	London Borough of Waltham Forest
Councillor Marshall Vance	Essex County Council
Councillor Kaz Rizvi	Epping Forst District Council

CO-OPTED MEMBERS:

Manisha Modhvadia	Healthwatch Barking & Dagenham
Ian Buckmaster	Healthwatch Havering
Emma Friddin	Healthwatch Redbridge

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

Protocol for members of the public wishing to report on meetings of the London Borough of Havering

Members of the public are entitled to report on meetings of Council, Committees and Cabinet, except in circumstances where the public have been excluded as permitted by law.

Reporting means:-

- filming, photographing or making an audio recording of the proceedings of the meeting;
- using any other means for enabling persons not present to see or hear proceedings at a meeting as it takes place or later; or
- reporting or providing commentary on proceedings at a meeting, orally or in writing, so that the report or commentary is available as the meeting takes place or later if the person is not present.

Anyone present at a meeting as it takes place is not permitted to carry out an oral commentary or report. This is to prevent the business of the meeting being disrupted.

Anyone attending a meeting is asked to advise Democratic Services staff on 01708 433076 that they wish to report on the meeting and how they wish to do so. This is to enable employees to guide anyone choosing to report on proceedings to an appropriate place from which to be able to report effectively.

Members of the public are asked to remain seated throughout the meeting as standing up and walking around could distract from the business in hand.

Essex County Council

Waltham Forest

Havering LONDON BOROUGH

London Borough of Redbridge

London Borough of Barking & Dagenham lbbd.gov.uk

NOTES ABOUT THE MEETING

1. HEALTH AND SAFETY

The Joint Committee is committed to protecting the health and safety of everyone who attends its meetings.

At the beginning of the meeting, there will be an announcement about what you should do if there is an emergency during its course. **For your own safety and that of others at the meeting, please comply with any instructions given to you about evacuation of the building, or any other safety related matters.**

2. CONDUCT AT THE MEETING

Although members of the public are welcome to attend meetings of the Joint Committee, they have no right to speak at them. Seating for the public is, however, limited and the Joint Committee cannot guarantee that everyone who wants to be present in the meeting room can be accommodated. When it is known in advance that there is likely to be particular public interest in an item the Joint Committee will endeavour to provide an overspill room in which, by use of television links, members of the public will be able to see and hear most of the proceedings.

The Chairman of the meeting has discretion, however, to invite members of the public to ask questions or to respond to points raised by Members. Those who wish to do that may find it helpful to advise the Clerk before the meeting so that the Chairman is aware that someone wishes to ask a question.

PLEASE REMEMBER THAT THE CHAIRMAN MAY REQUIRE ANYONE WHO ACTS IN A DISRUPTIVE MANNER TO LEAVE THE MEETING AND THAT THE MEETING MAY BE ADJOURNED IF NECESSARY WHILE THAT IS ARRANGED.

If you need to leave the meeting before its end, please remember that others present have the right to listen to the proceedings without disruption. Please leave quietly and do not engage others in conversation until you have left the meeting room.

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 AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (IF ANY) - RECEIVE.

3 DISCLOSURE OF INTERESTS

Members are invited to declare any interests in any of the items on the agenda at this point of the meeting. Members may still declare an interest in an item at any point prior to the consideration of the matter.

4 MINUTES OF PREVIOUS MEETING (Pages 5 - 10)

To agree as a correct record the minutes of the previous meeting held on 17 October 2024 and authorise the Chairman to sign them.

5 HEALTH UPDATE (Pages 11 - 36)

Documents attached – to be noted unless any urgent business arises

6 MEDIUM TERM FINANCIAL STRATEGY (Pages 37 - 42)

Documents attached

7 LONG TERM CONDITIONS (Pages 43 - 62)

Documents attached

Luke Phimister
Clerk to the Joint Committee

MINUTES OF A MEETING OF THE
JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Council Chamber - Town Hall
17 October 2024 (4.30 - 6.18 pm)

Present:

COUNCILLORS

Councillor Muhib Chowdhury (London Borough of Barking & Dagenham) Councillor Paul Robinson (London Borough of Barking & Dagenham), Councillor Robby Misir (London Borough of Havering),Councillor Sunny Brar (London Borough of Redbridge), Councillor Beverley Brewer (London Borough of Redbridge), Councillor Richard Sweden (London Borough of Waltham Forest), Councillor Marshall Vance (Essex County Council), and Councillor Kaz Rizvi (Epping Forest District Council)

Also present:
Zena Etheridge, NHS NEL (online), Henry Black, Chief Finance Officer (online), Alex Ewings. Associate Director of Ambulance Operations (NEL), Fiona Wheeler, Chief Operating Officer and Deputy Chief Executive, BHRUT (online), Paul Calaminus, CEO (NELFT) (online), Archna Mathur, Director of Specialised Services and Cancer, NEL ICB (online), and Diane Jones, Chief Nursing Officer, NHS NEL (online)

43 **CHAIRMAN'S ANNOUNCEMENTS**

Councillor Robby Misir, the Chair for the meeting welcomed all Members of the committee to the meeting and reminded everyone of the meeting protocol and the fire evacuation measures if required.

44 **APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (IF ANY) - RECEIVE.**

Apologies for absence were received from Councillors Donna Lumsden (London Borough of Barking & Dagenham), Councillor Christine Smith (London Borough of Havering), Councillor Julie Wilkes (London Borough of Havering) (substitute – Robby Misir),Councillor Bert Jones (London Borough of Redbridge), Councillor Catherine Deakin (London Borough of Waltham Forest) Manisha Modhvadia Healthwatch Barking & Dagenham, Ian Buckmaster Healthwatch Havering and Emma Friddin Healthwatch Redbridge.

45 **DISCLOSURE OF INTERESTS**

There were no disclosures of interest received.

46 MINUTES OF PREVIOUS MEETING

The minutes of the previous meeting held on 25 July 2024 were approved as a true and accurate record.

47 HEALTH UPDATE

The following reports and subsequent updates were provided:

NHS North East London: Update

Zena Etheridge, NHS NEL spoke to the following:

- Next steps in strengthening our collaboration across north east London.
- NHS England annual assessment of NEL ICB Performance.
- Improving access for local people.
- Improving outcomes for people with long term conditions.

Health Update: Surgery Review

Zena Etheridge, NHS NEL spoke to the following:

- Elective surgery contract specification review.
- Our approach.
- Developing our principles.
- Principles.
- Involving the public and stakeholders.

Health Update: NEL Winter Planning 2024/25

Zena Etheridge, NHS NEL spoke to the following:

- Looking back over winter 2023/24 – continuing to meet the needs of our population.
- Looking forward to winter 2024/25 – National Guidance.
- Place and system interventions to keep people well.
- Next steps.

Finance Overview

Henry Black, Chief Finance Officer spoke to the following:

- NEL ICS was reporting year-to date deficit of £87.2m (ICB £9.1m, providers £78.1m), which is a variance to plan of £53.2m.
- The year-end forecast was in line with the plan (£35.6m deficit for providers and a £0.6m surplus for the ICB).
- The key drivers for overspends at a provider level.

Provider Update: London Ambulance Service Performance Report

Alex Ewings. Associate Director of Ambulance Operations (NEL) spoke to the following:

- North East London performance report.
- Category 2 response times across London.
- Our performance across NEL in numbers.
- Other updates from London Ambulance Service.
- Support us to place defibrillators in your local communities.
- The communities in North East London in need of at least one Defibrillator.

Provider Update: Barking, Havering and Redbridge University Hospital NHS Trust

Fiona Wheeler, Chief Operating Officer and Deputy Chief Executive, BHRUT spoke to the following:

- Urgent and emergency care.
- Patients with mental health needs.
- Reducing our waiting lists.
- Finance.
- Cancer targets in July.
- St George's Health and Wellbeing Hub.
- Other news.

Provider Update: North East London Collaborative updates

Paul Calaminus, CEO (NELFT) spoke to the following:

- Mental Health, Learning Disability and Autism Collaborative.
- Community Healthcare Collaborative.
- Collaborative Priorities.
- Service user and carer priorities.
- Latest updates - Mental Health Crisis Support, Special review of mental health services at Nottinghamshire Healthcare, Additional areas of note.
- Improvement networks, updates and key updates.

Focus on Specialised Services

Archna Mathur, Director of Specialised Services and Cancer, NEL ICB spoke to the following:

- What are specialist services.
- How are specialised services currently commissioned, how this is changing and why.
- Why NHSE is delegating commissioning to ICBs – the benefits & opportunities.
- Specialised Service Transformation: Clinical Networks and examples of end to end pathway transformation.
- What happens next.

Best start in life: shaping future maternity and neonatal services

Diane Jones, Chief Nursing Officer, NHS NEL spoke to the following:

- Introduction.
- The programme so far.
- Case for change summary.
- How we engaged the public.
- Public feedback on the case change.
- Next steps.
- Engagement and decision making stages.
- Projecting Maternity Demand from NEL population growth.

The following answers were provided to Members based on their questions:

- Regarding tests in emergency departments for HIV, there were not issues with PREP and this highlighted the work that had the ability to link in with partners and the sexual health strategy with reaching targets and goals that had been nationally set. This meant that better assurances for HIV patients as many measures were put in place.
- In terms of improving access for local people, facility set up and scoping and research of facilities; it was explained that the ideas around the facilities grew out of vaccination centres and that was the thinking of providing a range of services in the Ilford exchange for example. The technique has worked and was not intended to be an impulsive decision. **AP: In regards to the details on the length of lease, Officers would need to come back on that and they would circulate the information to the Committee.**
- In regards to the budget overspend in relation to the Junior Doctors strike. It was confirmed that the figures were for the full year up to August and therefore had been incurred earlier than 31 August; however, the end date for the figures was the 31 August.
- Ambulance delays were like related to the 20/hr speed limits along with other added difficulties ambulances incurred travelling around London and surrounding areas.
- In terms of not spending funds and money allocated within the ICB for supporting both the general practice and PCN, it was explained that SDF primary care spending and project funding was similar to capital funding and therefore was not always in gift to spend. **AP: Officers would provide more details in writing.**
- There were reported increases in 24-hour breeches and especially long waiting times and challenges with high volumes for mental health in NEL and London as a whole. It was explained that this was far from ideal and that these delays meant there was risk of harm. Some of the waiting times were for mental health assessments and other physical health so there was a lot of work to do around trying to understand the reasons and the best way to ensure efficient system flow because the best way to deal with this was not in Emergency Departments (ED) but in systems flows. The winter plan also contained a strategy to tackle long waits.

- In terms of winter planning and ambulance response times it was acknowledged that the 30-minute target locally did not match the 18-minute national targets and more alignment was required. Inroads were being made on winter planning and beyond to ensure there was on-going collective work as a system for post patients and other pathways whilst examining a more strategic and sustainable provisions of ambulance off loads.
- There was also a query on the commissioning of private hospital beds and it was explained that due to the ED wait for mental health of 22 hours private bed use had increased and it was driven by the demand in the mental health crisis. The plans to reduce this included opening additional centres in both Redbridge and Goodmayes; however, the increase would be hard to eradicate completely as waiting times were often related to the complexity and range of factors that needed to be worked through to access. There was a need to adequately assess patients to ensure they received the right care and were sent to the correct facility which often took considerable time due to the often complex factors and many patients being new to the service.
- The delivery of services for learning disabilities and Autism was being implemented; there were now sensory wards at Goodmayes for Autism and there was scope to create capacity for another one. Key workers were employed to improve quality of service and quality of life for these patients. There was also a focus on residential accommodation, physical health and health checks and access to further physical health care.
- Any proposed changes to neonatal care would involve community and clinical colleague engagement.
- The definition of run rate pressure was excess cost where there was excess demand on services.
- Data and results on how the Ilford exchange was alleviating pressure on GP surgeries and impacting on other services in the area was at too early of a stage. **AP: Further modelling and early results would be brought to the Committee in due course.**
- In terms of balancing budgets and patient services, it was explained that there was work on cost efficiency and improvement plans with immense pressure to balance the budget. There was a statutory duty to not overspend; however, where there were clinical safety issues that would take precedent over budgets. The NHS had received 1% above inflation in funding but historically it was 3-4% and with the additional demand due to pandemic and its challenges this was even more difficult. Savings were not always deliverable; however, in relation to the work force there was a push to convert agency staff to permanent staff. All savings were evaluated with both quality and equality impact assessments.
- Overall improvements within BHRUT were due to a programme of work in partnership with other providers to provide preventative care by having the right facilities available in the community by working with staff to process and move patients from EDs into other

emergency care departments and referral by ambulances or GPs to assessment units with appropriate diagnostics and pathways into clinics to ensure those patients were in the right place. The front end of hospitals was impacted if there were not flow programme in place within the back end to ensure teams worked together to discharge patients on time. Real focus in targeting those areas and flow programs in place. It was to be noted that BHRUT had better performance was down to the system partnership and partnership support.

- In regards to cancer patients reduced waiting times for reports and diagnostic letters. **AP: Officers would respond in writing to Councillor Vance.**
- In relation to the national target for category 1 ambulance times and if that was dependent on handover times; it was explained that the national target was 7 minutes and this area's waiting times were slight above that. The good news was that there were not patient harm incidents due to this and if there ever were they would be investigated. There were prolonged in car and system pressures which caused the delayed times; however; there had been improvement made to ambulances are release times. Work around this was on-going and cyclical with system work to ensure this continue to happen.
- As for the Barking and Dagenham pop up clinics, a review of learning was underway to take forward a plan for residents who were not able to access services and also direct them to other services they required.

Special thanks was given to Officers for their presentations and the Committee wished to thank Robby Misir for chairing the meeting.

It was to be noted that Members also requested that questions be asked after each section in a more sequential manner, and that presenters be in person at future meeting to allow for better collaboration and to ensure they were able to allocate more time to the meeting.

RESOLVED that all reports and updates were noted and there were no further recommendations.

Chairman

Havering
LONDON BOROUGH

OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE, 14 JANUARY 2025

Subject Heading:	Health Update
Report Author:	Luke Phimister, Committee Services Officer, London Borough of Havering
Policy context:	Officers will give details on a variety of health issues impacting on residents of Outer North East London
Financial summary:	No financial implications of the covering report itself.

SUMMARY

The update provides highlights and information from various providers within the NHS

RECOMMENDATIONS

1. That the Joint Committee scrutinises the information presented and makes any recommendations or takes any other action it considers appropriate.

REPORT DETAIL

This item will be taken as read unless any urgent business is raised.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

NHS
North East London

Health Update – January 2025

Meeting name: ONEL JHOSC

Presenter: Zina Etheridge, Chief Executive

Date: 14 January 2025

NHS North East London: Update

Our response on the 10 Year Health Plan

In collaboration with colleagues from across our system and drawing on the insights of those who we serve across NEL, we have submitted a consultation response outlining what we want to see in the government's 10 Year Health Plan and how they can make their three big shifts in healthcare a reality. We would like it to include the following which will also help achieve the three shifts:

- Levers to identify issues and patient needs early and address the causes of ill health.
- Methods to improve services that bring together patients, practitioners and clinicians, equalising power to change.
- A focus on patient empowerment so that we can be clear with the people we serve on what they can expect of us or what we expect of them.
- A focus on building trust, embedding the priorities of our local communities, collaboration and leadership within improvement and research agendas.
- A view on allocating resources (human, financial, social) to facilitate change.
- A longer-term capital allocation to facilitate the future investment in infrastructure we need.

We encourage everyone to share their views on the Change NHS online platform, which will be live until Spring 2025.

NHS North East London: Update

Artificial intelligence set to improve outcomes across north east London

Thousands of people across north east London are set to benefit from personalised clinical coaching under a new NHS initiative that harnesses AI technology to better support those living with long-term health conditions.

NHS North East London, in collaboration with Health Navigator and UCLPartners, launched a new, three-year programme, providing preventative care for patients at greatest risk of needing unplanned emergency care. The initiative is designed to identify and better support people with long-term conditions, such as asthma, by helping them stay well and avoid the need for unplanned care. Through advanced AI screening technology, patients who can benefit most will be identified and offered personalised phone-based clinical coaching from healthcare professionals trained in delivering preventative care and self-management techniques. The programme has the potential to stop 13,000 A&E attendances annually.

AI will also help people across north east London who undergo chest X-rays to receive their results much sooner, following the rollout of an AI tool to help boost lung cancer survival rates. North East Cancer Alliance (NELCA) is using the technology to help radiologists and reporting radiographers prioritise urgent cases and enhance decision-making.

By rolling out AI-driven triage to local hospitals, NELCA aims to cut the waiting time for X-ray results from three weeks to just three days for scans with significant findings. This will ensure signs of lung cancer can be detected more quickly and enable patients who need follow-up or treatment to receive timely care – potentially boosting survival rates. It will also provide peace of mind sooner for patients where nothing is found on their scan. The software is now available to specialist teams at all major acute hospitals across north east London under a collaboration between Barts Health NHS Trust, Barking, Havering, and Redbridge University Hospitals NHS Trust, Homerton Healthcare NHS Foundation Trust, imaging IT provider Sectra and health tech company Qure.ai.

NHS North East London: Update

St George's Health and Wellbeing Hub is now open

The new health and wellbeing hub in Hornchurch welcomed its first patients in November when the St George's Country Park Surgery – formerly known as Upminster Bridge Surgery - opened at the site.

Health and care partners have worked together for several years to design the hub, which secured planning approval from Havering council in 2022. It is backed by £17milllion of government funding and £21million from north east London partners.

Once fully operational, the hub will provide access, seven days a week, to a wide range of high-quality health and wellbeing services all in one place; transforming the way health and care is delivered for around 250,000 people in Havering and surrounding areas. As well as a GP practice, this will include outpatient, mental health, children's and community services.

A new Ageing Well Centre will see frail residents supported through a comprehensive assessment service designed to support their physical and mental health needs. Patients will also be able to get scans and other diagnostic tests in a brand-new, purpose-built community diagnostic centre – avoiding the need for extra visits to local hospitals and helping clinicians provide faster, joined-up advice and support as part of the ground-breaking integrated care model that will be pioneered on site. The centre was backed by a further £5.6million in central capital funding.

NHS North East London: Update

Primary care quality outcomes framework

The objective of the Quality and Outcomes Framework (QOF) is to improve the care patients are given by rewarding practices for the quality of care they provide to their patients, based on several indicators across a range of key areas of clinical care and public health.

The latest primary care quality outcomes framework (QOF) data published in August 2024 shows just how well primary care in NEL, supported by colleagues from Queen Mary University of London (QMUL), are doing in some key areas of secondary prevention.

We are ranked first place in England for a number of indicators, including atrial fibrillation anticoagulation which is a great improvement as five years ago north east London was the second lowest in England. Without treatment atrial fibrillation leads to an approximately 30% risk of stroke over ten years but with treatment the risk is halved.

Other key achievements include a number of diabetes indicators, hypertension with blood pressure control and asthma or chronic obstructive pulmonary disease (COPD) indicators. We continue to work with primary care colleagues to improve health outcomes for people across north east London.

NHS North East London: Update

Designing responsive services for local people – NHS 111

We are reviewing the contract for the NHS 111 service in north east London, currently provided by London Ambulance Service. We want to ensure the specification meets the needs of local people, which is why we are asking what currently works well, what doesn't work well and whether anything needs to change.

We have already got lots of feedback from people that have used the service over the last couple of years, which highlights:

- a high level of satisfaction for both support and quality overall
- good communication and attitude, including positive examples from people with autism and learning disabilities who had some good experiences of being communicated with sensitively and appropriately. However, when things don't go as well as they should, communication and attitude is the thing most often identified as the problem
- prompt support and treatment. However, when there are delays – this caused distress and risk.
- NHS 111 does a great job to support services at GP practices and urgent and emergency healthcare to be more joined up for better patient care. However, this can always be improved and people had lots of constructive suggestions to help with improvements.

- We are now asking for views and experiences from our NHS 111 People and Communities Reference Group. Local people from across north east London attended the inaugural NHS 111 People and Communities Reference group in October, and the second meeting is scheduled for January. Members responded to a call out on the NHS North East London Patient's Panel to participate in the group. The People's Panel has over 2,000 people from across north east London who have signed up as interested to participate in health engagement.

We are currently at the early stages of this review and no changes to contracts or decisions have been made. We are committed to ensuring patient experience and voice feed into this work alongside input from clinicians and providers. We will continue to provide updates on the programme and opportunities to feed into this work.

NHS
North East London

Finance Overview

Meeting name: ONEL JHOSC

Presenter: Henry Black, Chief Finance Officer

Date:14 January 2025

To follow

NHS
North East London

Provider Updates – January 2025

NHS
North East London

Barking, Havering and Redbridge University Hospital NHS Trust

Urgent and emergency care

- In November, over 77% of patients were admitted, transferred or discharged within four hours of attending our A&Es which was higher than the London and national average. That month, we saw an extra 100 patients a day when compared to the previous November.
- This placed us 3rd out of 18 acute trusts in London and 16th out of 122 trusts in England.
- Our Type 1 performance (those who are most seriously ill) was 53.61%.
- We also saw more than 100 extra LAS ambulances per week in November 2024 (1,097) than we did in the year before. There would have also been arrivals from the East of England Ambulance Service.
- We're continuing discussions around the securing the £35m we need to redesign Queen's A&E which is crucial to helping us end corridor care.
- Elderly patients are now being seen in our new Ageing Well Centre at St George's Health and Wellbeing Hub, which will help keep them out of our A&Es and see them cared for in a more suitable environment.

Patients with mental health needs

- 363 patients referred to mental health services from our A&Es in November. Their average A&E stay was 22 hours.
- Our priority this winter will be to do all we can to reduce harm to patients and staff in our A&Es.

Reducing our waiting lists

- As of the end of November, 60,170 patients were on our waiting list, around 90% of them were waiting for an outpatient appointment and 1,082 had been waiting over a year.
- In the same month, we tripled the number of cataract surgeries on multiple days to help treat these patients quicker.
- Women, many needing gynaecological appointments, account for 79% of those who've waited more than 52 weeks. Our new Women's Health Hub in Ilford will help tackle our waiting lists.
- In September, our gynaecology teams held a super month where they treated 123 women, 80% of surgeries were major procedures.

Finance

- We ended November with a deficit of £23.7m, adverse to plan by £12.8m.
- Our work over the coming months will be carried out in the context of the difficult financial situation facing our Trust; the healthcare system in NEL, which is under a high level of scrutiny; and the NHS more broadly. We are working with the NEL Integrated Care Board and NHS London to implement a number of financial controls that are required by NHS England.

Cancer targets in October

- We met all three cancer targets - 28-day Faster Diagnosis Standard (75%); 31 days (96%); and 62-day (70%)
- Our second Community Diagnostic Centre at St George's has now opened
- We're running an innovative project to speed up diagnosis of mouth cancer using clinical photography
- Our use of Artificial Intelligence (AI) in chest x-ray results is reducing wait times from three weeks to three days to detect cancer

Other news

- Health Secretary Wes Streeting inspired by our work to help young adults with learning disabilities get into work.
- Professor Andrew Deaner is our new Chief Medical Officer.
- Bluebell A became our third ward to achieve gold in our ward accreditation scheme and the first at Queen's.
- We held our first Global Health event to celebrate the work our teams have done across the world to improve healthcare systems where we hosted the Tanzanian High Commissioner and Health Minister.
- We opened a new state-of-the-art CT scanner at Queen's that treats patients quicker and provides more accurate diagnosis.
- Apprenticeship success as we're the first NHS trust in the country to achieve The 5% Club's gold standard.

NHS
North East London

North East London Collaborative updates

Mental Health, Learning Disability and Autism Collaborative

Introduction

The North East London Mental Health, Learning Disability and Autism (NEL MHLDA) Collaborative is a partnership between the NEL Integrated Care Board (ICB), East London Foundation Trust (ELFT), North East London Foundation Trust (NELFT), and the seven place-based partnerships.

The aim of the 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.

Approach

We collaborate closely with service users and carers, communities, local authorities, primary care and the voluntary and community sector. The Collaborative includes a joint committee to carry out functions associated with investment, and the Programme Board to develop and deliver the Collaborative programme.

Community Healthcare Collaborative

Introduction

The North East London NHS Community Collaborative (NELCC) aim is to improve community health services by working collaboratively across NHS trusts, local authorities, and other healthcare providers including, East London NHS FT, North East London NHS FT, Homerton Healthcare NHS FT and Barts Health NHS Trust. NELFT CEO, Paul Calaminus is the SRO for the NELCC.

The collaborative focuses on delivering more integrated, person-centred care, improving outcomes for local populations, and enhancing the efficiency of community health services in the region. Through this partnership, they aim to address health inequalities and ensure that patients receive the right care in the right place at the right time.

Approach

To maximise benefits, it is advantageous if we - NEL providers - work together to reduce variance, improve equal outcomes for local residents, share best practice and provide mutual aid. The CHS collaborative can continue to add value as the coordinator, enabler and conduit for community care in NEL. It brings together PLACES and providers to progress system wide solutions, share local learning and ensure impacts of potential decisions are fully articulated to give a NEL wide umbrella position to NHSE.

Mental Health, Learning Disability and Autism Collaborative Update

Children & Young Peoples' (CYP) Mental Health in North East London (NEL) – Update

Challenges

- CYP with mental health conditions between 2017 and 2023 has doubled.
- Approximately 65,000 CYP in NEL have a probable mental health condition, up from 30,000 in 2016.
- Low-income families are 4.5x more likely to have severe mental health issues and are 10x more likely to be at risk of suicide.

Service developments

- Broadening access to support and maximising the impact of Mental Health in Schools Teams.
- Collaborating with the North Central East London (NCEL) Provider Collaborative to support those with mental health crises.
- Improving support for CYP with neurodevelopmental needs.

Addressing challenges

- Ensuring future investment takes into account historic under investment.
- Recognising impacts of poverty and diversity when setting ambitious goals.
- Working with local authorities to enhance and expand integration.
- Prioritising investment in self-harm prevention.
- Championing development of a NEL-wide CAMHS service specification and standard operating procedure.
- Ensuring we have the right clinical, lived experience and management capacity to drive CYP mental health transformation programme.

Mental Health, Learning Disability and Autism Collaborative Update

North Central and East London Child & Adolescent Mental Health Services (NCEL CAMHS) Provider Collaborative – Update

Collaborative is in its fourth year of operation. NHS England delegated commissioning responsibility to ELFT to commission inpatient services for CYP across north central and north east London.

Challenges

- Reducing out of area treatment and length of stay as an inpatient.
- Delivering agreed standards of care and reducing unwarranted variation.
- Investing into community and preventative services.
- Improving outcomes of service users to live life to the best.

Service developments

- Reducing overall patients by 46 per cent in 2023/24 and 47 per cent in length of stay since its formation.
- Approval of mental health specialised delegation to Integrated Care Boards (ICB) by April 2025 from NHS England.

Addressing challenges

- Understanding experiences of service users deemed Clinically Ready for Discharge (CRFD) but are unable to leave hospital.
- Reviewing findings from Learning Disability and Autism Strategic Health Needs Analysis.
- Refreshing Eating Disorder Clinical Strategy and embedding eating disorder clinical pathway.
- Understanding the impact of crisis teams and home treatment teams on admissions.
- Developing a workforce strategy across the footprint.

Mental Health, Learning Disability and Autism Collaborative Update

Intensive and Assertive Community Outreach – Update

In response to Valdo Calocane being convicted for killing three members of the public in Nottingham, NHS England asked all ICBs and Trusts to review its processes and undertake a rapid review of services for people who may not engage well.

Challenges

- Identification and holding in sight.
- Care co-ordination and planning.
- Policies on disengagement.
- Staff capacity.

Service developments

- Fast tracking flexible access to people with severe mental illness and triaging to more formal services.
- Creating an assessment framework and co-produced care planning tools.
- Creating a personalised model for service users to tailor support to enhance recovery and reduce risk of relapse.
- Using digital tools to categorise risk and acuity
- Providing support for rough sleepers via the Rough Sleeping and Mental Health programme (RAMHP) in inner north east London.
- Using Fast Assertive Community Treatment (FACT) teams to provide rapid step-up for patients at risk.

Addressing challenges

- Building on above positive developments and creating a NEL-wide improvement programme.

Community Healthcare Collaborative Update

Key updates

Improvement networks: Focus areas include working to ensure consistent, core offers for all North East London Residents, sharing best practice and learning, improving clinical pathways and service delivery and reducing waiting times. All the Improvement Networks align to the Darzi 3 shifts of Hospital to Community, Sickness to Prevention and Analog to Digital.

Community Nursing

- Developing a single high-quality service offer with lived experience experts
- Enhancing discharge pathway, e.g. Diabetes care and self-administration of insulin
- Reviewing the joint working between the rapid response team and the community beds
- Finalising the mapping of current patient pathways and developed patient education materials for self-care and support.

Musculoskeletal (MSK)

- Focusing on system-wide transformation to enhance prevention, timely detection, early advice, short waiting times and lifelong care in the community.
- Vision that no patient waits >6 weeks for an appointment in Adult MSK community services.
- The current focus of the network is to reduce the multiple access points by March 2025 and review workforce capacity and capability.

Children's Services

- Developing a core and consistent offer for Children's community nursing
- Developing equal Hospital at Home (virtual wards) access to reduce admissions to hospital
- Neurodiverse pathways- co-designing information materials to provide information and advice to parents of children with autism, standardising the Development Language Delay pathway and from January, streamlining clinical pathways for children who maybe autistic.

Rapid Response

- Developing core and consistent offers e.g. catheter care (as blocked catheters are a common cause of attendances at Urgent and Emergency Care)
- Enhancing joint working with other teams to streamline service offer to residents
- Winter pressures planning with leads to share learning, sharing and good practice.

Community and Intermediate Care Beds

- Developing an equitable and consistent offer for access across NEL and ensuring maximum occupancy to support UEC pressures, given a range of legacy commissioning arrangements across NEL.

Community Healthcare Collaborative Update

Key updates from other programme areas

Joint Planning for 2025/26

- Coordinate a joint approach to Planning to ensure a shared view of opportunities, risks and challenges
- 1st meeting planned January with 40 stakeholders from PLACES, providers, and the third sector.
- To agree core community collaborative strategy and priorities 2025 and provide clarity on income, expenditure, and pressures for our community services.

Promoting the Impact of Community Services (PICS)/Collaboration Across Regions

- PICS collaboration with leaders from North Central London, London ICS, Mid-South Essex, and NHSE policy and quality improvement leads.
- Aim to influence national strategies and establish a core community offer.
- December 2004, focused on plans to develop a ‘core offer’ for community services, national guidance expected during 2025.
- In line with the Darzi review, PICS has supported the development and use of a ‘Shift Left Investment Decision Evaluation Tool’. This will evidence the economic case for change for systems to increase investment in community services (return on investment and demonstrating the system-wide impact).

Latest NELFT Updates

St George's Health and Wellbeing Hub

- The state-of-the-art hub in Sutton Lane, Hornchurch opened its doors in November. Health and care partners worked together for several years to design the hub, which secured detailed planning approval from Havering council in 2022. It is backed by £17milllion of government funding and £21million from north east London partners.

Ilford Exchange

- Official opening and engagement event with local residents and stakeholders at the Ilford Exchange Health Centre. The centre occupying two floors of the shopping complex, has been designed as a 'one stop shop', offering easy access to a range of healthcare, social care and community services in a central location.

Enhanced Integrated Crisis Assessment Hub

- A new hub is under construction at Goodmayes Hospital for all mental health activity generated by the three local emergency departments at King George Hospital, Queens Hospital and Whipps Cross Hospital and will be aligned with the relevant psychiatric liaison teams. The Hub will offer extended 24/7 support alongside existing mental health services to support crisis resolution.

Redbridge Crisis House

- Opening early in the New Year, the Redbridge Crisis House will provide an alternative to acute hospital admission for individuals experiencing a crisis or relapse in their mental health. Delivered in partnership with clinical teams, they provide 24-hour short-term, intensive support, providing a credible community-based alternative to inpatient care for people in crisis as well as short-term transition from hospital to home.

The Havering Speech and Language Therapy team highly commended at the HSJ awards

- NELFT Havering Adult Speech and Language Team and the Havering Place based Partnership's project 'One Voice' was highly commended last night for the Primary and Community Care Innovation of the Year award at the annual HSJ awards. There were only 26 awards and 26 high commendations out of over 1350 entries.

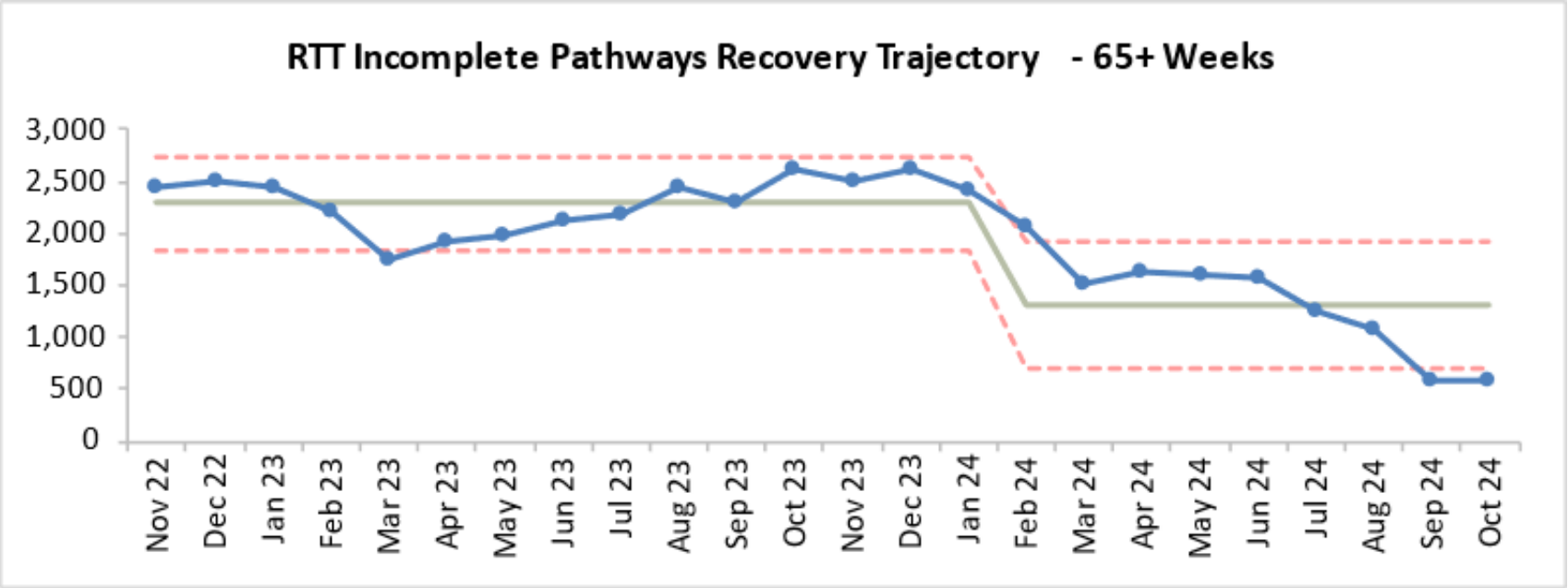
Nursing Times award for international recruitment experience

- NELFT's innovative international recruitment efforts have been recognised with a prestigious Nursing Times Award, celebrating our work in mental health nursing recruitment and pastoral care, delivered in partnership with NEU Professionals.

NHS
North East London

Barts Health NHS Trust

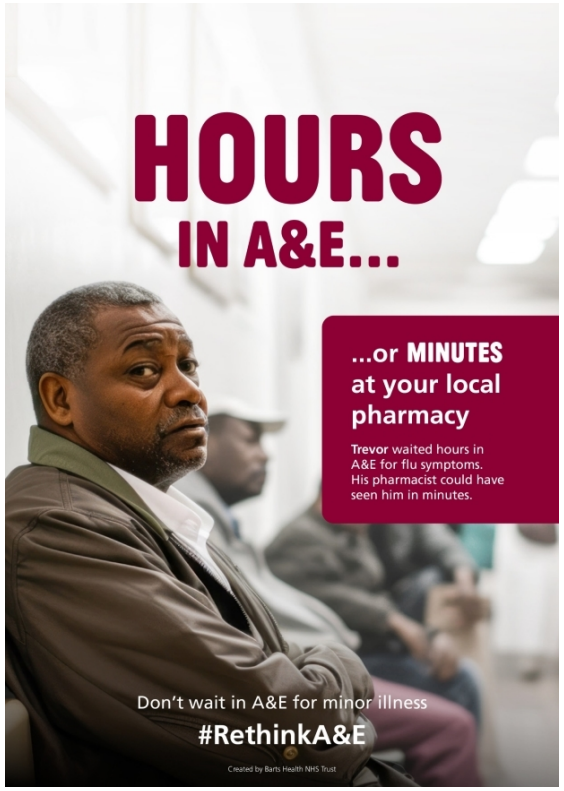
Elective Recovery

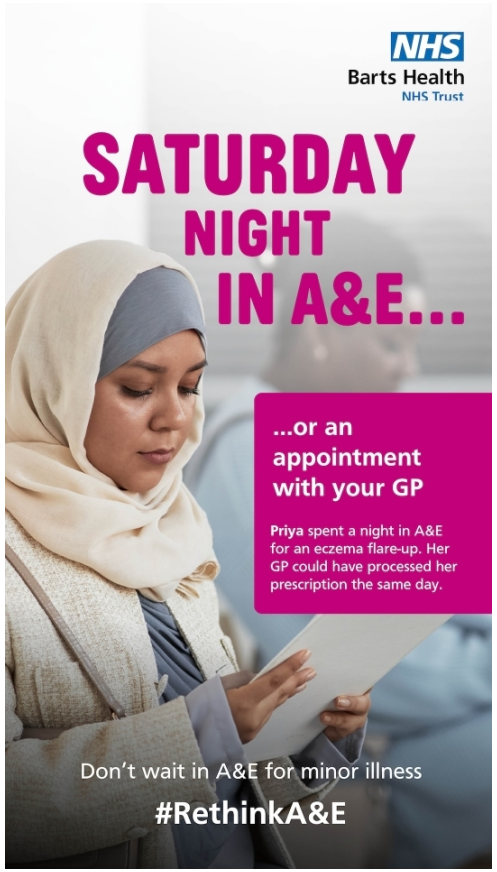


- We are prioritising treatment for our longest waiting patients.
- Over the last 12 months we have reduced the number of patients waiting over 65 weeks from around 2,800 to 588 in October.
- At the end of November, the number of 65 week waiters was just over 330.
- Many of those remaining require more complex surgery and we are working across the system to ensure they receive treatment as soon as possible.

Managing emergency pressures this winter

- We continue to report the highest number of A&E attendances in London, with over 50,000 people presenting in October, about 3,000 more than a year ago. The Royal London Hospital receives 40% of our urgent emergency attendances, with Whipps Cross and Newham Hospitals receiving 30% each. About 10% require hospital admission overnight.
- We are further expanding our Same Day Emergency Care (SDEC) facilities, with a set of new chairs installed at Newham and extra capacity planned at Whipps Cross, meaning more patients can be discharged the same day rather than be admitted. Health Minister, Karin Smyth recently visited Newham Hospital to see hospital preparations for winter.
- Our winter campaign is focussed around urging patients to #RethinkA&E and consider going to a GP or pharmacy instead, in line with the Finding the Right NHS Care messages of our local healthcare partners.
- All of our escalation beds are open, and we have increased the number of virtual ward beds to help keep patients out of hospital.
- We are also working with our partners to establish alternative pathways for patients with mental health issues who don't need to be in ED, while offering enhanced support through specialist nurses for those who do.





Operational updates

- A new initiative using artificial intelligence (AI) and personalised clinical coaching was launched on 12 December by NHS North East London in partnership with Health Navigator, UCLPartners, and Barts Health NHS Trust, this three-year programme will proactively identify patients at risk of unplanned hospital visits and provide them with targeted support. Forecasting models suggest it will significantly reduce A+E attendances and unplanned bed days.
- Patients with autoimmune diseases will have better access to treatment thanks to the opening of a new infusion centre at Mile End Hospital.
- We are delighted to announce that Professor Sanjiv Sharma will be joining us from Great Ormond Street Hospital next year as our new group chief medical officer.

Finance and planning

- We continue to work in an extremely challenging financial environment but are currently on track to deliver our new revised financial plan for 24/25. We are expecting planning guidance imminently for next year which will set out expectations for the coming 12 months
- In addition we expect an announcement on the government's 10 year health plan in the spring of next year

Further updates

- BBC Northern Ireland visited our Women's Health Hub, set up in December 2023 with the aim of reducing waiting lists for gynaecology care, to demonstrate how such services for women are beneficial to society.
- Clinicians from Barts Heart Centre won a Health Service Journal Award for developing a tool to identify patients most at risk of infection after receiving a cardiac device.

Havering
LONDON BOROUGH

OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE, 14 JANUARY 2025

Subject Heading:	Medium Term Financial Strategy
Report Author:	Luke Phimister, Committee Services Officer, London Borough of Havering
Policy context:	Officers will give details on a variety of health issues impacting on residents of Outer North East London
Financial summary:	No financial implications of the covering report itself.

SUMMARY

NHS officers will give details and update on the medium term financial strategy.

RECOMMENDATIONS

1. That the Joint Committee scrutinises the information presented and makes any recommendations or takes any other action it considers appropriate.

REPORT DETAIL

This item will give details on a number of areas relating to the NHS' medium term financial strategy.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

North East London Health & Care Partnership

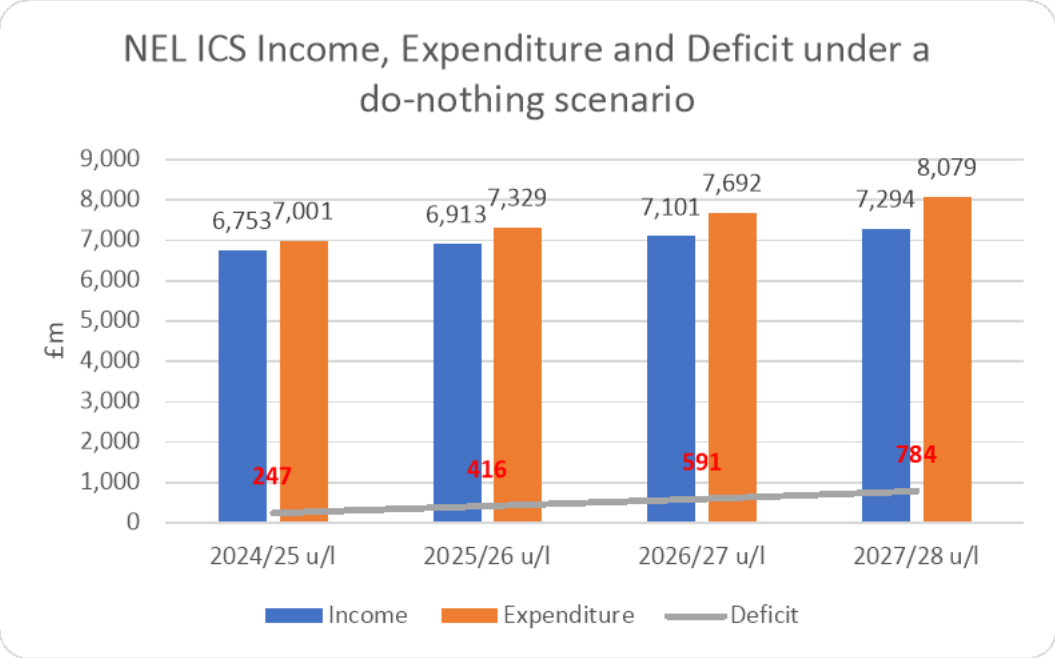
NHS North East London

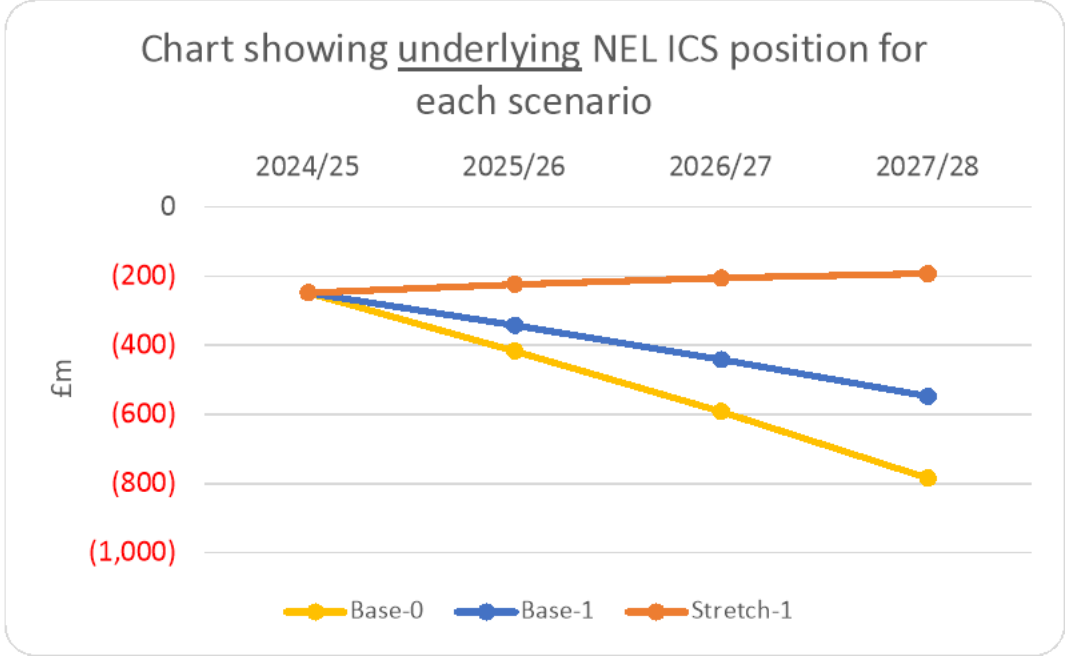
Medium Term Financial Strategy

Outer London Joint Health Overview & Scrutiny Committee

14 January 2025

Current system income and cost baseline





- The exit underlying position for NEL for 2024/25 is a deficit of £247m. Work will continue for the remainder of this year to reduce the exit underlying deficit.
- The NEL system is committed to delivering a sustainable recurrently balanced financial position over the medium term.
- The implication of a 'do-nothing' scenario is shown in the first chart above. This scenario assumes no efficiencies and that there will be a significant growing deficit. The second chart shows the underlying position under three forecast scenarios (Base-0 i.e. the 'no-nothing' scenario, Base-1 which assumes a level of savings equivalent to national pressures only and Stretch-1 which assumes a level of savings equivalent to that planned for the current year. As the Stretch-1 scenario only shows a modest improvement to the underlying position, it is clear that the current approach is insufficient to return the system to balance and that either more fundamental change in the delivery of services or cuts to the services offered will be required.

figures are based on the v3.7.1 of the Core Financial Model

System wide approach to efficiency programmes

The MTFS will build upon existing system working and financial recovery mechanisms to ensure we have a mixture of organisational, collaborative and system wide activities, as well as a combination of efficiency initiatives and transformational change programmes all underpinning our financial sustainability work.

The selection of the transformation schemes will be driven by the adoption of Population Health Management (PHM) modelling which will seek to identify service user groups with the highest spend and accurately forecast the potential saving from each service transformation. The four efficiency programme areas under the MTFS are:

Local organisation cost improvement programmes	Collaborative cost improvement programmes	System pathway transformation programmes	System led strategic transformational and structural programmes
Provider level savings schemes e.g. • WTE reductions • Productivity and efficiency • Non pay savings	Groups of providers coordinating action to generate greater opportunities for reductions e.g. • Procurement • Back office consolidation • Strategic estates management • Creation of NEL wide bank	Pathway transformations of existing services at specialty or individual provider level e.g. • MSK • Diagnostics • Dermatology	Systemwide transformational or structural programmes e.g. • Proactive Long Term Condition management in the Community • UEC flow and discharge • Think Home First frailty pathway programme

Increasing in value over the medium term

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Havering
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OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE, 14 JANUARY 2025

Subject Heading:	Long Term Conditions
Report Author:	Luke Phimister, Committee Services Officer, London Borough of Havering
Policy context:	Officers will give details on a variety of health issues impacting on residents of Outer North East London
Financial summary:	No financial implications of the covering report itself.

SUMMARY

NHS officers will give details and update on Long Term Conditions.

RECOMMENDATIONS

1. That the Joint Committee scrutinises the information presented and makes any recommendations or takes any other action it considers appropriate.

REPORT DETAIL

This item will give details on how the NHS is planning to develop a system wide approach to reducing the risk and management of Long Term Conditions.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

North East London Health & Care Partnership

NHS North East London

Developing a system wide approach to reducing risk and management of Long Term Conditions

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

January 2025

Introduction

This Slidepack sets out how we are working as a system to support everyone living with a long term condition in North East London to lead a longer, healthier life and to work to prevent conditions occurring for other members of our community. Our aim is to improve outcomes and tackle health inequalities with and for the **681,144 people in NEL (or 34% of the population aged over 15 years and over)** who are diagnosed with one or more long term condition.

Long term conditions is an umbrella term for a wide range of conditions with no cure currently. The impact of these conditions on those affected can often be alleviated or delayed when identified early and managed effectively, and some of them can also be prevented entirely through healthier behaviours. As the definition provided by the Department of Health and NHS is wide, multiple interpretations of specialities are included within the long term conditions definition, including severe depression and cancer. We are working collaboratively with a wide range of partners and with programmes across the system in recognition of the broad scope and the need for prioritisation and delivery of our key areas of focus.

In this Slidepack we focus on the prevention and management of those specialities which are NEL's core areas of focus in 2024/25 and map our future priorities for the years ahead: Diabetes and Cardiovascular disease

Background

Social determinants of health are known to have an impact on 80% of chronic disorder health outcomes. Across North East London, areas of significant deprivation are linked with an increased prevalence of long-term health conditions, longer years in ill health and lower life expectancy.

The pandemic and the increased cost of living have disproportionately affected our population in NEL. People living in deprived neighbourhoods and from specific ethnic backgrounds for example 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 a 30% higher severity of disease
- People of **South Asian ethnic origin are at greater risk of developing Type 2 Diabetes and cardiovascular disease**
- People with an **African or Caribbean family background are at greater risk of sickle cell disease**
- Obesity is a significant risk factor for long term conditions – we know that around **1 in 10 adults in NEL are obese**, a rate higher than the London average. Barking and Dagenham has the highest adult obesity rate in London and that in Barking & Dagenham, City & Hackney, Newham and Redbridge, levels of **childhood obesity are worse than England at reception and in year 6.**

National priorities are focusing on work to address long term conditions

Long term conditions have a national and regional focus as a core component of the Long Term Plan and are one of our four priorities as NHS North East London. Furthermore, as long term conditions are both a symptom and a cause of inequalities, a significant element of our work touches on addressing health inequalities and we support projects such as Core25Plus and the Innovation for Healthcare Inequalities Programme.

Having a long term condition significantly affects employment opportunities. **Approximately 2.8 million nationally people are economically inactive due to sickness**, and individuals with LTCs are less likely to continue working once diagnosed and or symptomatic compared to the general population.

Data from the Department of Health and Social Care (DHSC) reveals that long term conditions are more prevalent among those in unskilled occupations (52%) than in professional occupations (33%). This disparity may be linking their role to risk factors such as respiratory illnesses, sedentary lifestyle such increases risks of cardiovascular disease (CVD) and diabetes

- Long term conditions account for **half of GP appointments**, 64% of all outpatients and over **70% of all inpatient bed days**
- **£10bn a year** is spent on diabetes in NHS; 80% of this budget is spent on treating complications
- Those in the **most deprived 10% of the population are almost twice as likely to die** as a result of cardiovascular disease (CVD) than those in the least deprived
- Dialysis is a key driver of the economic burden of kidney disease, estimated to **cost** the **NHS £34,000 per year per patient in 2023**
- In England there are **1.7 million children and young people** in England with long-term conditions such as asthma and diabetes

Our local population are more susceptible to developing a long term condition, which has a big impact on them and on our health and social care system

Working with colleagues, we have utilised local knowledge, and the whole-population segmentation model as a cornerstone of a population health approach. Segmentation enables a system-wide perspective when considering and understanding needs, planning services or targeting interventions. The population segmentation model has identified:

- Only 19% of patients aged 18-44 have at least one long term condition, while half of those aged 45-64 have a long term condition, 4 in 5 of those aged 65-84 have a long term condition and more than 9 in 10 of those aged 85 and over have a long term condition.
- **A higher proportion of black patients (44%)** have at least one long term condition when compared to white (36%), Asian (32%) and mixed (31%) patients.
- **A higher rate of female patients aged 18 – 64 have a long term condition** compared to male patients, contributing to the overall higher proportion of females with at least one long term condition.

People with a long term condition in the population have higher levels of take up of services and activity across the system. In north east London, this accounts for about a quarter of the population. Analysis has demonstrated impact on the system, but also impact on people's quality of life attending multiple appointments and unplanned services:

- **A&E attendances** by long term condition patients are **almost double the attendance per capita of healthy patients**
- In all places except Newham, the rate of **hospital admissions for asthma (under 19 years) is above the England average.**
- **Emergency admissions per capita** increases **almost fourfold for those with one or more long term conditions.**
- **Elective admissions** per capita are **10 times higher** than those of healthy patients.
- **Outpatient attendance** per capita are **four and a half times higher** for long term condition cohort compared to healthy cohort.
- Patients with a long term condition are almost **three times more likely to have a GP encounter or contact with community services**.

Rapid and Significant Population Growth

The population growth in north east London, driven by population demographics and local housing plans, underpins forecasts that between 2022/23 and 2041/42 the number of people set to be living with one, two, or three long term condition is expected to grow by **20.4%, 34.5%, and 49.3%,** respectively. Barking and Dagenham, along with Newham and the City of London, are forecasted to experience the highest growth in both the general population and the number of people living with long term conditions, **at 51.7%, 42% and 39%,** respectively.

Developing a system wide approach to reducing risk factors and LTC via NEL LTC Portfolio

In light of the Lord Darzi review, which emphasises shifting the focus from treating sickness to prioritising prevention and delivering care closer to home, there is a significant opportunity to collaborate with system colleagues to address the needs of patients with long term conditions. By fostering a preventative approach and enhancing community-based care, we can provide holistic and accessible services that empower patients to manage their health effectively.

The Long Term Condition portfolio is both complex and far-reaching, encompassing every aspect of the North East London system. Across the seven boroughs in NEL, local priorities are shaped to meet the specific needs of their populations and deliver sustainable healthcare. Meanwhile, the NEL programme focuses on driving large-scale national and regional projects, facilitating transformative initiatives, and providing support to local areas in delivering their tailored projects.

Speciality – CVD, Diabetes and respiratory
Pathway – prevention and secondary prevention including early identification, stratification and medicine optimisation

Speciality – CVD, Diabetes, respiratory CKD
Pathway – prevention, secondary prevention and coordination of care

Speciality - healthy weight and obesity. Further work on speciality level
Pathway – better management of people living with LTCs, improved diagnosis

Speciality – CVD, Diabetes and respiratory
Pathway – prevention and secondary prevention, including early identification and optimisation

Speciality – CVD, Diabetes and CKD
Pathway – prevention and secondary prevention including early identification and optimisation

Speciality – CVD, Diabetes and respiratory
Pathway – secondary prevention including early identification and stratification and condition management

Speciality - Focus on hypertension, diabetes and respiratory. Along with a healthy weight and obesity across B&D
Pathway – prevention and secondary prevention including early identification and optimisation with a key focus on the future of the local incentive scheme

Developing a system wide approach to reducing risk factors and LTC via NEL LTC Portfolio. Cont

The newly established NEL Long Term Condition Strategic Board brings the system and place perspectives and work together, along with partners across NEL to develop a comprehensive understanding of long term conditions in NEL, which informs our decisions related to the allocation of long-term funds and resources to support the transition to upstreaming services. Chaired by Mathew Cole, Director of Public Health in London Borough of Barking and Dagenham and Charlotte Pomery, Chief Participation and Place Officer at NEL ICB, the board focuses on:

- Share expertise and research on preventing residents from developing Long term conditions, and if they do, **reduce the likelihood of developing co-morbidities** through education and early identification of risk factors
- Bring together **learning through listening to communities** to understand how we can support people in managing their own conditions and support careers
- Design **more joined-up and sustainable services**, if desired, commission services across more than one place
- Advocate and work together to **move funding toward upstream prevention and supporting people to live well with a long term condition**

We have structured our end-to-end pathway work into four themes, encompassing the full spectrum of care. This begins with primary prevention of long-term conditions in collaboration with neighbourhoods, local public health teams and the Voluntary, Community, and Social Enterprise (VCSE) sector and extends to tertiary prevention, which focuses on enabling people to live well with an existing long-term condition. The latter involves working with specialised services and social care, addressing the correlation between uncontrolled progression of long-term conditions and the increasing demand for complex care. These specialised services, such as renal dialysis and HIV treatment, cater to a smaller proportion of the population and are set to be delegated to the Integrated Care Board (ICB) in April 2025.

Based on evidence, we have selected two priority areas of focus for the year ahead: diabetes and cardiovascular disease.

Cardiovascular disease:
We see high and growing prevalence in north east London for both conditions across our populations and believe we can work differently and more preventatively to change the outcomes for people with these conditions. This could include for example, work to identify hypertension (high blood pressure) which is the biggest risk factor for cardiovascular disease and one of the top five risk factors for all premature deaths and disability. It is estimated that the prevalence of blood pressure is being underestimated with nearly half of the population with hypertension being unaware that they have it therefore not taking steps to reduce the risk of cardiovascular disease.

Diabetes:
Prevalence of both Type 1 and Type 2 diabetes is increasing across north east London, with a risk of complications and demand for other services.

Why is cardiovascular disease (CVD) our priority?

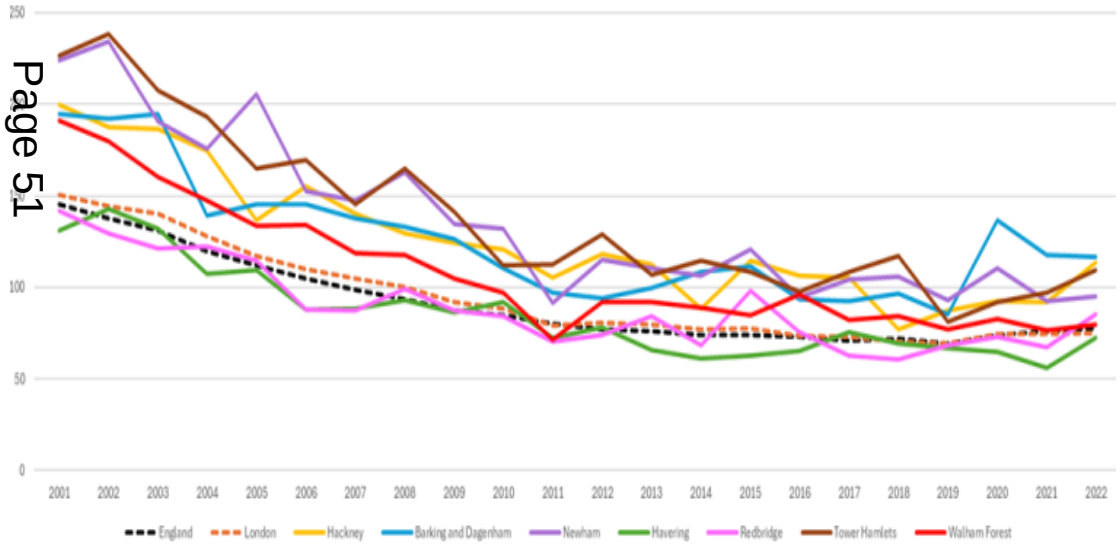
6.6% of people have CVD in NEL which is 127,189 people

(of 1.9m registered NEL patients 18+ in 2023)

This includes all patients diagnosed with at least one of the following conditions, atrial fibrillation, coronary heart disease, chronic kidney disease, heart failure, peripheral arterial disease and stroke.

In NEL the mortality rate for circulatory disease is on a downwards trend aligned to England and London but is **above the England and London value** (per 100,000) in all Places in NEL except Havering (2022).

Mortality rate trend for circulatory disease for all 7 Places across NEL (2001 – 2022)



Cardiovascular disease (CVD) is one of the leading causes of premature death in NEL and in England.

NEL has the **highest under 75 mortality rate** from **circulatory disease** of **all London ICSs** with 92.3 / 100,000 (1,096 people)

Fingertips, 2022

CVD is largely preventable and is often influenced by lifestyle.
1 in 5 people have a diagnosed CVD risk in NEL (hypertension, diabetes, obesity)

There are a wide range of risk factors for high blood pressure, including a range of lifestyle factors such as smoking, excessive alcohol, excess salt, unhealthy diet, obesity and physical inactivity. Those that are physically inactive are also more likely to have high blood pressure.

- NEL has a **higher proportion of adults who are physically inactive** compared to London and England.
- **~1 in 10 adults in NEL have obesity** which is higher than the London average (~191,300). Barking and Dagenham has the highest adult obesity rate in London.
- People with **SMI have a 53% higher risk of having CVD** and **85% higher risk of death from CVD.**
- **Hypertension is the biggest risk factor for CVD** and is one of the top five risk factors for all premature death and disability. It is estimated that the **prevalence of blood pressure is being underestimated** with nearly **half of the population with hypertension may be unaware** that they have it therefore not taking steps to reduce the risk of cardiovascular disease.

Those in the **most deprived 10% of the population** are almost **twice as likely to die as a result of CVD**, than those in the least deprived

In NEL there is a 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.

- Patients from more **deprived backgrounds and those with Asian ethnicity** are **more likely to smoke** (CVDPrevent).
- People from the **Asian, black, and 'other' ethnic groups were less likely to be physically active** than the national average (Active Lives Survey, 2024). Over 50% of our population comes from a BME background.

Why is diabetes (T1 & 2) our priority?

7,269 NEL population have type 1 diabetes which is increasing and most NEL places have higher prevalence compared to England (2023)

This is 3.0 type 1 diabetes patients per 1,000 registered population in NEL. 51.5% of type 1 diabetes patients in NEL were male.

Place	Population	Type 1 patients (count)	Type 1 patients (rate per thousand)
Barking and Dagenham	256,341	685	2.67
City and Hackney	347,476	1,086	3.13
Havering	295,208	1,174	3.98
Newham	466,174	1,114	2.39
Redbridge	361,836	1,032	2.85
Tower Hamlets	388,624	982	2.53
Waltham Forest	329,351	1,196	3.63
NEL	**2,445,010**	**7,269**	**2.97**

The drive towards transforming type 1 diabetes services has primarily been the consistently poorer outcomes for people with type 1 diabetes (T1DM) compared to people with type 2 diabetes.

People with T1DM have on average a seven year reduction in life expectancy compared to people with T2DM.

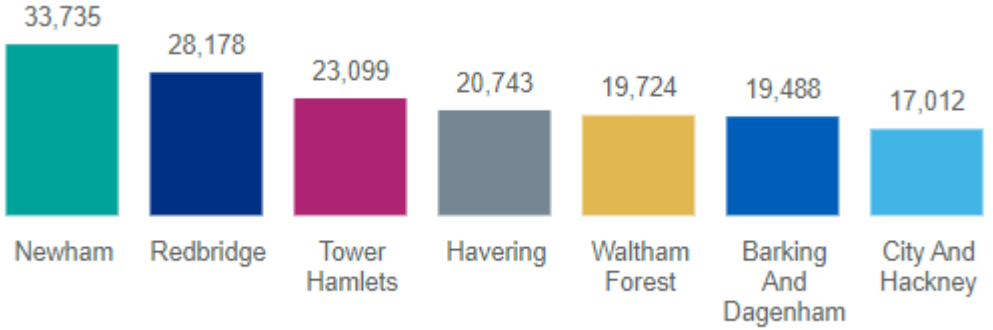
66.4% of the T2 diabetes population and only **35.7%** of the T1 diabetes population received all 8 care processes- this is the worst performing ICB in London (22/23)

Modelling has indicated an expected 63,138 additional residents to be diagnosed with diabetes by 2041/42

7.9% of NEL population have type 2 diabetes which is increasing at a higher rate compared to England and other London ICBs.

£10 billion / year is spent on diabetes in the NHS in England- 80% of this is spent on treating complications. In 2022/23 there were 66m items prescribed for people with diabetes in England, this increased from 42.5m prescription items 10 years earlier (Diabetes UK).

Number of people with diabetes mellitus by borough



Source: Discovery Data Service, NEL CCG system development & data management team, QOF case register, as of July 2024 (161,979 patients with condition)

People of Asian, Chinese, Black African and Black Caribbean ethnicities are 2 – 4 times more likely to have diabetes than White populations- these populations are more likely to develop at lower weight thresholds compared to White ethnicity.

In NEL the number of GP registered with diabetes are:

- 46% Asian or Asian British (73,889)
- 31% white (50,189)
- 17% Black or Black British (27,594)
- 4% 'other ethnic groups' (7,075)
- 2% mixed (2m897)

NHS
North East London

Overview of core themes

1. Primary long term conditions prevention & early identification

The theme recognises individuals experiencing higher levels of socio-economic deprivation tend to have shorter life expectancy and spend a greater proportion of their lives in poor health compared to others. By empowering and enabling residents to lead healthier lives and identify risk factors earlier, we can extend the number of years spent in good health. This not only improves individual well-being but also delivers positive benefits to the local economy and reduces pressure on the health and social care system.

Working in partnership with Local Authorities, the NHS Health Check is an opportunity for people who are aged between 40 and 70 who have no pre-existing condition to meet with a health professional to discuss how to reduce their risk of common long term conditions. Joint working between the organisations has led to 228,762 people in NEL being invited and 87,059 (38%) actually taking up a health check. Whilst take up was above the national average in some places, such as Barking & Dagenham and Redbridge, we're working with Directors of Public Health responsible for health checks across London to identify further opportunities to reduce variation.

Other examples of working with local communities and voluntary and community sector colleagues on prevention and early identification include:

General prevention and early identification including health checks via outreach events for communities/individuals who many are not in regular contact with their GPs:

- Across NEL we're partnering with West Ham United Foundation to delivery health checks focused on renal-cardiometabolic and respiratory at football driven events, community events and faith events, as well as social media events
- In Havering we have been deploying equipment in the community to improve the recognition of cardiovascular risk, which includes automated blood pressure machines and medical grade weighing machines installed at community sites such as phlebotomy clinics (3 in number, average use 1200 pa) and larger libraries (four in number, average use 900 pa). In addition, 100 portable blood pressure machines are on loan at libraries for those who want to control their blood pressure.
- Redbridge Council working with partners including NHS deliver health checks to the local community via Healthy Redbridge Bus
- In Barking and Dagenham the well-attended pop-up clinics continue, including populations more susceptible to long term conditions such as the Afro-Caribbean community

1. Primary long term conditions prevention & early identification (cont.)

We are also working with communities to co-design projects focused on jointly developed priorities for the local community and our system, these include:

- British-Bangladeshis are around twice as likely to have Type 2 diabetes than the general population and are at a higher risk of developing type 2 diabetes from a younger age. Across NEL we're working with the London Bangladeshi Health Partnership to co-design a project focused on developing trust within the community initially with a scope of pregnancy during diabetes
- In Barking & Dagenham, levels of health literacy are the lowest in London meaning some people find reading health guidance and medicine instructions a real challenge. We're working with VSCE colleagues to understand the impact of poor health literacy on diagnosis of diabetes, and these discussions will be used to co-design communication and engagement materials on prevention and management of diabetes
- In Redbridge and Havering work continues with local engagement at locality and ward level to improve outcomes and continue with social prescribing initiatives.

In addition, we have implemented new ways of working which have been informed by our local engagement this includes:

- In Havering, Barking and Dagenham to commission a family-based, multi-component lifestyle weight management service to support childhood obesity in areas of highest deprivation
- Working with Primary Care, we received national funding to make every contact count (MECC) by offering health checks at local dental practices to residents at risk of high blood pressure and AF (Atrial Fibrillation) who live in deprived areas who may not otherwise be in regular contact with a GP
- we have worked with all acute providers, local authorities, Fast Track Cities, and Positive East to screen people who attend A&E for HIV, Hepatitis B and C. 133,127 HIV tests have been performed with 42 new diagnosis, 132,249 Hep B with 90 new diagnosis and 133,373 Hep C with 45 new diagnosis (Apr 24 – Nov 24). There is an increase in testing 6% from Q1 to Q2 (2024) For those identified with HIV, Positive East will work with them to develop a client support plan which includes peer support, housing, immigration advice, food bank advice and, trauma-based psychology services for women and skills-building workshops. Through Homerton Jonathan Mann Clinic Peer navigators are provided (positively UK) often helping to connect people to care, offering additional support such as mental health and housing.

2. Secondary prevention and optimisation

The theme recognises that secondary prevention and optimisation are crucial for reducing the risk of disease progression and long-term complications in individuals with existing health conditions. By addressing modifiable risk factors, optimising treatment, and ensuring regular monitoring, secondary prevention improves patient outcomes, enhances quality of life, and reduces the impact on health and social care.

As part of the long term conditions Local Improvement Scheme (LIS), each place has been working across long term conditions and Primary Care teams with GP Practices, PCNs (Primary Care Networks) and Federations to embed care processes and treatment targets for diabetes, which are part of the National high impact recommendations. National data has highlighted that work related to the local LIS, has enabled improvementand NEL is now ranked highest in England for metrics related to CVD such as Atrial fibrillation, hypertension with blood pressure control and 4 diabetes metrics too.

Other examples of working across the system on optimisation and secondary prevention include:

- **Renal-cardiometabolic** - A total of 160 PCN pharmacists have been trained in early identification and management of CKD and Cardiometabolic patients. The trained pharmacists will play an active role in optimising medicine management in primary care therefore reducing the proportion of patients with end stage renal diseases and cardiovascular diseases, which cost the system over £21.3m in preventable admission per year for heart disease.
- **CKD** - Focused on secondary prevention, the virtual chronic kidney disease (VCKD) is a higher acuity integrated Neighbourhood Team, which has been developed with Barts Health NHS Trust to improve the detection and management of CKD within the community and enable patients to have specialist input earlier in the pathway. On average, only 10% of patients referred to the virtual clinic need a face-to-face hospital appointment, with 45% patients discharged back to their GP with advice to manage their CKD in primary care and the other 45% of patients had virtual follow up by the nephrologist. This approach is being implemented at BHRUT in December 2024, initially testing the approach with Havering Crest PCN, with the aim of expanding across Havering, Barking and Dagenham and Redbridge.
- **Diabetes** - The rollout of The NHS Digital Weight Management Programme offers online access to tier 2 weight management services for adults living with obesity or a diagnosis of diabetes, hypertension, or both to manage their weight and improve their quality of life and longer-term health outcomes, personalised to their needs. We are one of the top performing areas in England, having achieved 81.8% (4,204) of our target (4,830) for 24/25 by the end of October.

3. Co-ordinated care and equability of service

The theme highlights the importance of integrated and co-ordinated care for those living with long term conditions. The feedback from the Big Conversation reflects the need to join up care and move forward with a person-focused approach. Via the NEL long term conditions Strategic Board, we are committed to working with partners and those with lived-in experience to review current provisions and reduce unwarranted variation in care across the pathway to improve health outcomes.

NHSE London has supported ICBs in delivering community-based models of care for patients with sickle cell disease. Working with specialised service team, a pilot has been co-designed with The Sickle Cell Society, and acute, mental health, and community providers are working together to enable better coordination across the boroughs and disciplines, increasing access to holistic care through a multi-disciplinary approach with a new team of acute consultants, pharmacists, psychologists, nursing, and advocacy working together to bring care closer to home and ensure optimal community care reducing acute presentations to emergency departments.

This is conjunction with Sickle Cell Society peer support mentoring service pioneered in NEL and expands into a broader advocacy project involving patients, carers, and link nurses, which has demonstrated at the pilot stage to reduce A&E attendances by 45% and inpatient episodes by 47%.

Other examples of working across the system on Co-ordinated care and equability of service include:

- **Stroke (community)** – Utilising national funding, we have worked with the Community Collaborative to employ rehabilitation support workers to increase the available workforce to support the delivery of stroke rehabilitation in the community and release AHP (Allied Health Professional) time to focus on more complex patient delivery. All teams demonstrated better service user experience, and more people received intense intervention. One team increased ESD provision from two weeks to six weeks, resulting in less demand on overstretched CST services; two teams were able to deliver a longer, more intense intervention (average increase of 3 days) and one team increased rapid pick up by nearly 100%.

- **CVD/Cardiology** – working with specialised services teams in NEL and London and the North London Cardiac Clinical Network, we have implemented a remote platform, which has been used across the cardiology pathway for patients who were deteriorating while waiting for cardiac surgery. These patients had treatment brought forward to reduce potential harm; in doing so, we reduced complications, and cost analysis indicated an average saving of £345 per patient. This has now also been rolled out to patients following a heart failure episodes. A total of 56 patients (20 inpatients and 36 outpatients) were successfully onboarded onto the ORTUS platform in November 2024. A total of 50 patients were successfully offloaded on the ORTUS platform in November 2024.

- **HIV** - Working with Fast Track Cities, implemented GP HIV champions are now in post working to collaborate to provide integrated primary and secondary care and support the stigma charter across organisations in NEL. This work aligns with the NEL wide Sexual Health Strategy, co-ordinated and led by local government colleagues.

4. Enabling people to live well with a long term condition and tertiary prevention

The theme focuses on the practical support and management for people living with long-term conditions, emphasising the need to address complexity and shift away from a single-condition approach. In NEL, 3 in 5 patients with a diagnosed long-term condition have only one condition, while 2 in 5 face multiple co-morbidities, with diabetes and hypertension being the most prevalent. Aligning with the regional strategy, we are working across NEL to implement a renal-cardiometabolic approach. This person-centered model aims to support individuals with, or at risk of, diabetes, cardiovascular disease (CVD), chronic kidney disease (CKD), and liver disease, ensuring holistic and integrated care.

Working with specialised services team and Barts Kidney continue to deliver home dialysis for patients across NEL and continue being highest performing ICB. Further work is planned in Q4 with a roadshow roadshows to boost referrals into the training programme.

In addition, due to housing challenges across NEL, work continues the first of its kind dedicated home therapies/ home from home dialysis unit for self-care, which is due to open in April 2025, and will have dedicated a purpose-built unit for young adults on dialysis to improve their experience, reduce crisis admissions and co-locate with other young adults

Other examples enabling people to live well with a long term condition and tertiary prevention include:

- **Rehabilitation** - We are also working with the Community Collaborative to maximise opportunities for recovery and rehabilitation with a focus on stroke, cardiac and pulmonary rehabilitation. Where possible and supporting people to manage their own health both through prevention and ongoing management. As well as empowering and enabling patients, this supports the system in keeping hospital stays short.
- **Cancer** – As part of the successful cancer prehabilitation services, they have been supporting people with one or more LTCs and providing advise and guidance to reduce risk factors. The care plans help residents achieve the most significant health benefits in the pre-operative period including increasing activity levels, healthy eating, and redirect to local stop smoking, this has had a positive impact for those patients who also had one or more long term conditions. There is a further opportunity to work with the Cancer Alliance are being scoped, as 70% of people living with cancer have one or more long term conditions

Plans for the remainder of 24/25 and 25/26

We continue to focus on our existing priorities, CVD and diabetes, as reflected throughout this paper and further integrating working with colleagues in BI to establish impact and trajectories of local and national project

In addition, the NEL LTC Strategic Board, has agreed to focus on the initiatives below to improve the physical and mental health of people at risk of or living with one or more long term conditions. These are:

Stroke - A recent pan London audit highlighted several key areas for improvement in our local response to stroke focused on achieving national standards in acute and community settings. As result the NEL Stoke Improvement Plan has been co-produced with the Community Collaborative and Acute providers and has demonstrated already improvements in thrombolysis as part of system wide improvement network.

Renal pathway - Working with the London Kidney Network (LKN) and specialised service team, we have commenced a deep dive into renal care across the pathway, including short, medium and long-term options for renal dialysis as well as continuing our focus on prevention and early intervention. We are also modelling the impact that interventions along the pathway will have on the medium/longer-term growth anticipated in dialysis capacity.

Integrated Neighbourhood Working and opportunities to support people with multiple long term conditions via renal-cardiometabolic approach – building on existing work focused on Integrated Neighbourhood Teams, in quarter 4 we will work with colleagues across the system to develop our approach for people living with multiple long term conditions. We will explore a potential model of long term conditions hubs integrated into teams at a neighbourhood level to provide a holistic, patient-centred approach to people living with or at risk of developing multiple long term conditions.

Frailty - In early 2025, we will collaborate with system partners to scope and develop a strategic approach to frailty as a long-term condition, moving beyond an age-specific framework. While frailty is often associated with older age, we recognise that it affects individuals at much younger ages in North East London

Maintaining people with long term conditions in employment - Allied to one of our other ICB strategic priorities, we are keen to develop our approach to ensuring that people most at risk of and living with long term conditions are supported to enter and or to sustain employment where of working age. Working with UCLPartners, we are exploring in 2025/26 if we can quantify the impact of CVD on the North East London local economy, along with personal impact of living with an LTC. This builds on the wider focus nationally to create greater opportunities for economic growth by better alignment of health and wellbeing and employment.

NHS
North East London

Risks and issues

Challenges which require a system wide response

The three key issues and risks for long term conditions are complex and intertwined. Significant population growth and increased complexity are driving cost pressures. A system wide strategic shift toward prevention is essential to mitigate rising secondary care demands and optimise outcomes.

1. Variation in performance and service provision

One main focus of the newly established NEL Strategic Board is to reduce variation across North East London. Addressing variation is complex and requires on-going work between Primary Care Collaborative, Places and NEL and targeted recurrent funding. Non-recurrent projects such as Health Inequality Projects in Barking, Havering and Redbridge have demonstrated improvements in reducing variation and towards national standards but have lost momentum or stopped once non-recurrent funding has finished.

2. Non-recurrent funding

NEL is successful in securing National and Regional funds, but unfortunately, these funds are often non-recurrent, usually lasting 12-18 months. The majority of projects outlined in the paper are reliant on non-recurrent funding, and embedding change after this funding has stopped has proven to be difficult.

3. Investment in upstreaming

Analysis in Newham has provided insight into the cost of long term conditions across the systems and highlighted that investment of 2% of the health budget can potentially mitigate demand growth by 25%, partially within GPs and secondary care. This system approach of reviewing funding and moving it towards upstream activities is a focus for NEL, with system-wide work necessary before savings can be made.

In addition, the Tony Blair Institute for Global Change has estimate that a 20 per cent reduction in the incidence of six major disease categories that are keeping people out of work – cancer, cardiovascular disease (CVD), chronic respiratory illness, diabetes and mental-health and musculoskeletal disorders – would have significant macroeconomic benefits. This “improved-health scenario” could raise GDP by an estimated 0.74 per cent within five years – an annual boost of £19.8 billion – and by 0.98 per cent within ten years, equating to £26.3 billion annually. Annual fiscal savings from increased tax revenues and reduced benefit payments could amount to £10.2 billion and £13.0 billion by 2030 and 2035, respectively.

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