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COMMITTEENAME
AGENDA

MeetingTime	MeetingDate MeetingDate	MeetingLocation

Members 2: Quorum 2

COUNCILLORS:

For information about the meeting please contact:
MeetingContact
MeetingContact_2

AGENDA ITEMS

Ian Burns
Acting Assistant Chief Executive

MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD
Council Chamber - Town Hall
30 July 2025 (1.00 - 2.56pm)

Present:

Elected Members: Cllr Gillian Ford (Chairman) and Cllr Natasha Summers

Officers of the Council: Andrew Blake-Herbert, Mark Ansell, Luke Squires and Samantha Westrop

NEL ICB: Kirsty Boettcher, Narinderjit Kullar, and Luke Burton

Other Organisations: Fiona Wheeler, Lynn Hollis, Vicki Kong (NHS Clinical Director), Anne-Marie Dean (Healthwatch Havering), Carol White, Paul Rose (Voluntary & Community Sector) and Sarita Symon

Present Online: Kurt Ramsden (NECS Pharmacist) and Anthony Wakhisi (Public Health Principal)

21 **CHAIRMAN'S ANNOUNCEMENTS**

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

22 **APOLOGIES FOR ABSENCE**

Apologies were received from Councillor Paul McGeary, Councillor Oscar Ford, Barbara Nicholls, Tara Geere, Patrick Odling-Smee and Neil Stubbings. It was noted that Luke Burton, Luke Squires and Kirsty Boettcher would arrive later.

23 **DISCLOSURE OF INTERESTS**

There were no disclosures of interests.

24 **MINUTES**

The minutes of the previous meeting were agreed as a correct record and were signed by the Chairman.

25 **PHARMACEUTICAL NEEDS ASSESSMENT**

The Board were presented with the Pharmaceutical Needs Assessment (PNA) (NHS Pharmaceutical Regulations 2013).

This PNA examined the current provision of pharmacy services in Havering and evaluated potential gaps in service delivery.

It covered the following areas:

- An overview of the PNA process, including the identification of localities.
- An analysis of current and future health needs.
- A description of community pharmacies in Havering.
- An evaluation of existing service provision, accessibility, and any gaps.
- Insights into potential future roles for community pharmacies.
- An assessment of community pharmacy's contributions to the Health and Wellbeing Strategy.
- Key findings from stakeholder engagement and the statutory consultation.
- A summary of findings and the PNA statement.

The Assessment had the following Conclusions:

Current provision of necessary services:

- There is no current gap in the current provision of necessary services during normal working hours across Havering to meet the needs of the population.
- There is no current gap in the current provision of necessary services outside normal working hours across Havering to meet the needs of the population.
- No gaps have been identified in the need for pharmaceutical services in future circumstances across Havering.

Improvements and better access:

- There are no gaps in the provision of advanced services at present or in the future (lifetime of this PNA) that would secure improvements or better access in Havering.
- There are no gaps in the provision of enhanced services at present or in the future (lifetime of this PNA) that would secure improvements or better access in Havering.
- Based on current information no current gaps have been identified in respect of securing improvements or better access to locally commissioned services, either now or in specific future (lifetime of this PNA) circumstances across Havering to meet the needs of the population.
- Members noted that pharmacies serve broader roles than dispensing and called for greater national awareness.

The assessment requested that members note and participate in the online consultation (link given).

The Board was asked to confirm approval process for the final report as the next HWB meeting will be after statutory publication deadline (1st October 2025).

26 HEALTHY WEIGHT STRATEGY ANNUAL REPORT

The purpose of this annual report is was to provide an overview of the progress made in the first year of implementing the Havering Healthy Weight Strategy (approved by Cabinet in May 2024).

The report served as a review document for the strategy's steering group, comprising key partners across the Council, NHS, CVS, and primary care, and was presented to the Health and Wellbeing Board for further scrutiny and guidance.

The Report was introduced by Mark Ansell and presented by Luke Squires.

The Board noted the achievements, challenges, and next steps from the annual report. The board confirmed their continued support and leadership for the strategy.

Members reinforced the shared responsibility across sectors to help embed healthy weight into broader work on health inequalities and prevention.

27 SUICIDE PREVENTION ANNUAL REPORT

Members were warned that the content of this Annual Report may be emotionally challenging as it discussed suicidality and self-harm.

The report was introduced by Mark Ansell and presented by Samantha Westrop.

It was reported that there had been a significant national increase in the suicide rate in England and Wales, reaching the highest levels since 1999. This rise was observed across both males and females, all adult age groups and particularly among males aged 45–49 and females aged 50–54.

The report stated that in Havering, an average of 18 suicide deaths per year had been recorded over the past decade, with the age-standardised suicide rate remaining higher than the Outer London and Greater London averages (though no longer statistically significant).

The board agreed to keep the following priorities within the report:

1. Adopt and implement a local all-age suicide prevention strategy to ensure best use of local data, intelligence and partnership working
2. Continue reviewing each suspected suicide amongst Havering residents to gather relevant information to inform prevention efforts
3. Gain clarity on the outputs of reviews conducted by wider systems partners and scope possible access to reports with timeline review and

incorporation of finding and recommendations into our local prevention efforts.
4. Scope the possibility of obtaining additional data sources for suspected suicides beyond nRTSSS.
5. Work with GP Practices across the borough to include their expertise in the suspected suicide review panel process.
6. Implement the agreed action plan resulting from the Havering strategy.

The Board approved the recommendations as set out in the report.

28 **NHS 10 YEAR PLAN BRIEFING**

The briefing was introduced and presented by Luke Burton.

The briefing summarised the key elements of the NHS 10 year plan.

Members noted three major shifts and five enabling reforms.

Shifts:
1. From hospital to community
2. From analogue to digital
3. From treatment to prevention

Reforms:
1. A new operating model
2. Enhanced transparency of quality of care
3. Workforce transformation
4. Innovation and technology
5. Financial sustainability

The briefing stated a strong focus on prevention, and development of Integrated Neighbourhood Teams – adopting a population health approach to supporting local people at a neighbourhood level.

Members noted and discussed the details of this update, setting out the key elements of the NHS 10 Year Plan, and the implications for the London Borough of Havering, and Havering Team at Place.

Chairman

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HEALTH & WELLBEING BOARD

Subject Heading:	Draft NHS System Strategy and Outline Commissioning Intentions
Board Lead:	Charlotte Pomery, Chief Strategic Commissioning Officer
Report Author and contact details:	Lee Walker, Head of Strategic Planning and Impact, lee.walker4@nhs.net

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

☐	The wider determinants of health • Increase employment of people with health problems or disabilities • 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. • 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 • The prevention of obesity • Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups • Strengthen early years providers, schools and colleges as health improving settings
☐	The communities and places we live in • Realising the benefits of regeneration for the health of local residents and the health and social care services available to them • 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 • Development of integrated health, housing and social care services at locality level.
☒	BHR Integrated Care Partnership Board Transformation Board • Older people and frailty and end of life • Long term conditions • Children and young people • Mental health • Planned Care Cancer Primary Care Accident and Emergency Delivery Board Transforming Care Programme Board

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SUMMARY

The ICB has been working in line with national planning guidance to complete the 'foundational stage' of the NHS medium-term planning process. This culminates at the end of September with the dissemination to providers of **outline commissioning intentions for 2026/27**.

The package of materials issued to providers on 30 September to meet the requirements of the planning process included a **refreshed system strategy** and **data and evidence pack**; which were intended to accompany the commissioning intentions.

In the next stage of the planning process the system strategy will progress towards approval via the ICB Board and ICP Committee; and NHS organisations in NEL will be asked to reflect on strategies and plans that have been refreshed in the initial stage, and then work together to develop outputs which are submitted to NHS England for validation:

- Strategic commissioning plans covering a 5 year period
- Integrated delivery plans covering a 5 year period
- Detailed templates covering activity, performance, financial and workforce information for the initial year (2026/27)

RECOMMENDATIONS

The Health and Wellbeing Board is recommended to:

1. Note the contents of the documents at the completion of the initial phase of the NHS planning round

2. Comment on the approach expressing a view on the following:
   - (i) Does the strategy cover the core aspects we should emphasise as a system and is anything critical missing?
   - (ii) In what ways can we fully utilise an Outcomes and Equity framework in our system?
   - (iii) What are the collaborative ways of working we want to hold onto as a whole system to deliver our new strategy?
   - (iv) Given the status as precursors to the final strategic commissioning plans, are there any important concerns or initial input you have regarding the commission intentions?

REPORT DETAIL

1. Introduction and Background

1.1 The ICB has been working in line with national planning guidance to complete the 'foundational stage' of the medium-term planning process. This culminates at the end of September with the dissemination to providers of outline commissioning intentions for 2026/27.

1.2 The ICB has developed a suite of products to sit alongside the commissioning intentions to create overall clarity on priorities and expectations for the period ahead. These materials consist of:

- **A data and evidence pack**, collating and presenting a range of evidence to support the medium-term planning process. This is an evolving product which will continue to develop in order to create a common evidence base to support system planning. This has been issued to providers to support their planning processes and for feedback on coverage and appropriateness of the data.

- **A draft of a refreshed system strategy** for North East London, which has been developed with engagement from a range of partners. The strategy sets out key priorities for the system in the context of the population health challenges we face and the evolving national policy context. This has been issued to providers for ongoing feedback and engagement with the aim of agreeing a final version in November. A copy of the draft strategy is attached at Appendix A.

- **A comprehensive set of commissioning intentions** for the period ahead, covering all of the key commissioning areas overseen by the ICB and framed within the context of an over-arching commissioning plan. Each commissioning area has produced a detailed plan along with a headline summary of key priorities. This has been issued to providers to inform planning and contracting arrangements for the period ahead. A copy of the headline commissioning intentions is attached at Appendix B.

- **A summary of proposed commissioning changes** which will impact on contracting arrangements for 2026/27. The purpose of this is to give providers the required 6 months notice of contractual changes in line with guidance. This has been issued as formal contractual notices on a provider specific basis alongside the wider commissioning plans.

1.3 The package of materials was issued to providers on 30 September in order to meet contractual timeframes and the requirements of the planning process. The evidence pack and system strategy will be subject to ongoing development, and the commissioning intentions will be developed into more detailed commissioning plans as part of the next stage of the planning process.

1.4 In the subsequent developmental stage of the medium term planning process NHS organisations are asked to reflect on the strategies and plans that have been refreshed in the initial stage, and then work together to develop:

- Strategic commissioning plans covering a 5 year period
- Integrated delivery plans covering a 5 year period

- Detailed templates covering activity, performance, financial and workforce information for the initial year

1.5 The exact requirements will be confirmed with the publication of national planning guidance expected later in November.

2. Proposal and Issues

2.1 At this point in the process the ICB is engaging with partners across the system to help inform how the planning document are developed and help with system alignment.

2.2 While the funding resource allocation for 2026/29 and the final planning guidance has not yet been confirmed, and that means the national objectives are still subject to clarification, it means we have the opportunity to collect feedback that will inform the next stage of the process.

2.3 The Health and Wellbeing Board and ICB Sub-Committee is therefore being asked to comment on the approach expressing a view on the following:

(i) Does the strategy cover the core aspects we should emphasise as a system and is anything critical missing?

(ii) In what ways can we fully utilise an Outcomes and Equity framework in our system?

(iii) What are the collaborative ways of working we want to hold onto as a whole system to deliver our new strategy?

(iv) Given the status as precursors to the final strategic commissioning plans, are there any important concerns or initial input you have regarding the commission intentions?

3 Approval process and timeline

3.1 The system strategy is following an ICB and system approval path via:

ICB Board – 25 September 2025
ICB Population Health Improvement Committee – 1 October 2025
ICB Board on 27th November
ICP Committee on 8th January 2026

3.2 The indicative national timeline for medium term planning activities is:

Publication of the planning framework guidance and clarification of planning outputs –November
Development of integrated commissioning, operational, financial and workforce plans – November
System triangulation and regional dialogue – December
Full plan submission – end of December
Regional assurance process – January
Full plan acceptance – February

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IMPLICATIONS AND RISKS

4.1 **Joint Strategic Needs Assessment**

The assessment of health needs will use JSNAs as a source of information and commissioners will use this alongside the data and evidence pack.

4.2 **Health and Wellbeing Strategy**

NHS organisations have been informed that separate guidance will be released in relation to the Better Care Fund for 2026/27 and that planning for the BCF will be for one year only pending a more fundamental reform of BCF priorities starting 2027/28.

4.3 **Financial Implications**

In this planning round the NHS resource allocations for 2026 to 2029 (3 year) will be confirmed alongside the release of the final planning guidance. The ICB finance team are attempting to estimate the cost of the commissioning intentions at the present time and, based on what we expect to receive in 2026/27 and the month to date 2025/26 position, make a conclusion on whether the NEL system will continue to be in deficit next year.

4.4 **Legal Implications**

No legal issues raised.

4.5 **Risk Management**

It is important for the ICB and NHS organisations to comply with the NHS medium term planning process as well as make the most effective use of resources as out disposal.

BACKGROUND PAPERS

- Appendix A - Draft NEL System Strategy
- Appendix B - Outline Commissioning Intentions
- Planning framework for the NHS in England, Version 1, 10th September 2025 (NHS England » Planning framework for the NHS in England)
- NHS 10 Year Health Plan for England: fit for the future, 3rd July 2025 (10 Year Health Plan for England: fit for the future - GOV.UK)

- Update on the draft Model ICB Blueprint and progress on the future NHS Operating Model, 29th May 2025 (NHS England » Update on the draft Model ICB Blueprint and progress on the future NHS Operating Model)

DRAFT IN DEVELOPMENT (v4)

Improving equity and outcomes for our population in North East London

A refreshed strategy for the ICS

September 2025

Foreword from Dame Marie Gabriel

In 2022 Partners across North East London committed to a shared ambition to “work with and for all the people of North East London to create meaningful improvements in health, wellbeing and equity”. Our shared endeavour, underpinned by a determination to “improve quality and outcomes, create value, secure greater equity and deepen collaboration”, continues to define our approach to strategic commissioning.

Our first system strategy in 2022, highlighted our four system priorities: **babies, children and young people; long term conditions; mental health; and employment.** It also focused on ***how*** **we would work together** as a system, with and for the people of North East London:

- **co-producing** with local people and communities;
- tackling **health inequalities** and shifting our approach upstream to support greater **prevention**;
- ensuring the services we deliver are **personalised** and focus on what matters most to each individual;
- developing our approach as a **learning system** to increase the impact we have on quality, outcomes and equity;
- and working towards a **high trust environment** supporting collaboration across all partners and building trust with local people.

Working together in these ways we have achieved a lot...

Neighbourhoods defined in all places with local partners working collaboratively in alignment with our agreed system vison

Development of the VCSE Collaborative recognising the key role partners have to play in creating health in communities and tackling health inequalities

Our focus on improving primary care led to North East London achieving the best performance in the country for 12 of 48 measures in the national Quality and Outcomes Framework last year

Circa £6m dedicated to tackling health inequalities within all of our places and at the system level through the Health Equity Academy

Consistently secured the benefits of working together across NEL with LA partners e.g.. joint approach to analytics securing shared understanding of population health

£490k secured as part of *Get Britain Working,* to engage, train and employ local people in healthcare - focusing on underrepresented groups.

Big conversation with local people leading to Resident Success Measures, Good Care Framework and the integration of community insight to our work

NEL ICS is now the highest performing in England for five indicators in CVD/Stoke, three diabetes and one respiratory QOF (Quality Outcome Framework)

Testing AI innovation to prevent urgent or emergency hospital admissions, keeping more people well in the community

New mental health and community facilities with models of care co-designed with local people eg. Barnsley Street, St George's

Foreword from Dame Marie Gabriel

We are proud of our joint successes, but understand there is more to do. This includes ambitions to secure greater equity, both within North East London and between NEL and the rest of London and the country. We came together in 2024 to develop our anti-racism strategy, recognising the unacceptable and avoidable health inequalities that individuals and diverse communities experience as a direct result of their ethnicity. **Tackling racism and securing greater equity for our diverse population will remain a core commitment for all of us in NEL.**

We are increasingly working towards delivering **better population health outcomes** as a system, as defined by residents through their ICB **Success Measures** and the **Good Care Framework.** As part of our population health approach, we will retain our focus on **tackling health inequalities** and **securing greater equity** for all local people. While the national context has changed significantly since the ICB was established, many local challenges persist. Our diverse, economically challenge but hugely aspirational **population continues to grow at the fastest rate in the country**, while also **changing demographically** – ageing rapidly in places where historically we have had a relatively young population and doing the reverse in other places.

The people of North East London continue to drive our work: most recently they have guided us on how to deliver the three 'big shifts' in our area. They are also shaping the way care and support works in their neighbourhoods so that it meets their health ambitions. **We are steadfast in our commitment to work in partnership with local people across communities:** enhancing the agency of our communities, to building on their strengths, assets and resourcefulness, and embracing community power and resident led action, all central to our approach to improving health outcomes and moving towards prevention and greater equity.

Being true to the needs and aspirations of our population also means that the **money we have should be allocated equitably** to meet our greatest needs. Our system strategy focuses on how we can ensure over time that our resources are distributed fairly, optimising our impact on prevention, and that we can release funds to support new ways of working driven by our **clinical and care professional leaders**.

Finally, following a period of what has at times felt like relentless change, it is important to **restate our commitment to working as a system with and for local people,** collaborating effectively as partners across NEL.

*As chair of the ICB and the wider system partnership, I look forward to our **continued collaboration and progress** towards **improving quality of care, population health outcomes and equity for the people of North East London.***

Executive summary

- **North East London is a vibrant, diverse and resilient set of communities across seven places.** Partners including local authorities, NHS organisations, and a thriving voluntary sector work together with communities to address a range of issues which lead to relatively poor health outcomes and high levels of health inequalities, Our health system needs to change to respond to rapid and significant population growth with increasing demand and complexity posed by long-term conditions and chronic disease.
- Our new system strategy focuses on the fast growing and changing needs of our population: our **NEL Outcomes and Equity Framework** draws on the outcomes that local residents have told us are important to them and our system approach to commissioning and resource allocation will increasingly take account of population health need in line with improving outcomes.
- Our focus will be on **a shared set of priorities**: identifying risk and providing support at an early stage in order to prevent ill health; joining up care and support with patients and residents having more control over their health; getting the basics right in line with our **Good Care Framework**, and improving equity of access and outcomes for our population. The growing use of a range of digital tools and the innovative use of data will be vital to making these changes happen.
- There are already many examples of this approach in action in NEL: the *Health Navigator* programme is using new techniques to identify patients at risk of hospital admission and intervening earlier to provide support in the community; our women's health hubs are providing joined-up and accessible care in new settings, and our ELoPE cardiovascular prevention programme is helping to improve outcomes and address health inequalities. Our strategy, **driven by clinical and care professional leaders** across our system, focuses on embedding evidence, scaling up what works in our system while continuing to innovate.
- Unlocking change at the scale and rate that is needed to address our population health challenges will mean **moving resources to where need is greatest and releasing funds to support transformation** and new integrated ways of working. Our strategy describes a new approach to resource allocation and the creation of a multi-year transformation fund to support prevention, integration and innovation. Northeast London does not receive its fair share of revenue funding and is badly short of capital relative to other areas; we will continue to make the case for **increased investment in our area**, particularly in light of the unique level of population growth we face.
- Whilst this strategy focuses on the NHS commissioning portfolio we will continue to work closely as a system through **a thriving partnership across the NHS, local government, the voluntary, community, faith and social enterprise sector and our communities and residents**. This strategy describes a refreshed system operating model, to build on our strengths and assets in the period ahead.

Scope of our system strategy

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."

What is important to local people - Good Care Framework

We want to **enable everyone to thrive** and deliver Good Care that is:

Accessible | Competent | Person centred | Trustworthy

The Good Care Framework, together with the national CORE20PLUS5 approach, has informed our Outcomes and Equity Framework that takes a life course approach

NEL Outcomes and Equity Framework – our resident led success measures

Starting Strong	Living Well	Managing Conditions	Supporting Complex Needs
Dying Well	Quality Care and Access	Health Inequalities and Communities	Sustainable Services

Shift 1: Hospital to community

Moving healthcare services from traditional hospitals into local communities to provide care closer to people's homes

Implement our vision for neighbourhood working, building a **'team of teams'** for people with multi-morbidity, children with complex needs and mental health

Shift 2: Treatment to prevention

Shifting the focus from treating illnesses to preventing them in the first place, with an emphasis on public health and well-being

Deliver six-step prevention framework, moving us towards **preventing illness using tools such as PHM Optum platform**

Shift 3: Analogue to digital

Transforming the health and social care system from a traditional, paper-based model to a modern, digital one

Delivery digital innovation and empower local people and staff, through initiatives such as **NHS App, Health Navigator** and **ambient voice technology**

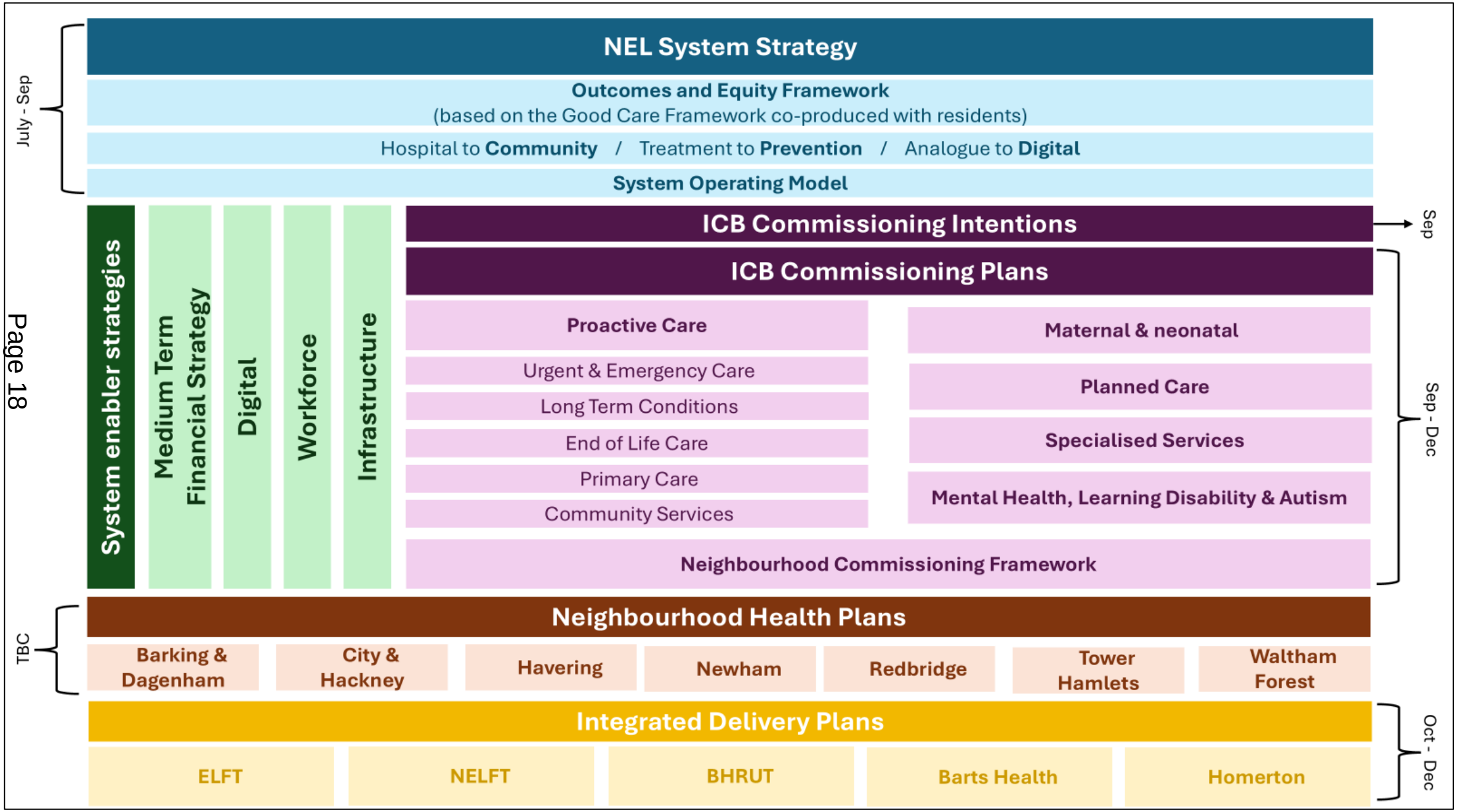
Enabling the Change

- Provides a stable **economic environment** enabling shift to prevention, reallocation of funding to drive quality whilst also delivering a more standardised set of services across the system
- Improving our physical **infrastructure**
- Create meaningful **work** opportunities and **employment** for people in NEL

Transitioning to a new system operating model

- Moving to the new system approach for strategic planning and commissioning
- Changing responsibilities across region, our system and providers
- Continuing to build our collaborative culture to support system working – co-production, building a high trust environment and a learning system

How the system strategy fits within our wider planning framework



The case for change in North East London

Population growth and health inequalities

- North East London has the fastest growing population in the country and some of the poorest and most deprived communities in England. This growth and deprivation is causing a strain on existing services which we cannot address by continuing as we currently are.
- The scale of our challenge is stark: we've grown by 500,000 people since 2001, double the growth of other London regions. Another 200,000 residents will arrive in the next 15 years - equivalent to adding a new London borough the size of Barking and Dagenham.
- Our overall population mix is shifting towards later life course stages. We will have 29% (68,000) more over 65s in 10 years. The 19-64 age cohort will grow by 8% or 126,000 people. Already 65% of NEL's over 65s have multiple morbidities (long term conditions and/or risk factors). While ageing is the overall trend, in some of places we will see the opposite demographic shift ie. an increasingly young population.
- People in NEL are developing long term conditions earlier than in other parts of the country and so our population need is growing rapidly. As these more complex needs require more health and care support they lead to higher costs for the NHS and its partners, outstripping the money available to us. We need to respond in a different way if we are going to support this increased need including adopting a more preventative approach with children and young people.

Access to care

- Emergency departments continue to be pressured, with increased activity. There are significant challenges in our emergency departments for people in mental health crisis and for young people with complex needs, with high out-of-area placements, and a need for improved crisis pathways.
- For our planned care services there is continued pressure with significant variation between the three Acute Trusts with growth in our waiting lists, with some patients having very long waits
- Our community waiting lists remain above pre-pandemic levels, with long waits especially in the Community Paediatrics Service.

Long term conditions – rising demand

- 665,699 people are living with a long-term condition (LTC) in NEL. Of whom 22% are living with 3 or more conditions and 6% have 5 or more conditions.
- Rates of new LTC diagnoses are growing at 13% year on year; with those developing a second or more LTC growing at 14% per year.
- Large numbers of people with long term conditions in NEL remain undiagnosed, from around 20% of people with diabetes to 65% of people with chronic obstructive pulmonary disease.
- People with multiple LTCs are admitted to hospital 2.5 x more often than people with one LTC, and 6 x more often than healthy people.

How local people have shaped our priorities and plans for the future

Our population is diverse and vibrant, and we are committed to our '*Working with people and communities*' strategy, working with local people and those who use our services to identify priorities and the criteria against which we will monitor and evaluate our impact.
In Summer 2023 we engaged with around 2000 people in our 'Big Conversation' through an online survey, face to face community events and focus groups including Turkish mothers in Hackney, South Asian men in Newham and Tower Hamlets, Black African and Caribbean men in Hackney, older people in the City of London, patients with Long Covid in Hackney, men in Barking & Dagenham, Deaf BSL users in Redbridge, young people in Barking and Dagenham and Pakistani women in Waltham Forest leading to our resident defined success measures.

This learning forms the basis for how we will track our system progress towards population health through a new NEL Outcomes and Equity Framework.

What does good care look like for local people in NEL?

Good Care is **Trustworthy:**	Good Care is **Accessible:**
• Listening to patients, honest and empathetic care • Follow-on, ongoing appointments • Reassurance, supported self-care • No gatekeeping • Anticipative, not just reactive care • Communication • Accountable care	• Availability of appointments • Affordable care • Improved booking systems • Adequate staffing • Convenient opening times • Accessibility – disabled patients • Convenient locations
Good Care is **Person-centred:**	Good Care is **Competent:**
• Patient involvement in treatment options • Patients having a choice about where/how they access care • Shared medical records, consistency of care • Holistic approach to care • Continuity of care • Health and care services working with each other • Collaboration beyond health and care	• High quality of care • Adequate staffing – skills and numbers • Services that know/understand specific conditions /medical needs • Services that know/understand patients' cultural and social needs • Evidence-based medicine • Prompt, efficient diagnosis process • Adequate funding, resourcing, facilities

We will continue to shape and design our work based on this insight and other engagement with residents.

What local people have told us the three national shifts mean for them

Hospital to community

- Moving care from hospitals to the community could have a profound positive impact in particular on waiting times and patient experience
- Potential to be more cost effective
- Could aid recovery as people are looked after in more familiar surroundings , making use of community assets and focusing on prevention
- Need to consider impact on unpaid carers who are already under pressure as well as how services would be monitored to ensure high quality

Better use of technology

- Across the groups, people could see the potential benefits for the increased use of technology, however overall, it was felt that there still needs to be options which do not exclude people who are unable to access digital tools, information or services
- Could be beneficial in enabling early diagnosis and supporting prevention of long-term conditions through empowering individuals to manage their health and wellbeing
- Need to consider digital exclusion

Preventing sickness

- People felt that focusing on prevention and early intervention, could reduce hospital admissions, improve self-management, and promote healthier lifestyles. This would not only save money but also enhance the overall well-being of individuals and communities.
- Government's focus should be on primary prevention, rather than secondary prevention
- People wanted to focus discussions on things that can have a positive influence on people's health, such as good quality housing, information about nutrition and employment

Our community assets

Building community capital and resilience is fundamental to enabling the strategic shifts outlined in this strategy: our communities have the potential to lead the process of preventing illness, improving health and reducing inequalities. Through our neighbourhood programme and in other areas of our work, we will adopt a strengths-based approach which builds on the assets of individuals, families and communities.

The people of North East London – over 2 million people bringing vibrancy and diversity, sharing what is important to them, co-producing services, delivering solutions and taking greater control over their own health and wellbeing. Only though taking a strengths-based approach to building capacity in individuals, families and communities will we enable resilience, address inequalities and build greater sustainability for our system.

Neighbourhoods - the development of 37 neighbourhoods, across NEL, familiar to the communities they serve, strongly rooted in local communities, enabling local capacity and connected to their community assets including community networks and partners, to support holistic wellbeing.

Voluntary, Community, Faith and Social Enterprise organisations – thousands of community organisations operating across NEL, engaging with local people, directly delivering services with a significant impact on the health and wellbeing of local people, and building resilience and community capital.

Primary care - Our 260 GP practices, 369 community pharmacies, 222 dental practices and 220 optometrists key to meeting the changing needs of our communities, and working in an increasingly integrated way serving local people in their neighbourhoods.

Our workforce - one of the largest collective employers in North East London, with over 130,000 people working locally in health and care, our workforce draws significantly from the communities we serve.

Our buildings – a total of 363 physical assets across NEL including 23 large centres bringing different services together, closer to our communities.

Clinical and care professional leadership

To deliver an ambitious system strategy for our population in North East London, we need to ensure that clinical and care professional leaders across our whole system are empowered to redesign care and drive the changes that are necessary including safeguarding vulnerable people and addressing complexity. Our clinical and care professional leaders ensure our clinical strategies are aligned to population health needs, that our plans are driven by the best available evidence, and that we are working effectively across professional, organisational and sector boundaries to join up pathways of care in partnership with local people.

Professional networks – we have established strong professional networks bringing together clinical and care professional leaders from across disciplines to support a more strategic approach across NEL, to facilitate greater collaboration and enable shared learning. These networks include NEL Directors of Children's Services, Directors of Adult Social Care, Directors of Public Health and our Allied Health Professionals Council.

Multi-disciplinary approach – as a system we take a multi-disciplinary approach to transformation with clinical and care professional leads working hand in hand with each other to develop clinical strategies and transform care with residents at the heart. Our ongoing working to review our maternity and neonatal services exemplifies this approach and has involved clinical teams from across Northeast London.

Improvement networks - Clinical and care professional leaders come together in improvement networks across our system to review pathways of care, develop new models of care and improve all aspects of quality and safety in services.

Clinically-led approach to system impact review – in NEL we have established a clinically-led process for the review of system impacts to ensure that we are working as a system to understand the wider impacts of service changes including any quality impacts; and are working collaboratively as a system to mitigate and manage those impacts.

NEL Clinical Advisory Group – the clinical and care professional leadership of our statutory NHS organisations, local authority Directors of Public Health and other clinical and care professional leaders come together fortnightly as a clinical leadership group for the system. As well providing the mechanism for ensuring the ICS can draw on clinical advice, the CAG supports a specific focus on collaborative working. This includes understanding the culture within different parts of our system, and working to overcome barriers to successful collaboration and integration e.g. across things primary and secondary care (in all sectors).

The NEL Outcomes and Equity Framework

To support us to deliver equitable health outcomes for all our residents, we will adopt a **NEL Outcomes and Equity Framework.**

This draws on our resident-led success measures, the **Good Care Framework** co-produced with local people, and the **national CORE20PLUS5** approach, disaggregating all outcomes by deprivation and ethnicity to expose unwarranted variations that must be addressed.

This is a **system-wide framework** taking a **lifecourse approach**, responding to specific needs at every age and with cross-cutting themes relating to **quality**; **health inequalities & communities; and sustainability** (workforce, financial and environmental). It will guide our goals and priorities across all areas and increasingly influence the outcomes we seek from our providers, building on the approach this year including **commissioning plans which respond deliberately to each age.**

The framework provides a vital tool for **addressing health inequalities** across the services we commission, enabling us to **allocate resources to areas of greatest need**.

Life course segment	North East London Population Outcomes	Population aspiration
1. Starting Strong	Outcome 1: All children have the best start in life	"I want to have the best start in life"
	Outcome 2: All families get the support they need	"I want my family to be supported when we need help"
2. Living Well	Outcome 3: People live longer, healthier lives	"I want to live a long and healthy life in my community"
	Outcome 4: People can stay in good work and have financial security	"I want to stay healthy enough to work and support my family"
	Outcome 5: People can prevent illness and stay healthy	"I want to be supported to stay healthy and avoid preventable illness"
3. Managing Conditions	Outcome 6: Health problems are caught early and managed well	"I want my health conditions detected early and managed effectively"
4. Supporting Complex Needs	Outcome 7: People have good mental health and wellbeing	"I want to feel mentally well and cope with life's challenges; I want timely access to local mental health services when I need them"
	Outcome 8: People can age well in their own communities	"I want to stay independent and connected as I get older"
5: Dying well	Outcome 9: People have choice and comfort at the end of life	"I want to die with dignity in the place of my choosing"
6: Quality Care and Access	Outcome 10: People can access the right care when they need it	"I can get the care I need, when I need it, without long waits"
	Outcome 11: People receive safe, high-quality care wherever they go	"I can trust that I'll receive excellent care wherever I'm treated"
7: Health Inequalities and Communities	Outcome 12: Everyone has a fair chance of good health, regardless of background	"I want the same opportunities for health as everyone else in my community"
	Outcome 13: Communities are strong, connected and resilient	"I want to feel connected to my community and supported when I need help"
8: Sustainable Services	Outcome 14: Health and care staff feel supported and can thrive at work	"I want to work in health and care and feel valued and supported"
	Outcome 15: Services are financially sustainable and provide value	"I want excellent health services that represent good value for public money"
	Outcome 16: Services are low carbon	"I want healthcare delivered without environmental harm"

Our overarching strategy for change and improvement in North East London

Working with partners to understand and address the wider determinants of ill health and health inequalities collaborating together as one system

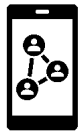
Proactively identifying those at risk and intervening earlier to prevent poor health

Investing in our workforce to develop the relational ways of working which will integrate care, empower patients and build our community assets

Providing more care locally or at home and improving access to hospital care where it is needed, working with local authorities to optimise the connectivity with social care

Getting the basics right by providing trustworthy, person-centred, accessible and competent care

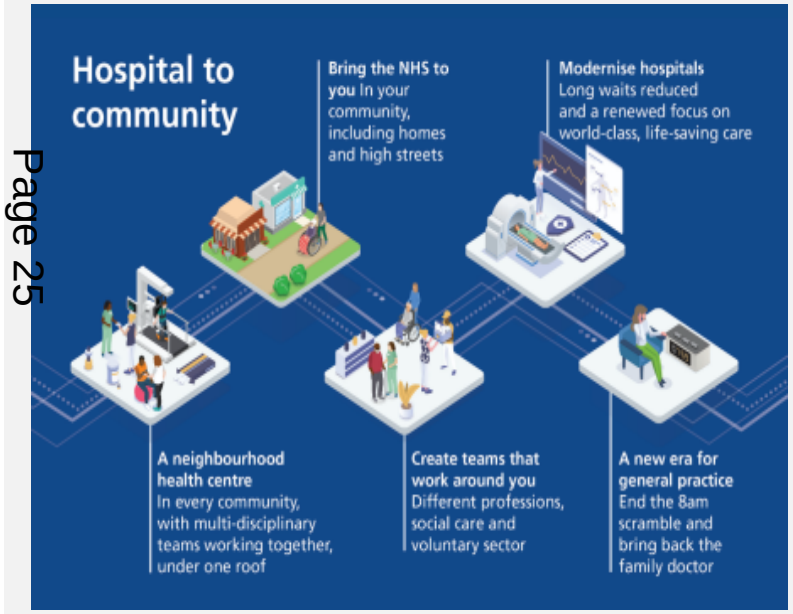
Using digital tools and data to support changes and focus on the health of our population



Improving productivity, allocating resources based on need and increasing our financial sustainability

Delivering our strategy: the role of the three shifts

Partners in North East London will need to work together in a range of areas to deliver our strategy. Central to delivering our priorities will be making progress on the three sets of changes outlined in the recent Ten Year Health Plan: redesigning care to move the focus of care into neighbourhoods and communities; moving our focus upstream to prevent ill health and intervene earlier, and using digital tools and data to enable changes and improvements and give more power and control to patients and residents. The sections that follow outline our over-arching approach to achieving these changes in North East London.



Moving healthcare services from traditional hospitals into local communities to provide care closer to people's homes

Transforming the health and social care system from a traditional, paper-based model to a modern, digital one

Shifting the focus from treating illnesses to preventing them in the first place, with an emphasis on public health and well-being

Hospital to **community**

How we ensure care is delivered as locally as possible, develop our neighbourhood health service and reduce pressure on our scarce and valuable hospital capacity

Community: our local context and case for change

- North East London has increasing levels of co-morbidity and complexity in our population, 24% of our people in NEL are living with a long-term condition, though this figure is higher in areas with greater deprivation
- More NEL residents are presenting to our health services with social needs which include financial pressures, loneliness and housing issues
- We are seeing critical and growing pressures on urgent care, primary care and hospital services and our residents tell us that services are disjointed and hard to access
- By providing more preventative, person centred, continuous and integrated care in primary and community settings we can better support people with complex medical and social needs without the need for a hospital admission. In addition to supporting the needs of the population this shift will lower costs and support the overall sustainability of the health and care system. Developing community-based care will also allow us to target resources at those areas most in need.
- Success will be measured through the NEL Outcomes and Equity Framework: reduced activity in urgent care, preventable admissions and delayed discharges; increased investment in the voluntary sector and improved health outcomes for people with long term conditions and complex needs.

Our continuing journey:

- We are not starting from scratch – we have already developed many community based and integrated services that support people closer to home including virtual wards, urgent community response teams, multi-disciplinary teams for people with Long Term Conditions, discharge hubs and women's health hubs

Over the next three years we will:

- Implement our vision for neighbourhood working, building cross-organisational relationships through our multi-disciplinary workforce within each neighbourhood, building a **'team of teams'** that supports people with multi-morbidity, children with complex needs and mental health, taking a Population Health Management approach. These teams will be better integrated with the wider VCFSE sector and community to support a truly preventative approach. We will, increasingly see a broader range of services delivered on a neighbourhood footprint, including specialist and diagnostic services.
- Use the neighbourhood footprints to deliver more services in local communities including more specialist and diagnostic services. Many of these will be delivered through neighbourhood health centres that also include social care and voluntary sector services
- Implement our care closer to home approach in urgent and emergency care, by developing a model of community based urgent care that supports people away from hospital settings, and delivers fast and effective discharge supported through deep integration of out-of-hospital health and social care. This enabled by system wide coordination, strengthening of single point of access and operationalised through INTs.
- Improve access to and experience of Primary Care by the development of an integrated, coordinated approach to same day access, 111, and utilisation of enhanced hubs.

Our vision for integrated neighbourhood teams

Everyone in North East London lives in a neighbourhood which supports and actively contributes to their physical and mental health and wellbeing

As partners across the system we will work closely together in local neighbourhoods. This means **creating an environment in which a range of assets, facilities and services are available to enable local people to start, live and age well and healthily.**

Our Vision

Based in and for local geographic communities

Coordinated and joined up

Strengths based – building on the assets of the individual, family and the local community

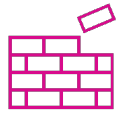
A culture of prevention in all interactions

Use the hyper local footprint to address local need

Targeting and seeking to reduce health inequalities

Our Approach

Use data to target our resources on those in most need



Build on existing integration work

Co-produce with communities

Recognise that this is a cultural change that will require new ways of working

Our four strategic goals and desired outputs

Goal	Desired outputs
Work with and for local communities	1. Care delivery in a community setting wherever possible 2. Enable individuals and families to take greater agency over their health and wellbeing 3. Work effectively with local communities to co-produce solutions to the health and wellbeing issues which matter to them 4. Work in a strengths-based approach to build capacity in individuals, families and communities, enabling resilience 5. Leverage local assets, including community networks and partners, to support holistic wellbeing
Work in a proactive, preventative way to address rising need	1. Use data to identify and target resources for individuals and groups at the highest risk of health decline / deterioration 2. Prioritise early intervention, preventative and proactive care to address health needs before they escalate 3. Maximise use of digital tools to support self care and to share information with health and care professionals
Deliver integrated, accessible care	1. Neighbourhood to provide timely and coordinated interventions 2. Promote continuity of care for individuals with long term or complex needs 3. More targeted support for families and the highest users of services 4. Deliver care aligned with the Good Care Framework, ensuring services are trustworthy, accessible, competent and person centred
Support service sustainability	1. Consider aligned financial incentives to support the quality and financial sustainability of core services ensuring the most effective role for general practice at the heart of neighbourhood services 2. Address current and future workforce pressures through workforce and care pathway transformation

Sickness to **prevention**

How we better identify those at risk, intervene earlier to prevent ill health and slow the progression of conditions, and work as a system to address the wider determinants of ill health and health inequalities

Prevention: our local context and case for change

Our system continues to focus primarily on treating illness rather than preventing it - this is unsustainable in the context of a rapidly growing population with increasing health need. Acute care spending has risen from 47% to 58% of our budget since 2002, while spending on primary care has fallen to just 18% - the opposite of what a prevention focus requires.

Failures in prevention compound health inequalities. In our local population we are seeing -

- **Rising multimorbidity**, an ageing population, and persistent health inequalities
- **Economic inactivity** due to ill health costing the NEL system £500m annually
- The **cost of living crisis** disproportionately affecting our most vulnerable populations, creating direct health impacts especially for children and families in temporary accommodation

The case for a more focused system approach to prevention -

- 'Prevention' means different things to different people across our system, hindering focused action
- Responsibility is too dispersed and accountability is lacking
- Benefits fall outside traditional business case models focused on short term deficit reduction
- Current investment is piecemeal and we lack a full understanding of impact
- Traditional approaches focus on doing 'to' rather than 'with' people

Without a more focused approach to prevention across our system, demand will outstrip our resources by 2030

Foundations for us to build our new system upon:

- **1% of our commissioning budget** is currently spent on a range of prevention initiatives
- All partners signed up to our **NEL anchor charter** containing commitments to tackling wider determinants
- Established a range of **evidence-based prevention programmes** across our system including tobacco dependency services alcohol care teams in secondary care, and comprehensive vaccination programmes
- Invested in **population health management** resource for the system linking to places and neighbourhoods
- Strong **voluntary sector relationships and community connections** that provide delivery infrastructure

Our theory of change

Drawing on a range of work sitting in different partnership groups across the ICS including the NEL Long Term Conditions Board and the NEL Directors of Public Health Group, we have begun to develop a more strategic approach to prevention for the system which we will test further with partners over Autumn 2025.

The problem we face

Unsustainable demand: Acute spending risen 47%→58%, primary care fallen to 18%

Health inequalities: Years lived with disability disproportionately affect disadvantaged communities in NEL

System barriers: Lack of clarity, dispersed responsibility, paternalistic approaches

Financial reality: Without change, demand will outstrip resources by 2030

Our strategic aims

System transformation: Shift proportion of £4.6bn commissioning spend from treatment to prevention (currently 1%)

Health equity: Narrow inequalities gap through evidence-based upstream interventions

Culture change: Prevention shifts from something we commission to how we think

Sustainable impact: Reallocate ringfenced % of spend upstream by 2030

Key policy changes: six step framework

Step 1. System-wide prevention reframing

Step 2: Clear leadership and accountability

Step 3: Wider determinants focus - addressing the cause of the causes

Step 4: Long-term resource allocation

Step 5: Community activation and co-design

Step 6: Evidence and learning

Evidence based interventions

Secondary Prevention (NHS leads): Cardiovascular case-finding, cancer screening, mental health early intervention

Primary Prevention (Partnerships deliver): Tobacco control, weight management, immunisation with equity focus

Wider Determinants (System acts): NHS as anchor employer, social prescribing, housing interventions

Key Enablers: PHM tools and support, workforce development

Expected outcomes

Short-term (1-2 years): Acute spend identified for reallocation, prevention improvement plans, clinical champions

Medium-term (3-5 years): £millions shifted to prevention, reduced preventable admissions, inequalities gap narrowing

Long-term (5-10 years): Prevention-first as business as usual, increased healthy life expectancy, financial sustainability

Our vision

By 2035, NEL will be known not just for how well we treat illness, but for how successfully we prevent it. Our residents will maintain good health for longer, take greater control of their own health and have more of their health needs managed in the community. The years that local people live with disability from preventable long-term conditions will be dramatically reduced across our diverse population.

Prioritising evidence-based interventions within our system approach

As part of developing a comprehensive framework for embedding prevention across the system, we need to identify the evidence-based interventions that we want to prioritise for investment. Given the current financial context, our immediate focus must be on interventions that deliver measurable returns whilst building the foundation for broader culture change towards a 'prevention first' approach.

Immediate priorities

Tobacco dependency – sustaining treatment services linked to whole pathways of care

- Smoking causes half the life expectancy gap between rich and poor, costing NEL £56.7m annually in NHS treatment
- Opportunity to prevent 1.4k readmissions, free up 19 beds daily and save £2.2m pa.

Cardiovascular prevention - embedding a whole system approach

- CVD is highly preventable yet mortality is increasing
- Opportunity to optimise pathways e.g. heart failure which would reduce c. 118-315 admissions worth £659k-£1.9m pa.

Emerging priorities

Weight management – a whole population approach

- NEL has highest childhood obesity rates nationally, and some of the highest rates of type 2 adult diabetes with increased risk of CVD, CKD etc
- Preventing early onset of type2 diabetes for ages 20-40 with specific risk factors would address outcome inequalities for our population and reduce healthcare use significantly

Social, welfare and legal advice – embedding in healthcare settings alongside social prescribing

- Poverty is a major determinant of health and related factors disproportionately affecting NEL residents include access to benefits, debt, and poor housing.
- Academic evidence supports SWLA as a key intervention for tackling health inequalities. We have an opportunity to build in existing good practice including social prescribing.

Genomics and personalised medicine

- Leverage our lifesciences capabilities and partnerships to identify and exploit opportunities including precision and personalised medicine

What a 'prevention first' approach could mean for local people

Early years (0-18): Children in NEL grow up supported by a strong family environment with educational attainment that sets foundations for lifelong health. Schools become health-creating environments addressing childhood obesity, mental health, and health literacy.

Working years (18-65): Adults maintain physical and mental wellbeing through supportive employment, accessible healthcare, and strong community connections. Early identification and management of risk factors prevents progression to long-term conditions.

Later life (65+): Older residents age well in their communities with maintained independence, social connection, and cognitive function. When health conditions arise, they are well-managed to preserve quality of life.

Analogue to **digital**

How we can use new digital tools and innovative data systems to support prevention and integration and to give patients more power and control

The digital and data opportunity for Northeast London

We want to build on our strong track record across NEL of our collaborative approach digital developments. This is evident for example in the work on shared records, the level of digital maturity within most of our providers, as well as how the providers are working towards using common systems. Digital technology is already responding to the challenges our system faces, for example Health Navigator working to lower avoidable admissions by using AI and health coaching; digital approaches being used in dermatology and ophthalmology to improve elective access; as well as online consultations and bookings to improve primary care access.

Building on our success to date:

- Electronic Patient Record (EPR) rollout at Barking Havering and Redbridge University Trust (Oracle Millennium) aligning with Barts Health and Homerton
- London Care Record connecting most health and care sites
- Secure Data Environment enabling predictive modelling and AI use
- NHS App providing the patient gateway to tools like DrDoctor and Patient Knows Best
- Adopting AI tools including risk stratification (Health Navigator); digital scribes (Heidi, AccuRx), diagnostic imaging
- Digital therapies for mental health freeing up clinical time
- Virtual Wards supporting remote monitoring of complex patients
- Expanding community diagnostic centres and digital triage in ophthalmology
- Genomics leadership via QMUL's Genes & Health
- Primary care access improving via online consultations, NHS App, and new phone systems

Our challenge is to go further and faster towards systematic and innovative use of digital technology, improving outcomes by empowering patients and freeing up staff time.

Ambitions in the 10 Year Health Plan

- **Single Patient Record**: National unified record enabling integrated, personalised, and predictive care.
- **NHS App by 2028**: Becomes the main access point with AI-driven features – advice, referrals, booking, medicine, and care planning ("doctor in your pocket").
- **HealthStore**: Marketplace for NICE-approved digital health apps.
- **Federated Data Platform**: Connects siloed data to support AI tools and boost productivity.
- **Digital supports financial sustainability**: Cuts duplication, admin, and costs; national AI procurement framework launches in 2026/27.
- **Ambient Voice AI** ("AI Scribe"): Expected to reduce paperwork by 51%, freeing up clinical time.
- **Genomics Integration**: Enhances personalised care via the Single Patient Record.

How digital and data innovation can enable change and improvement

We aim to **transform healthcare delivery through digital innovation**, and by doing so empower local people and staff, **address health inequalities and rising demand**, make our health system more financially sustainable and reduce environmental impact. By embracing digital transformation, we seek to **create meaningful, measurable improvements in health outcomes for all residents**.

To transform the digital landscape across NEL and to deliver the vision outlined above, we have identified **five themes** that we believe are essential to make the step changes needed:

1. **Patient leadership**: We see digital-first as a key step to give patients the tools to manage their own health, especially for routine interactions such as prescriptions and appointment management. This will then free up time and resources for complex care to be personalised around a persons need, with the right professionals supporting them.
2. **Pathway redesign**: We want to accelerate work across NEL to innovate, find new solutions and co-design digitally enabled pathways with staff from across the system. This is not only to streamline pathways, but also to enable staff to spend more time on what is important to patients, as well as increase productivity.
3. **Clinical integration**: Clinical integration is key to improving the clinical experience of delivering care, and to enable staff to spend more time on what matters the most to them and to our patients – improving patient outcomes.
4. **Single system**: We see the single system as a fundamental component to enable the best possible care to our local people in an integrated way. This will provide a single version of the truth in common functions through simpler interoperability
5. **Data and innovation**: We see the importance in the systematic use of data, especially to inform decisions based on the needs of our population. To meet those needs, we are also committed to continue to innovate to finding cost-effective interventions that are tailored to our local people.

We are committed to a**dopting and adapting national innovation and standards**, leading in the uptake of the NHS App and the implementation of the Federated Data Platform

We will co-design and test **London wide initiatives** such as London Health Mission, London Care Record, and Health Data for London

We will adopt a learning approach based on testing, adapting to feedback , evaluation and shared learning.

Our key priorities for digital and data

Patient leadership
- **Patient Health Records / Patient Experience Platform in place across all providers**, giving patients access to their complete health record, the ability to manage appointments and to engage in consultations.
- **The NHS App deployed to all patients that can use it**, with training and continuous communication campaigns.
- **Supports patients in staying healthy** through promoting specific actions, from general health messages to intensive interventions
- **Addressing inequalities** through training programmes, access to devices, and mobile data.
- Co-designing solutions with communities and commissioners
- Providing **non-digital alternatives** to ensure inclusivity

Pathway redesign
- All our pathway redesign activity to have a **digital first approach**
- **A single virtual ward set of technologies** will be in use
- **All pathways to optimise the use of digital technology**
- **Same day access pathway** utilises digital technology efficiently to improve patient flow and improve the patient experience
- **Universal Care Plans** are in place for 95% of those with complex care needs by 2027

Digital inclusion:
- A significant cohort of the NEL population are effectively digitally excluded, either through language, ability to use the tools or lack of access (to devices, mobile data or broadband). Initiatives need to be expanded by all ICS organisations to support the digitally excluded by use of translation, education, encouragement and cheap or free provision of devices and data

- Those who cannot be supported and those who are excluded for religious / cultural reasons, will always need to have equal access to services via other means such as walk-in, letter and telephone.

Single System
- The **fewest number of systems** used within each sector, e.g. all acute trusts to use the same EPR (electronic patient records) instance and a single mental health and community EPR
- Specialist services as standardised as possible in each organisation and the same order systems between GPs, trusts, and pathology labs
- **Single patient record** in use across all providers, via a patient centric, rather than organisation centric, EPR
- Development of **hybrid mail systems** and automation tools
- **Joint procurement of IT equipment** to be in place to improve value for money
- All systems, to the extent that is possible, to be **cloud based**
- **Cybersecurity upgrades** and cloud migrations to ensure resilience
- **INTs** will have easy **access to all required information** about the patients they are working with and be able to undertake all required activities within a single system

Clinical integration
- Expand the use of advice and refer across primary care
- Ambient voice technology to be available across all our providers as the preferred way to create notes and make pathways more efficient
- All care homes, nursing homes, pharmacists, dentists and optometrists to be connected to London Care Record (LCR), contributing and viewing
- All clinicians and other relevant professionals making use of the LCR whenever it is

Data and Innovation
- AI used to support clinician and administrative staff to undertake tasks where safe and efficient, potentially such as note summarising (using ambient AI), pathway navigation, triage and supporting advice and refer
- Online consultation tools will use AI to triage to the maximum extent safely possible and guide patient to the right pathway; self-care, pharmacy, other primary care clinician, GP or other healthcare professional

Enabling the **change**

How we will allocate our resources to support the delivery of our strategy

Our strategic financial objectives

Our financial strategy will support the delivery of the system strategy and the 'left shift' whilst ensuring we meet our statutory requirement to keep within our delegated resource allocation. The ICB financial plan will contribute to the overall financial sustainability of the system, but will focus primarily on commissioning plans and how these are developed to meet the needs of local people and deliver the requirements of the national Ten Year Health Plan.

We have two key financial objectives in NEL:

1. **To develop and deliver an ICB financial plan that provides a stable economic environment to support continued improvement in healthcare and outcomes and across our system**

2. **To reduce health inequalities and improve health outcomes through targeted investment funding,** allowing resources to be reallocated between care settings over time

These will be delivered through:

a. Setting of resource plans with an **allocation strategy** that aligns funding and incentives to commissioning plans

b. Enabling and supporting **provider driven efficiencies,** aiming for a step change in **productivity in line with national guidance**

c. Using population health data to identify high impact **commissioner led strategic plans** involving interventions that reduce variation by addressing inequalities in service levels and outcomes, and where possible deliver at scale

d. Develop contract forms to support **market management and promote the viability of providers** to deliver commissioning plans

e. Manage **risk** as activity and funding shifts from one setting to another, ensuring incentives are aligned to avoid failure

f. Address the shortfall in **capita**l funding to meet the infrastructure investment needed to deliver the change required

g. Identify and establish by 2030/31, a **3% (circa £200m) revenue transformation fund** to enable and resource the three shifts. All system partners will be involved in decisions about how this fund will be deployed

Our financial principles

Financial Sustainability:

- No default generic growth will be applied to any contract. The first call on allocation of growth funding will go to address the overspend on commissioned services before we look to expand services. Our core principle is that we cannot allocate what we don't have.
- Remaining growth funding will be allocated to address known gaps and inequity in line with our strategic planning principles
- Provider sustainability is a core strategic aim, therefore any initiative will need to take account of, mitigate and minimise adverse impacts e.g. avoiding stranded costs, supporting cost redeployment
- We will focus on cost control and efficiency improvements to generate headroom for investment

Value-Based Care:

- We will prioritise evidence-based interventions with the highest return on investment and robustly evaluate interventions to ensure benefits are realised, including prevention interventions
- Recognising our current shortfall in capital funding we will prioritise investment in digital solutions to promote efficiency and effectiveness
- We will support rapid adoption and spread of innovation

Data-Driven Decision Making:

- We will base all financial projections and decisions on robust data and evidence
- We will regularly update models with the latest available data
- We will maximise the usage of all available benchmarking tools

Long-Term Planning:

- We will balance short-term savings with long-term system sustainability
- We will move to a long-term model of resource allocation based on population health which reflects our strategy and the three shifts.

Developing our financial allocation strategy

1. Financial Modelling

The forecast underlying exit rate from 25/26 will be analysed along with demographic growth changes, the impacts of an ageing population, increased demand, and expected inflationary pressures in excess of annual funding. Other factors that impact the base case scenario will be reviewed which include insufficient capital funding to invest in better infrastructure and a reduced workforce to drive efficiencies.

Demographic changes will be modelled through population health data. Mandatory arrangements such as delegated primary care funding and mental health investment standards will continue to be met and modelled through our medium-term financial strategy.

The baseline position will require an inherent efficiency in line with national tariff assumptions of 2% per year.

2. Creating and Ringfencing transformation funds

The medium term financial strategy (MTFS) will outline how the ICB will plan to spend 3% of funds on transformation. This will begin with 1% in 26/27 and increase over the 5 year period. To enable this the ICB will review the allocation of growth funds and block contracts.

Transformation Funds

- The MTFS will allocate 1% of funding growth in the first year for transformation and enabling the commissioning decisions to drive the three shifts. Analysis will need to take account of strategic priorities, double running, stranded costs and where relevant the repatriation of activity to local provided services
- We will explore ways to expand funding available to us as a system to invest in transformation including through partnerships with social finance, research and life sciences.

Deconstructing Contracts

- Fixed and pass-through funds that have been paid since 2020 are currently under review nationally. Where these are over and above activity levels we will aim for a minimum 1% productivity above annual productivity requirement to fund transformation (note: 1% acute funding = approximately 0.5% system allocation).
- The MTFS will assume fixed and pass-through funds are repurposed across the duration of the medium-term plan and be used at a system level to aid delivery of the three shifts. The reallocation of funding will contribute to provider demographic pressures and transformation arrangements. As an enabler, contract form and payment mechanisms will be reviewed to reflect agreed activity plans and future commissioning intentions.

3. Prioritisation of funds and reducing variation

The ICB will determine the prioritisation of growth funds following a resource allocation process. Through this process the ICB will drive allocative efficiencies intended to aid the underlying financial sustainability. Resource allocation will take account of:

- Assessment of population needs.
- A focus on prevention.
- Tackling Health Inequalities
- Addressing the core service offer within Primary Care, Community and Mental Health to support transformation.
- A reallocation of funding within individual pathways to drive quality whilst also delivering a more standardised set of services across providers and locations.

This approach will be aligned to our NEL Outcomes and Equity Framework and commissioning plans.

Our workforce

Our ICS vision is to "**work together to create meaningful work opportunities and employment for people in NEL now and in the future**'. Supporting people to be in work so they can contribute to the economy and improve their health outcomes is key. As one of the largest collective employers in North East London, our workforce is drawn largely from the communities we serve. Addressing employment, wellbeing, and diversity challenges is therefore central to improving outcomes for our population.

Delivering on our current ambitions: As a network of **anchor institutions**, we need to create employment opportunities for local people, including clear career pathways across our system. The **NEL Training Hub** is well positioned to support **primary care recruitment** by linking with Connect to Work teams within Local Authorities, helping GP practices fill vacancies while creating employment routes for local residents. Efforts are underway, through **local employment schemes**, to increase NHS and social care employment among residents through targeted joint working with local authority employment teams, education providers and employers so residents can be supported into training and job opportunities .

Secondary care trusts across NEL are coordinating recruitment efforts with colleges, DWP with Barts Health leading a £500k Widening Access project to expand health career opportunities for identified specific under represented groups. **Care Providers Voice** is leading the care component of the Widening Access project, establishing referral pathways into social care job placements across NEL. NEL is mobilising a system-wide response to the **national guarantee of NHS employment** for newly qualified nurses and midwives, with early funding focused on midwifery and future planning underway.

Delivering the three shifts through our workforce -

The requirements within the 10 Year Health Plan mean that we need a high-skilled, resilient and future-ready workforce to deliver new transformative models of care. As a system we will need to support the cultural change that is needed to successfully embed integrated neighbourhood working and the other strategic shifts including investing in OD and continuing to develop the relational aspects of our work.

Community: Moving care closer to home requires a workforce that is flexible, community-oriented, and able to work across traditional boundaries.
Prevention: Shifting to prevention requires a workforce that is proactive, skilled in behaviour change, and able to work beyond the clinic or hospital.
Digital: A digitally confident and competent workforce is essential for delivering seamless, efficient, and patient-centred care in a modern NHS

Our diverse and skilled workforce across our system is **key to delivering sustainable and effective change.** To support our workforce we need development of education programmes with Higher Education Institutes and employers alongside, feeding into workforce planning that will be delivered by London region. **Key areas include** -
New skill mix: Staff will work in multidisciplinary neighbourhood teams, including GPs, nurses, Allied Health Professionals, Pharmacists, social care, and voluntary sector professionals.
Personalised care: Staff will co-create care plans with patients, support self-management, and deliver more care at home or in community settings.
Liberation from admin: AI scribes and automation will free up clinical time, allowing staff to focus on patient care.
New ways of working: Staff will use the NHS App, Single Patient Record, and remote monitoring to deliver care virtually and in-person.
Prevention focus: Staff will be trained to deliver prevention, early intervention, and health promotion, not just treatment.
Community engagement: Staff will work with local partners, schools, and employers to address social determinants of health.

Our physical infrastructure

The North East London ICS Infrastructure Strategy (July 2024) outlines a 20-year, system-wide plan to modernise physical and digital infrastructure, ensuring high-quality, resilient, and equitable health and care services. It aims to build a world-class, sustainable infrastructure that supports staff and patients, drives innovation and integration, and meets the needs of a rapidly growing and diverse population. Our Infrastructure priorities for the system are:

1. Improve infrastructure safety and quality
2. Enable increased productivity
3. Integrate services within our communities to support health and wellbeing
4. Accelerate innovation
5. Develop new additional capacity

Delivering on our current ambitions:

St George's Health and Wellbeing Hub opened in spring 2024 and provides a key example of a neighbourhood health centre. Residents can book appointments and see a range of professionals in one visit as it brings together a range of services wrapped around primary care such as community and mental health, CT, MRI and other diagnostics

Community Diagnostic Centres have improved capacity and access for residents to diagnostics services and reduced inequalities of services across North East London

Barts Health Life Sciences Campus will deliver on three healthcare priorities – prevention, prediction and precision. The campus focuses on digital health, genomics, and clinical innovation to advance healthcare by transforming research into everyday patient care.

Delivering the three shifts through our infrastructure strategy -

Hospital to community: The shift of care to the community requires modern, accessible, and well-equipped community facilities.
Analogue to digital: Digital transformation is only possible if the physical estate is digitally enabled, secure, and fit for 21st-century care.
Sickness to prevention: Prevention and early intervention require accessible, welcoming, and multi-purpose spaces embedded in communities.

We aim to create **modern, multi-functional community health hubs** that bring together multiple services under one roof to provide proactive and preventative care and improve access to care closer to home. By focusing our **limited capital** on essential projects on areas such as critical infrastructure risk, replacement, upgrades and growth areas, as well as maximising our current estate, we will ensure the flexibility to deliver new models of care. We will aim to do this through a number of ways:

Neighbourhood Health Centres: Establishing an NHC in every community will provide modern, accessible, "one-stop shops" for care, open at least 12 hours a day, 6 days a week
Co-location: NHCs will host prevention, screening, and health promotion services alongside clinical care.
Repurposing existing estate: Improving the utilisation of underused NHS buildings for community care.
Flexible, modern spaces: Co-location of services will support integrated multidisciplinary teams working.
Digital-ready buildings: Community and primary care estate will be upgraded to support digital care, remote monitoring, and new models of working.

Working as a **North East London system**

How partners will work together to deliver our system strategy

We must maintain strong system partnership across North East London

Maintaining a strong and engaged North East London system is vital to achieving our long-term goals. We are committed to maintaining and strengthening the strategic, clinical and operational partnerships that underpin our system.

We will further develop our **Integrated Care Partnership** and our vital relationships with Local Authorities in their democratically mandated Place making roles as well as across the wider social care system. We will work with the VCFSE across engagement, delivery and capacity building, with providers, and with local communities

We will work closely with our **public health** community on setting strategies, shared analytics and prevention

We will build on our links with adult social care to understand and respond to local needs ensuring residents can live well in in their homes and communities with a range of conditions

We will work collaboratively as a system by ensuring providers are involved in the development of commissioning plans, including **NHS, independent sector and voluntary sector partners**

We will continue to embed the **agreed principles** in our system of co-production, building a high trust environment and developing as a *learning system*

We will develop **local neighbourhood teams** in order to integrate care at a local level, embedding joint working at every layer of the North East London system

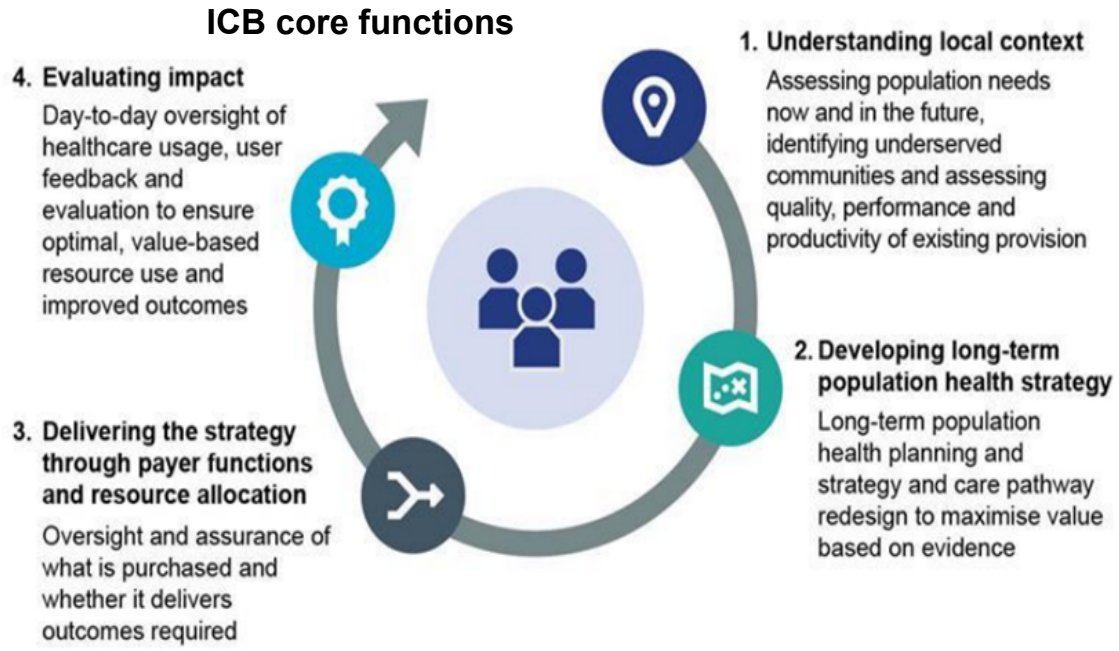
We will strengthen our relationships with local authorities and partners to improve outcomes for babies, children, young people and families, working closely with children's social care leads and with the NEL Commissioning Partnership

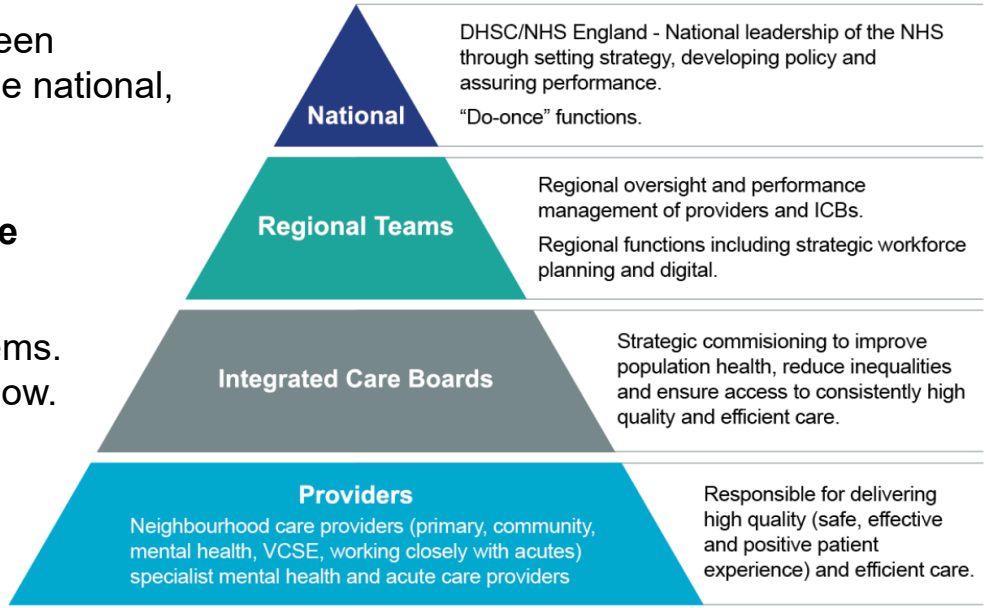
Key national changes affecting systems

As well as major policy changes, **significant structural changes to the NHS** have been announced this year. The changes affect all parts of systems, from the very local to the national, and clarity about some of the changes is still emerging. The changes have important implications for our system operating model.

Regions are taking on a strategic leadership role with a clearer focus on **performance management** and improvement.

ICBs are moving more clearly into a **strategic commissioning role** within local systems. Their functions are described as part of a strategic commissioning cycle as shown below.





While there are no new structural changes for **providers** (they remain accountable to their board for delivery of safe, effective, and high-quality healthcare services, as well retaining their duty to collaborate within local systems), the *Dash Review* has placed greater emphasis on **quality and safety** with clearer oversight from regions on this as well as provider **finances**.

Further clarity is also anticipated on the new **Integrated Health Organisation** role which will is being developed nationally as part of the neighbourhood model.

Co-production and engagement with local people

Our vision for co-production and engagement as outlined in the **ICS Working with People and Communities Strategy published in 2022**, is to ensure that participation is at the heart of everything we do.

*Our **standards for participation** include:*

- ***Commitment**: We will develop an infrastructure of participation within our governance and leadership*
- ***Collaboration**: We will work across the ICS and with our people and communities to deepen collaboration*
- ***Insight and evidence**: We will gather insight and evidence to inform our priorities and target our participation efforts*
- ***Accessibility**: We will ensure that all people and communities are aware of and are supported to participate*
- ***Responsiveness**: We will ensure that the impact of participation is clear to people, communities and partners*

Community Insight System – how we are listening to local voices

Our nationally recognised live database collates feedback on healthcare experience of local people to ensure the patient voice is present in health and care decision making.

- 24 sources of data form the CIS, from Healthwatch engagement reports to social media posts, capturing the sentiments on the experience of healthcare.
- Over 400 system staff are trained to access the CIS, they request around 15 bespoke reports per quarter to inform commissioning and delivery plans.

The People's Panel – our mass engagement tool

Hearing from residents about health service development and improvement for them and their families helping to shape health and care plans and local services.

- Membership of over 2,400 people receiving a monthly e-newsletter with participation opportunities.
- Participation in surveys, workshops, focus groups etc. to improve health and care locally while offering opportunities for self development, building new skills and networking with other local members.

Operating as a learning system

Our vision is to embed research, innovation, continuous learning and quality improvement in all that we do as a system, including how we plan, deliver, integrate and improve our services across NEL

Progress so far

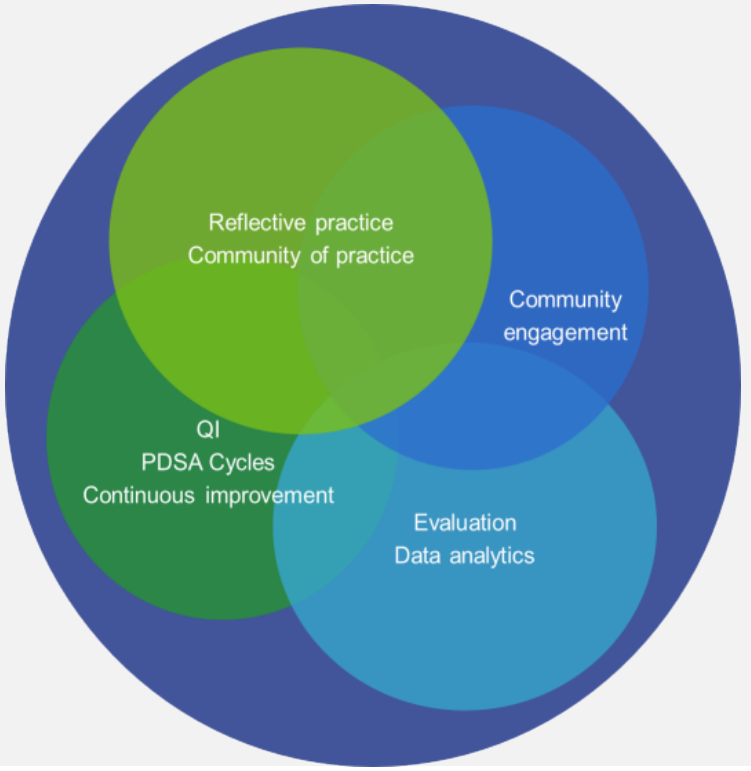
- **Building our strategic capacity and capability as a system in population health management** towards a more proactive and value-based approach to planning and delivery. Launching a new PHM platform to support embedding this approach in Autumn 2025.
- Partners including Barts Health and NELFT are **creating an open repository for local learning,** research and innovation, available to the whole system to support continuous improvement.
- Increasing our focus on **using evidence to drive plans.** Horizon scanning to find the latest innovations and evidence-based or high impact interventions to meet the needs of our population, working closely with clinical leads and other subject matter experts and through groups such as improvement networks.
- Secured **continued funding for our Research Engagement Network** which is building capacity within local communities to participate in and lead research. We will be transitioning to a new sustainable model by embedding within existing structures such as the VCSE collaborative.
- Developing **a more strategic relationship with academic and innovation partners** to increase the value they bring to the system.

Next steps

- Drawing on expertise from academic partners, we are **increasing our focus on evaluation** including development of an evaluation framework for the system.
- **Deliver enabling support for neighbourhoods** to help integrated teams target proactive care using population health management tools, increasing impact and value.
- Evolve our **ICS research and innovation strategy** in the context of national changes.

Defining a learning system in NEL:

Research, informatics, incentives, and culture aligned to support continuous improvement and innovation. Evidence and best practice seamlessly embedded into delivery and new knowledge and learning captured.



Building a high trust environment

Our vision is to create a high trust environment for all partners in NEL to enable seamless delivery across pathways spanning social care, primary and community care and secondary care regardless of organisational or sector boundaries. Building this truly collaborative and high-trust culture will enable our evolving partnership to work most effectively for local people. Through co-production and engagement, as set out above, this vision extends to building trust with the people and communities we serve across NEL.

Progress so far

- Developed collaborative ways of **working together across organisational and sector boundaries** to address tricky system challenges e.g. urgent and emergency care, winter planning.
- Agreed a mechanism for system partners to **share impact assessments for any service changes in a transparent way**, enabling collective understanding and supporting a more proactive and partnership approach to mitigation. Some of our place-based partnerships also held discussions about local financial challenges, coming together as local partners to find solutions.
- Our *Integration Roadmap* was approved by the Population Health and Integration Committee in February 2025 following extensive engagement with the full range of system partners. This included work to develop **collaborative approaches for system enablers** such as OD and leadership, workforce, finance, contracting & commissioning, estates, digital and communities.

Next steps

- System partners participated in a rapid review of our system to determine the **key areas of value and local connectivity** they want to see secured through any changes to our system operating model. This included retaining the mechanisms that support continued collaboration across all partners.
- Increasing our **collective understanding of how money is spent** in our system and the impact it has for different segments of our population, utilising new tools that we are introducing for the system. We will share this insight openly and use it to support identifying actions we can take as a system to increase our collective impact and value.

What happens next

This strategy refresh has been developed extremely rapidly following the publication of the Government's Ten Year Health Plan and national draft planning guidance in order to set the direction for system commissioning intentions due at the end of September 2025.

The strategy builds on our previous Integrated Care Strategy published in 2022, and while the tight timeline has not allowed for extensive engagement, we have sought to involve a range of stakeholders, including local people, in conversations to inform key areas – see right.

The strategy will be developed further over the course of Autumn 2025 before going to the ICB board for approval on 5 November 2025.

To provide comments on the document or for more information, please contact:

nelondonicb.strategicdevelopment@nhs.net

Stakeholder input

The current draft has been informed by discussions at -

- Stakeholder system workshop including clinical leads focusing on the three national 'shifts' (80+ attendees)
- System Strategy Group workshop
- Provider CFOs and Strategy Directors workshop
- Public Health Directors workshops
- Neighbourhood Steering Group
- The People's Panel – engagement on the Ten Year Health Plan

NHS
North East London

North East London ICB: commissioning intentions

September 2025

Strategic context

September 2025

Introduction

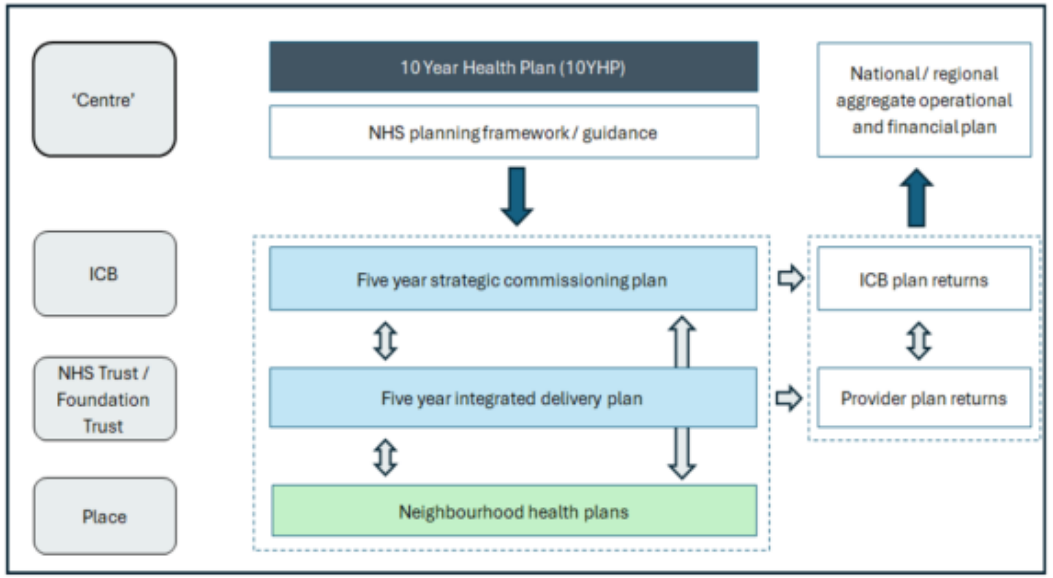
We developed our first NEL Commissioning Framework at the beginning of 2025 to support the delivery of our first interim NEL integrated care strategy. Since then, the 10 Year Health Plan (YHP) has been published and structural changes announced nationally which together have given us an opportunity to refresh our System Strategy to ensure it meets the needs of our local people and delivers the 10YHP. This document sets out our commissioning intentions which show how we will develop and change services over the coming five years, working collaboratively with partners. We are committed to refreshing our commissioning intentions and plans annually.

We are working to build on the national planning architecture over the coming months, please see diagram, with NHS providers responding to our commissioning intentions in their five year integrated delivery plans, each place expected to develop neighbourhood health plans and the ICB creating strategic commissioning plans to flesh out our commissioning intentions. These plans will become our operational and financial plans with specific focus on year one.

The NEL System Strategy sets out the improvements in the population outcomes we want to see based on our Good Care Framework, and it focuses on how we will enable the national policy three shifts, from hospital to community, from analogue to digital and from treatment to prevention. We have considered local health data and population needs, community and system assets, feedback and engagement with local people, patients and communities, value for money and long-term sustainability

This shared understanding of the challenges and opportunities also forms the basis for our commissioning intentions, together with clinical evidence and best practice. As per the national guidance, the commissioning intentions cover 5 years, with more detail about actions in the immediate 1-3 years. They will then shape and be influenced by the Integrated Delivery Plans NHS Providers are developing in order for the ICB to create strategic commissioning plans.

Relationship between key elements of the national planning architecture



Over the course of the coming months, we will create a strategic commissioning plan for north east London which sets out a shared understanding of the challenges and opportunities, linking to the system strategy case for change, and which will have the following chapters (specific commissioning plans): 1) Maternity & Neonatal, 2) Mental Health, Learning Disability and Autism 3) Planned and Specialised Care 4) Proactive Care, including specific plans for Urgent and Emergency Care (UEC), Long term conditions (LTC), End of Life Care (EoL), Primary Care and Community and 5) Neighbourhoods.

We are sharing our commissioning intentions as part of the process of developing strategic commissioning plans. Both our intentions and our plans take a population approach, are all age and include where appropriate links to Better Care Fund, Continuing Healthcare, and Medicine Optimisation as well as a range of other detail.

What we want to achieve

- NEL is a vibrant and diverse, yet deprived geography of communities across seven places, served by a broad range of partners including local authorities, NHS providers, and Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations.
- We are refreshing our NEL System Strategy, an overview is included in the diagram, to ensure we highlight the opportunities from the three national shifts as set out in the 10YHP as well as building on the work in our previous system strategy and responding to known pressures and challenges in the short term.
- Through this work, we are launching a new NEL Equity and Outcomes Framework, based on what local residents have told us is important to them as well as our four system priorities of Babies, Children & Young People; Long Term Conditions; Mental Health; and Employment. The framework will be used progressively to shape a new commissioning approach towards a greater focus on population health. Our approach to allocating resources will also start to take account of population health need in line with the outcomes we have set out for the system.
- Our strategy will provide direction for our system commissioning intentions in September 2025 and subsequent commissioning plans towards improved health outcomes and greater equity for our population in NEL.

Our objective is to commission services that:
- Enable local residents to maintain optimal health for as long as possible;
- Ensure care is delivered as close to people's homes as feasible;
- Facilitate patients receiving the appropriate care, in the right setting, at the first point of contact, by leveraging digital and artificial intelligence interventions.

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."

What is important to local people - Good Care Framework

We want to **enable everyone to thrive** and deliver Good Care that is:

Accessible | Competent | Person centred | Trustworthy

The Good Care Framework, together with the national CORE20PLUS5 approach, has informed our Outcomes and Equity Framework that takes a life course approach

NEL Outcomes and Equity Framework – our resident led success measures

Starting Strong | Living Well | Managing Conditions | Supporting Complex Needs

Dying Well | Quality Care and Access | Health Inequalities and Communities | Sustainable Services

Shift 1: Hospital to community

Moving healthcare services from traditional hospitals into local communities to provide care closer to people's homes

Implement our vision for neighbourhood working, building a **'team of teams'** that supports people with multi-morbidity, children with complex needs and mental health

Shift 2: Treatment to prevention

Shifting the focus from treating illnesses to preventing them in the first place, with an emphasis on public health and well-being

Deliver six-step prevention framework, moving us towards **preventing illness using tools such as PHM Optum platform**

Shift 3: Analogue to digital

Transforming the health and social care system from a traditional, paper-based model to a modern, digital one

Delivery digital innovation and empower local people and staff, through initiatives such as **NHS App, Health Navigator** and **ambient voice technology**

Enabling the Change

- Provides a stable **economic environment** that enables shift to prevention and reallocation of funding to drive quality whilst also delivering a more standardised set of services across the system
- Improving our physical **infrastructure**
- Create meaningful **work** opportunities and **employment** for people in NEL

Transitioning to a new system operating model

- Moving to the new system approach for strategic planning and commissioning
- Changing responsibilities across region, our system and providers
- Continuing to build our collaborative culture to support system working – co-production, building a high trust environment and a learning system

The case for change in Northeast London

Population growth and health inequalities

- North East London has the fastest growing population in the country and some of the poorest and most deprived communities in England. This growth and deprivation is causing a strain on existing services which we cannot address by continuing as we currently are.
- The scale of our challenge is stark: we've grown by 500,000 people since 2001, double the growth of other London regions. Another 200,000 residents will arrive in the next 15 years - equivalent to adding a new London borough the size of Barking and Dagenham.
- Our overall population mix is shifting towards later life course stages. We will have 29% (68,000) more over 65s in 10 years. The 19-64 age cohort will grow by 8% or 126,000 people. Already 65% of NEL's over 65s have multiple morbidities (long term conditions and/or risk factors). While ageing is the overall trend, in some of places we will see the opposite demographic shift ie. an increasingly young population.
- People in NEL are developing long term conditions earlier than in other parts of the country and so our population need is growing rapidly. As these more complex needs require more health and care support they lead to higher costs for the NHS and its partners, outstripping the money available to us. We need to respond in a different way if we are going to support this increased need including adopting a more preventative approach with children and young people.

Access to care

- Emergency departments continue to be pressured, with increased activity. There are significant challenges in our emergency departments for people in mental health crisis and for young people with complex needs, with high out-of-area placements, and a need for improved crisis pathways.
- For our planned care services there is continued pressure with significant variation between the three Acute Trusts with growth in our waiting lists, with some patients having very long waits
- Our community waiting lists remain above pre-pandemic levels, with long waits especially in the Community Paediatrics Service.

Long term conditions – rising demand

- 665,699 people are living with a long-term condition (LTC) in NEL. Of whom 22% are living with 3 or more conditions and 6% have 5 or more conditions.
- Rates of new LTC diagnoses are growing at 13% year on year; with those developing a second or more LTC growing at 14% per year.
- Large numbers of people with long term conditions in NEL remain undiagnosed, from around 20% of people with diabetes to 65% of people with chronic obstructive pulmonary disease.
- People with multiple LTCs are admitted to hospital 2.5 x more often than people with one LTC, and 6 x more often than healthy people.

Please note that each of our commissioning chapters include a more detailed case for change specific for that area.

Improving lives for local people

NEL is one of the most diverse and deprived areas in England, with significant health inequalities experienced by our populations. In our NEL wide anti-racism strategy, we recognise the unacceptable and avoidable **health inequalities** that individuals and diverse communities experience as a direct result of their ethnicity. Tackling racism and securing greater equity for our diverse population remains a core commitment for all of us in NEL.

In these commissioning intentions, and through our strategic commissioning plans, we aim to secure greater equity, both across NEL and between NEL and the rest of London and the country. We will continue to work with local authorities as commissioners of a range of services which are often interwoven with the services we commission to keep people well at home.

We will commission services informed by our **Good Care Framework**, which aims to improve the experience of all those using services, so that everybody in NEL can thrive, and that our services will be trustworthy, accessible, person-centred and competent.

Our NEL Outcomes and Equity Framework also draws on our resident led success measures and the national CORE20PLUS5 approach, disaggregating all outcomes by deprivation and ethnicity to expose unwarranted variations. This is a system-wide framework that provides a vital tool for addressing health inequalities across our programmes and services.

We are committed to improving access, experience and outcomes for our whole population, across the life course from babies and children through to older people. We will do this by co-producing and engaging with our local people and the public, in line with our **ICS Working with People and Communities Strategy**, and to ensure that participation is at the heart of everything we do. Whilst time has been tight in developing this set of commissioning intentions, we have reflected outcomes from feedback, engagement and co-production in our proposals and are committed to continuing to engage with local people as we take them forward.

Social value impact commitment

We recognise the important role anchor organisations play in improving health and wellbeing. We want to see the ICB and Trusts, and the organisations that they partner with, deliver measurable social value impact across social, economic, and environmental pillars.

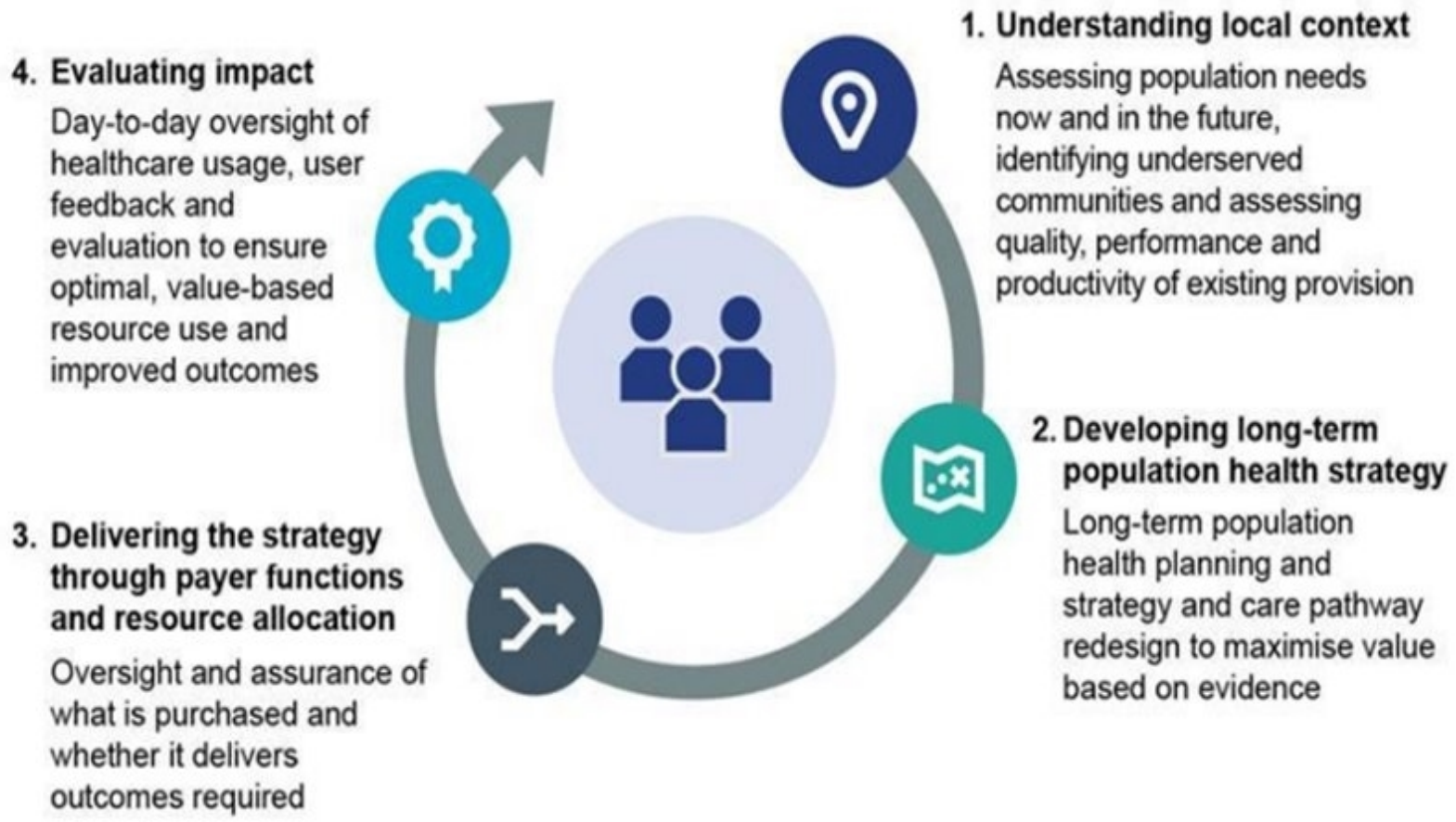
Aligning with internal policy, system strategies such as the Anchor Charter and System Green Plan will take into account the updated Social Value Model that must be implemented from October 2025.

We are also updating our Procurement Policy to place a stronger emphasis on ensuring social value throughout our significant commissioning activity.

Strategic commissioning processes and content

September 2025

Strategic Commissioning Cycle – these commissioning intentions form part of the overall commissioning cycle we are using to move to responding to our local needs to ensuring effectiveness of delivery



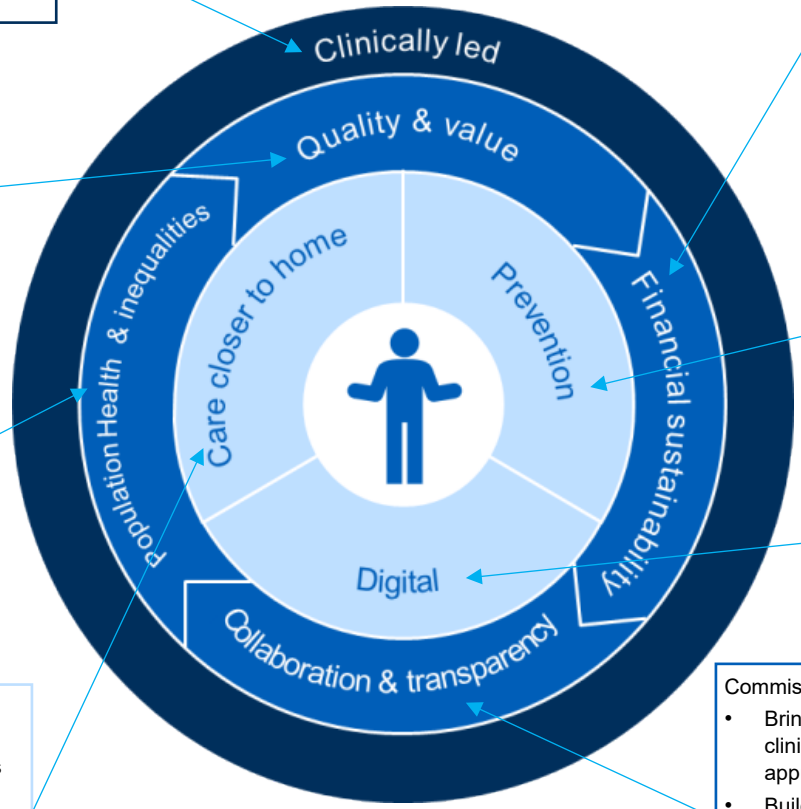
Strategic commissioning principles: developed to support us to be clear what local people can expect of us and what we expect of them and ensure information is easily accessible to all our residents.

Our commissioning is clinically led, meaning:
- Services are designed with insight of how they are delivered
- Clinicians are involved in all stages of the commissioning cycle
- Diverse perspectives are considered, reflecting the diversity of patient needs and the expertise within our healthcare system.

Strategic commissioning must ensure the care delivers quality and value by:
- Clearly setting expectations around safety, effectiveness and patient experience
- Addressing health inequalities and promotes equity in outcomes, access and experience
- Prioritising interventions with demonstrable impact and value.
- Monitored and overseen in dialogue with providers.

Commissioning decisions should be grounded in population health data and insights, with a clear focus on reducing health inequalities by:
- Using data to identify and address disparities in access, outcomes, and experience
- Embedding health equity impact assessments into commissioning cycles
- Prioritising investment in underserved communities and conditions
- Ensuring commissioning groups reflect local needs and assets.

Commissioning should enable integrated delivery models, in the most appropriate setting:
- Aligning services across health, social care, and voluntary sectors
- Supporting neighbourhood teams to co-design and deliver care
- Supporting community-based models that reduce reliance on acute care
- Building the resilience of our communities, developing and driving resources to support communities.



Strategic commissioning must balance ambition with financial realism:
- We allocate resources in line with population health needs
- Aligning commissioning plans with the Medium-Term Financial Strategy (MTFS)
- Making best use of contracts and reducing duplication
- Promote productivity and demand management.

A shift from reactive to proactive care is central. This involves:
- Commissioning services that prevent illness and promote wellbeing
- Identifying needs and issues early and seeking to address the causes of ill health
- Embedding prevention into all commissioning plans, including mental health, urgent care, and long-term conditions.

Commissioning should support the digital transformation of care:
- Investing in innovative digital tools that enhance access, coordination, and outcomes and makes our staff more efficient
- Using real-time data to inform commissioning decisions
- Supporting digital inclusion to avoid widening inequalities.

Commissioning:
- Brings together local people, service users, practitioners and clinicians to improve services, equalising power to change. Our approach to research and innovation will follow the same principle
- Builds trust, connectivity, and have resident led priorities and collaboration at the heart of our improvement and research agendas
- Jointly with local authority partners, with other ICBs and across London where joint commissioning drives improved outcomes and efficiency
- Clear, inclusive, and robust, with decisions based evidence.

Key:

Commissioning **person centred** service based on the need of our population

Setting out the principles (**what**) that informs our commissioning

Setting out the principles on **how** we commission service

Setting out the principle that all our commissioning is **clinical led**

These principles are supported by all the enablers; workforce, physical infrastructure, contracts, etc. Details outlined within our strategic commissioning cycle.

Contracting and contracting intentions

- Our commissioning is underpinned by contracting processes which will enable us to enact our ambitions and service level proposals, including contracting intentions.
- We are working collaboratively with providers and have reinstated a number of contracting forums ensuring they link effectively to strategic commissioning and enable us to make best use of new contracting models and payer mechanisms. These provide an important forum for on ongoing dialogue about changes, challenges and opportunities. This will continue to evolve as we deliver this commissioning plan.
- Commissioners and commissioning groups work to support integration, outcomes and tackling any quality, safety and performance challenges while contributing to financial sustainability. They will take account of any changes in national, regional or local policies.
- In the appendix, we have set out the business as usual requirements we are building into contracts as a matter of course. These will be familiar as they reflect established local and national requirements to be reflected across service delivery.
- We would like to draw attention to three areas of work which have the potential to change quite fundamentally how we contract over coming months:
    - First, the process of deconstruction of the blocks – this is being led by national processes and timetables and locally, it has been a useful and much needed exercise in further understanding some of the historic and legacy elements that make up the fixed elements of the contracts. The ICB will work with trusts over the next 6 months to ensure these elements are appropriately reflected in contracts.
    - Second, as we carry out the commissioning involved in our intentions, we will pay attention to areas such as working together and agreeing up to date service specifications
    - Third, we are keen to ensure that we are all working to consistent recording ad data capture approaches and striving for the highest standards of data quality to enable us to monitor demand, activity, impact, spends and costs effectively and efficiently.
- Finally, we will be circulating to individual providers a letter outlining our contracting intentions – that is formal notice where we are intending to terminate, reduce, change or transfer services. These letters will act as the formal notice required within existing contracts and should be considered separately and as requiring action.

Our priorities

Our overarching priorities are driven by our vision – to work with and for the people of north east London to improve their health and wellbeing. The three strategic shifts highlighted in the 10 year health plan, and set out in detail on the next slide, frame what we do and require us to change our overall model considerably over the coming period. An increasing focus on prevention, care closer to home and digital are all aspirations we have held and sought to deliver for many years and we believe they form part of the solutions we need to implement to address the significant health inequalities, complex needs and increasing demand we are experiencing across the system.

We have asked ourselves what these changes mean for our system going forward and are elevating the following eight strategic areas:

- For general practice and for wider primary care, the immediate aim to develop a vision and strategy to support sustainable services, to enable neighbourhood working and to build a commissioning framework. This is set out in our commissioning intentions
- For our acute providers, the shared ambition to work closely across our hospitals and clinicians to understand what the shifts mean for them and to develop more centres of excellence, review fragile services and reduce duplication in order to support sustainability
- For maternity providers, a focus on preventative measures to ensure women are healthy leading up to and through a pregnancy, ensuring we are working collaboratively and as close to home as possible
- For the voluntary sector, an assertion of the importance of their role in strengthening resilience in communities and the need to ensure the sector is sustainable and engaged with our work, as strategic partners, as service providers, as engagement enablers and as capacity builders
- For mental health, the need to address allocation of resources to the sector and ensure we are responding to the changing pattern of mental health needs across all ages in our population, including a holistic and strategic approach to neuro-diversity through the life course, effective neighbourhood working and links to severe and enduring mental illness
- For long-term conditions, a fundamental shift to prevention and early intervention, with a renewed focus on system and neighbourhood approaches
- For digital, a recognition of the fast pace of change and opportunity, and the need to be nimble and collaborative in harnessing technology to what is best for our residents
- For the system, the focus on multi-agency, multi-disciplinary and relational ways of working, with new delivery mechanisms through hubs and neighbourhoods

The development and implementation of these priorities will be through shared clinical leadership across our system, our providers, networks, collaboratives and commissioning groups.

The three shifts – prevention, community and digital

Shift 1: Hospital to community

Moving healthcare services from traditional hospitals into local communities to provide care closer to people's homes

Examples of how we are delivering this in our commissioning intentions:

1. Neighbourhood-Based Care Models – our fundamental enabler of the hospital-to-community shift. Neighbourhoods will be used to address health inequalities, build community capacity, and improve interfaces with acute services.

2. Community Services Expansion – we aim to standardise community core offers across boroughs to reduce variation and improve equity.

3. Urgent and Emergency Care (UEC) Integration – we want to see an integrated solutions across primary, community, and secondary care, including Single Points of Access (SPoA) and virtual wards.

4. End of Life Care in the Community - aims to increase the use of Urgent Care Plans (UCPs) to enable more people to be cared for at home.

5. Increase Primary and Maternity Care in Community Settings – increasing the use of community midwifery and pharmacy, to enable delivery of care closer to home.

Shift 2: Treatment to prevention

Shifting the focus from treating illnesses to preventing them in the first place, with an emphasis on public health and well-being

Examples of how we are delivering this in our commissioning intentions:

1. Proactive and Preventative Care Models – focus on a shift towards person-centred, proactive care, aiming to reduce demand on urgent and planned services through early intervention and prevention.

2. Addressing Long-Term Conditions – emphasising primary and secondary prevention through better management of cardiovascular, respiratory, and metabolic conditions.

3. Community frailty services – aims for earlier prevention strategies to reduce the burden of chronic illness and improve long-term outcomes.

4. Primary Care – by optimising uptake of immunisation, vaccination and screening conditions will either be fully prevented or identify early on in its development.

Shift 3: Analogue to digital

Transforming the health and social care system from a traditional, paper-based model to a modern, digital one

Examples of how we are delivering this in our commissioning intentions:

1. Digitalised Urgent & Emergency Care – focussing on a Single Patient Records, AI-enabled triage such as Health Navigator, and digital access models including virtual wards and Single Points of Access.

2. Primary Care Digital Access – promotion and uptake of the NHS App and online consultations, with continued focus on equitable access for digitally excluded groups

3. Planned Care Digital Pathways – aims to use digital applications to help patients track their place on waiting lists, expand Advice and Refer and to digitalise outpatient care, as well as patient initiative follow ups

Commissioning intentions

September 2025

Commissioning intentions

Our commissioning intentions which follow form the basis of the next steps of our planning – shaping and being shaped by integrated delivery plans, strategic commissioning plans and our NEL System Strategy which are in development.

These plans span our activity – and where no specific commissioning intentions are identified then business as usual measures will continue to be delivered, mindful of our overarching priorities and strategic aims.

In taking forward these commissioning intentions, we aim to support our whole workforce's wellbeing, development and retention to enable the delivery of high-quality, clinically led services across all ages, with increasing levels of trust and cross-organisational working, while commissioning care that meets or exceeds national standards.

We do not commission in isolation: we work closely with local authorities which commission a range of services and interventions to keep people well at home and in their communities. We work with our neighbouring ICBs to deliver cross-boundary care which works for local people, we work with the other ICBs in London, as a region, to build consistency and coherence and we work on a national footprint too to drive the best health and wellbeing outcomes for our population across north east London.

- Maternity and Neonatal
- Mental Health, Learning Disabilities and Autism
- Planned Care, including Specialised Services
- Proactive Care: Community
- Proactive Care: End of Life Care
- Proactive Care: Long Term Conditions
- Proactive Care: Primary Care
- Proactive Care: Urgent and Emergency Care
- Neighbourhoods

Maternity and Neonatal: Current Situation

NEL population context

- The population of north-East London is highly diverse, with 53% coming from global majority, non-white backgrounds and over 100 different languages spoken. We have high levels of deprivation, with nearly a quarter of our population living in one of the 20% most deprived areas of the country. We see stark health inequalities linked to this deprivation: in our poorest neighbourhoods 60% of people have a long-term condition, compared to 30% in our least deprived. Our population is growing rapidly, an additional 300,000 people will be living here by 2040 – this equivalent to is a whole additional borough.
- In North East London we are facing a growing population and an increase in complex pregnancies and births, due to a community with other health conditions and challenging social factors. We know that service offer, pathways and processes are not consistent across NEL, meaning pregnant people with similar needs have a different experience depending on where they choose to give birth. . In addition, there are stark and persistent inequalities in outcomes for people from different population groups which exacerbate rates of maternal and neonatal morbidity and mortality.

Population health approach

NEL ICB has been undertaking over the last 2 years a system wide review of the capacity and demand experienced by Maternity and Neonatal services. We are now at the stage of developing draft care models and subsequent options appraisal with collaborative from a wide range of inputs from multiple system partners, including an extensive public consultation building on findings from LMNS Equality and Equity Strategy.

Current Maternity and Neonatal Service performance

- NEL has seen improvements in performance throughout 25/26 across a number of key metrics including workforce and retention, pre-term optimisation, tackling health inequalities linked to Saving Babies Lives and MIS year 6 with all trusts meeting the requirements. There continue to be areas that we need to improve on for example aligning the perinatal pelvic health service offer to the national specification, increasing MNVP capacity to enable trusts to meet the requirements of MIS year 7, implementing a model of care across NEL that ensures that capacity is available where we have the greatest demand and that mothers receive the care they need for themselves and their baby at the right place, right time and with the correct medical team for their acuity. We are also looking to improve digital access for our women across NEL through digital access of their maternity care record and continue to reduce inequalities experienced by our women through interventions such as continuity of carer and improving pathways through women's health hubs where appropriate to do so e.g. earlier access to fertility advice, post natal contraception or postnatal pelvic health.
- The outline commissioning intentions for Maternity and Neonatal services will drive performance improvements as well as quality, access, capacity and financial sustainability benefits for our population in North East London.

North East London Health & Care Partnership

Maternity and Neonatal - Delivering the three strategic shifts

The table below summarises how the NEL Maternity and Neonatal strategic commissioning priorities will support the delivery of the three strategic shifts (Acute to Community, Treatment to Prevention and Analogue to Digital) over the next 3-5 years.

Maternity and Neonatal programme area	Service area	Timeframe
Prevention	Commission an integrated maternity and neonatal pathway spanning primary, community, and acute settings, with aligned neonatal capacity planning. Co-develop maternity service specifications outlining the new model and offer across NEL.	2026-2029
	Commission a holistic women's health model aligned with Women's Health Hubs, embedding reproductive, maternal, and postnatal care across the life course using virtual engagement and group consultation as a medium.	2026-28
	Commission an Independent Senior Advocate (ISA) function in line with national recommendations (Ockenden / Kirkup).	2026-27
	Deliver localised, evidence-based pelvic health services as part of maternity and women's health pathways.	2026-27
	Commission and coordinate workforce development, training, and recruitment initiatives to address shortages in midwifery and neonatal staffing.	2026-29
Care Closer to Home	Commission an integrated maternity and neonatal pathway spanning primary, community, and acute settings, with aligned neonatal capacity planning. Co-develop maternity service specifications outlining the new model and offer across NEL.	2026-2029
	Commission MNVPs at scale, ensuring capacity (e.g. WTE leadership roles) to influence service redesign.	2026 - 2027
	Neighbourhood health i.e. Universal, holistic services from pre-conception to early years and beyond delivered though neighbourhood MDTs working in the community.	2026-2028
Specialist services	Jointly commission with Specialised Commissioning a review of preterm and neonatal pathways, updating specifications to meet national standards. This will include ICB responsibility on delegation of spec comm with services such as AIP, Fetal Medicine, antenatal and Newborn screening.	2026=2027
Digital	Commission a NEL-wide end-to-end maternity IT system with interoperability across GP, acute, and neonatal systems.	2026-28

North East London Health & Care Partnership

MHLDA Strategic Commissioning Vision - Headline Goals Summary

We will deliver relational, whole person and whole system care though a co-produced approach that centres on the service user and is supported by partnership working that is linked to the person's local community. We will provide timely access to community services that offer alternatives to hospital care.

We will deliver more inpatient care closer to home, improve the inpatient experience and provide the right care in the right time and place for those experiencing a mental health crisis.

We will deliver an integrated all age neurodiverse pathway that links NHS primary care and secondary care, with local authorities, VCS organisations, communities and families and Right to Choose providers.

Children and Young People will receive better access to timely intervention as part of a whole system approach that embeds the Thrive Model.

We will deliver personalised whole person, whole system care for people with Severe Mental Illness

We will deliver recovery focused aftercare

We will deliver integrated whole system, whole person care through our neighbourhoods

We will deliver whole person, whole system care for our residents with learning disabilities.

Underpinned by population health management approach and MHLDA outcomes framework

Alignment with UEC programme over MH in ED, LTC Programme over co-produced care planning, Neighbourhoods Programme over whole system MHLDA in neighbourhoods. Policy alignment with the draft Mental Health Personalisation policy and the Intensive and Assertive programme and the 24/7 open access pilots.

MHLDA - Delivering the three strategic shifts

The table below summarises how the NEL MH strategic commissioning priorities will support the delivery of the three strategic shifts (Acute to Community, Treatment to Prevention and Analogue to Digital) over the next 1-5 years.

MHLDA Programme Area	Headline Goal	Timefame	Acute to Community	Treatment to Prevention	Analog to Digital
MHLDA CYP and Adults	**1. We will deliver more inpatient care closer to home, improve the inpatient experience and provide the right care in the right time and place for those experiencing a mental health crisis.**	2026-2030	Yes	Yes	Yes
Neurodiversity	**2.We will deliver an integrated all age neurodiverse pathway that links NHS primary care and secondary care, with local authorities, VCS organisations, communities and families and Right to Choose providers.**	2026-2029	Yes	Yes	Yes
MH Adults	**3. We will deliver personalised whole person, whole system care for people with Severe Mental Illness.**	2026-2028	Yes	Yes	Yes
CYP MH	**4. Children and Young People will receive better access access to timely intervention as part of a whole system** approach that embeds the Thrive Model.	2026-2029	Yes	Yes	Yes
MHLDA CYP and Adults	**5. We will deliver recovery focused aftercare**.	2026-2030	Yes	Yes	Yes
MHLDA CYP and Adults	**6. We will deliver integrated whole system and whole person integrated care through our neighbourhoods**	2026-2029	Yes	Yes	Yes
Learning Disabilites	**7. We will deliver whole person, whole system care for our residents with learning disabilities**	2026-2029	Yes	Yes	Yes

Planned care vision inNEL

- Over the next 5 years, NEL ICB will strategically commission planned care services that provide timely, equitable and high-quality outpatient and elective surgery services for the population. We aim to commission services with faster access, better outcomes and improved patient experience, while reducing unwarranted variation and health inequalities.

- The commissioning intentions are based on a whole pathway approach to incentivise efficiency from referral to discharge and build on the principles of resilience, patient choice and quality, embedding best practice pathways and recommendations (GIRFT), requirements within the national elective reform guidance and 10-year plan for cancer.

Our 5-year plans will evolve; our ambition is to:

- Ensure no patient waits more than 18 weeks for their treatment and that cancer diagnosis is rapid leading to quicker treatment. We will improve our waiting times year on year by maximising our theatre capacity, waiting list reviews, pathway transformation and the commissioning of demand management initiatives; and work with our provider partners to maximise capacity and productivity.
- Ensure that all patients know where they are on the waiting list through digital applications.
- Increase the volume of outpatient care in the community; this could be through digital support, embedding Advice and Refer, managing care closer to home through neighbourhood care models & optimising clinical decisions to reduce repeat attendance.
- Wherever clinically possible, enable patients to have their pre-operative and post-operative assessments managed outside of a hospital setting, freeing up capacity to treat patients of highest clinical need in the hospital.
- Develop day case activity by high level specialty and give our residents a choice of location for the top 10 most common procedures.
- Scale up prevention efforts by driving uptake of cancer screening and embedding community-led education to reduce modifiable cancer risks and tackle inequalities.
- Commission high-quality, timely cancer treatment by improving 62-day pathway performance, embedding personalised care models, and ensuring equitable access to innovative therapies across all boroughs.

Measures of success and outcomes by 2030/31

Goals

Access & Waiting Times: Achieve national waiting time standards, RTT, diagnostic waiting times (DM01), and cancer standards particularly for deprived communities

Demand Management: reduce demand growth for planned care through redesign of pathways and more care in the community

Shift planned care from hospital to community & Primary Care settings to manage demand and ensure sufficient capacity for the hospitals to see more complex patients

Digital Pathway Redesign: Digitally enabled, streamlined access to planned care, cancer and diagnostic services e.g. digital booking

Personalisation: expand self-management, self- care for patients

Equity and health inequalities: Use data to reduce variation and improve access and outcomes – ensure equitable and consistent ICB wide service models to reduce geographic inequality

Targets

- 92% patients to receive first appointment within 18 weeks
- Zero patients waiting over 52 weeks
- 99% patients receive a diagnostic test within 6 weeks of referral
- Manage referral demand for planned care
- Shift more outpatient care to the community
- 85% of patients begin first definitive treatment within 62 days of urgent cancer referral
- 96% patients start their first cancer treatment within 31 days of the decision to treat
- 80% patients receive a diagnosis (or rule out cancer) within 28 days
- 75% of patients will be diagnosed with cancer at stage 1 or 2

Outcomes

- Patients can access the right care when they need it
- Everyone has a fair chance of good health, regardless of background
- Patients receive safe, high quality care wherever they go
- People can stay in work and have financial security
- Patients live longer healthier lives
- Health problems are caught early and managed well
- Services are financially sustainable and provide value

North East London Health & Care Partnership

Planned care - Delivering the three strategic shifts

Planned Care	Commissioning Plan	Timeframe	Acute to community	Treatment to prevention	Analogue to digital
Demand Management	Implement Single Points of Access in as range of specialties using, where appropriate Women's Health Hubs as a blue print. This includes, MSK, ENT, Ophthalmology, Dermatology, Fertility and Gynaecology	2026 - 2028	Yes	Yes	
	Work with providers to include Patient Initiated follow ups (PIFU) in any re-design of services.	2026-2027 and ongoing			Yes
	Expand the availability of Advice & Refer and Advice & Guidance across specialties, agreeing principles required to manage pathways. We will include our planned care community services in developing A&G, e.g. Community Dermatology	2026/27	Yes	Yes	Yes
Pathway Transformation	Explore principle of reducing OPA and shifting activity to neighbourhoods over 5 years, identifying a pilot area in year one, e.g. rheumatology.	2026/2031	Yes		
	Identify top 10 conditions that can be managed outside of hospital care: • Self management • Care at neighbourhood level • Pre- inpatient assessment in CDC's	2026-2028	Yes	Yes	Yes
Service re-design	Commission services to revised specifications to ensure equity across NEL and addressing and quality or clinical anomaly areas. This includes: Women's health hubs, Audiology, Urology, Minor Surgery, MSK, Ophthalmology, Pain Management & Gastroenterology	2026-2028	Yes		
Surgery	The ICB will support NEL Acute Trusts to implement GIRFT best practice for the following pathways: • ENT Surgery • General Surgery • Gynaecology • Ophthalmology • Orthopaedic Surgery • Spinal Surgery • Urology Surgery	2026-2027 and ongoing			

North East London Health & Care Partnership

Diagnostics - Delivering the three strategic shifts

Diagnostic Programme area	Service area	Timeframe	Acute to community	Treatment to prevention	Analogue to digital
Demand management	Primary Care/ Community Demand Management- MRI and ultrasound	2026-27	Yes		
	Acute/ UEC Demand Management- managing top 10 most mis-requested tests	2026-28		Yes	
Community focus	CDC development- enhancement of service model and expansion of capacity, including support for and integration with Neighbourhood Health Hubs	2026-30	Yes	Yes	Yes
	Community GPDA IS provision/ integration	2026-27	Yes		
	Primary Care service design and SPoA support for various interface triage solutions	2026-27	Yes	Yes	
	Screening and prevention- supporting enhanced screening programmes across a range of disease pathways	2026-30		Yes	
Digital focus	Capability enhancements- integration of PACS and AI reporting enhancements	2026-30			Yes
	Patient Access enhancements- patient booking and results access	2026-30	Yes		Yes
	Demand Management enhancements- iRefer decision support software & test registries to prevent unnecessary repeat testing	2026-28			Yes
Productivity	Urgent and Emergency flow improvements- A&E, SDEC, UTC/ and community/ primary care pathways	2026-27			
	Straight to Test and other efficient diagnostic pathways to manage demand in secondary care and reduce unnecessary outpatient appointments, including symptom-based pathways which look to significantly reduce time to diagnosis	2026-28	Yes		
Innovation	Pathway and clinical testing improvements in Pathology, Endoscopy, Imaging and Physiological Sciences	2026-30	Yes	Yes	Yes

Increasing early diagnosis of cancer through screening and surveillance

The ambition over the next 5 years is to continue to design interventions using an inequalities lens with a focus on the CORE20PLUS5 and the inclusion groups (seldom heard communities). We will work with local communities to develop tailored, culturally appropriate initiatives to increase uptake of screening programmes and reduce disparities in participation, targeting areas with the lowest uptake or high late-stage diagnosis rates.

We will continue our focus on supporting community-led awareness raising initiatives and increase joint working with community groups who are trusted amongst their peers and tailor early diagnosis initiatives to reach underserved groups. Mobile units like the “Living Well” buses that bring health checks and cervical screening into hard-to-reach neighbourhoods are examples of taking services to the people.

We have built a strong foundation and will increase outreach interventions for the underserved communities, targeting areas with low screening uptake and low rates of early diagnosis.

Genomic Testing to improve cancer care

Genomic testing is transforming how the NHS prevents, diagnoses, and treats cancer by identifying genetic risks and enabling personalised treatments.

Genomics helps detect inherited mutations early, allowing for timely screening and prevention. Tumour DNA analysis guides targeted therapies and improves trial access, making them more personalised.

The NHS aims to make genetic testing standard in cancer care. Expanding genomics will support earlier diagnosis, better treatments, and prevention, while managing uncertain results carefully.

Within the next 5yrs we will look to mainstream the following:

- **Lynch Syndrome**
- **BRCA Testing**
- **Further rollout of the Vaccine Launchpad**
- **Personalised Therapies**

North East London Health & Care Partnership

Increasing early diagnosis of cancer through screening and surveillance

We will locally implement all national screening programmes as they are developed, and focus on maximising uptake of the following screening programmes

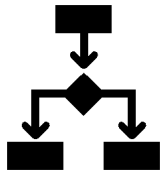
Cancer	Commissioning Plan	Acute to community	Treatment to prevention	Analogue to digital
Bowel:	by 2030/31 we will aim to achieve the target of screening 76% of eligible residents.		Yes	
Breast	TBC		Yes	
Cervical	By 2030 we aim to eliminate cervical cancer in north-east London, in line with NHS England's regional plan. We will do this by : • Ensuring cervical screening coverage does not fall below 70%, while still aiming to reach the target of 80%, focussed on 18-25s & Gay and bi-sexual men who have sex with men (GBMSM) up to the age of 45 • Supporting national programmes to implement more accessible and acceptable screening methods such as HPV self-sampling. • Increasing the uptake of the HPV vaccine for those who have missed it at school.		Yes	
Lung	Extend the lung Cancer Screening Programme to all eligible residents in NEL by 2029, ensuring the proportion of people diagnosed with lung cancer at an early stage via screening, remains above 75%.		Yes	
Surveillance pathways are also key to optimising early diagnosis in people with a higher risk of developing cancer due to genetic or environmental factors. We will establish surveillance pathways for tumour sites which will achieve high impacts and improve outcomes.				
Pancreatic	Continue to support the long-term EUROPAC study for people with an increased familial risk of pancreatic cancer by promotion of referral pathways from primary and secondary care and through the genomics services		Yes	
Liver	Establish the liver surveillance pathway in all three Trusts for people at high risk of developing liver cancer due to other high-risk diseases, ensuring these are supported by electronic patient management and call and recall systems so that vulnerable residents do not slip through the net.		Yes	
Oesophageal	Expand the use of the capsule sponge as a surveillance tool for patients with a risk of Barrett's Oesophagus		Yes	
Ovarian	Implement NG241 to enable women with a high genetic risk of ovarian cancer to avoid risk reduction surgery and loss of fertility		Yes	

Headline Goals & Outcomes by 2030 Aligned to the NEL Outcomes Framework

In the next 5 years, the strategic commissioning of specialised services will increasingly reflect the wider system shifts towards prevention, community-based care, and digital innovation.

GOALS

- Zero HIV transmissions by 2030
- 90% uptake of ED opt-out testing
- Mechanical Thrombectomy access to 15% of eligible population
- Kidney DOM sustainably reduced to < 90%
- TAVI waiting times reduced to 18 weeks
- Reduced acute sickle cell admissions
- Waiting times for vascular surgery reduced to 18 weeks



OUTCOMES

- Health problems are caught early & managed well
- People live longer healthier lives
- People can access the right care when they need it
- People receive high-quality, safe care wherever they go
- All families get the support they need
- Services are financially sustainable & provide value

Together, these shifts will require the strategic commissioning of new models of service design, workforce capability and digital infrastructure, ensuring specialised services are more sustainable, accessible, and aligned with the future population health needs of NEL ICS.

DRAFT

Specialised Services - Delivering the three strategic shifts

SS programme area	Service area	Timeframe	Acute to community	Treatment to prevention	Analogue to digital
Blood and Infection	Sickle Cell: shift acute sickle cell care to the community	2026 - 2030	Yes	Yes	Yes
	HIV: Implement agreed actions from the NEL joint sexual health strategy	2026 - 2030		Yes	
Internal Medicine	Renal Dialysis: prevention programme and capacity expansion	2026 - 2030	Yes	Yes	Yes
	Vascular: review of service model	2027-2030	Yes	Yes	
	Cardiac: reduce waiting times and manage demand	2026 - 2030	Yes	Yes	Yes
	Liver & Hepatitis: pathway review to support prevention and early detection	2026 - 2030	Yes	Yes	Yes
	ED Opt-out testing: achieve 90% uptake in all NEL EDs	2026 - 2027		Yes	
	Interstitial Lung Disease: shared care agreement and local provision	2026		Yes	Yes
Major Trauma/Neurosciences	Mechanical Thrombectomy: review of service model	2026 - 2028		Yes	Yes
	Major Trauma: re-alignment of pathways to support more local provision	2026 - 2029		Yes	Yes
	Critical Care: demand and capacity review	2026 - 2027			Yes
Cancer	Implementation of the ICB specialised cancer long-term strategic approach	2027 - 2031			Yes
Women & Children	Complex Urogynae: reduce waiting times and service spec compliance	2026 - 2030	Yes	Yes	
	POSCU: meet requirements of a new enhanced service specification	October 2026			Yes
	Neonatal Transfer Service: commission a sustainable Pan London neonatal transfer service (hosted within NEL)	2026 - 2028			Yes
	Paediatric Long-Term Ventilation: review of Pan London service model/principles	2026 - 2030	Yes		Yes

North East London Health & Care Partnership

Community Strategic Commissioning Headline Goals

Integrate community services through neighbourhood-based multidisciplinary teams, aligning with local people's needs and the NHS 10-Year Plan to deliver care closer to home

Deliver consistent Community Core Offers across NEL

(UCR, Stroke/Neuro, CYP Therapies in partnership with MHLDA, Intermediate Care, Frailty, CYP & ARI, Virtual Wards, Adult Nursing)

to reduce variation and improve equity of access

Integrate services through neighbourhood-based multidisciplinary teams, aligned to local authority footprints, to ensure care reflects local people's needs and the NHS 10-Year Plan

Reduce waiting lists and improve performance by cutting open pathways from ~57,000 (July 2025) to ~40,000 by March 2027, eliminating waits over 52 weeks, and meeting UCR and Virtual Ward targets. This will need to be done in partnership with a wide range of partners and commissioning areas

Enhance productivity and digital enablement by embedding Single Points of Access, care navigation, remote monitoring, and digital self-management tools across all places

Strengthen workforce resilience and sustainability through skill-mix redesign, joint workforce planning with partners, and reducing dependency on agency staff

Underpinned by population health management approach and NHS OF

Alignment with Community Programme:
Core Offers (UCR, Virtual Wards, Intermediate Care, Frailty & ARI, Community Nursing, Neuro & Stroke, CYP Therapies); Place-based and neighborhood delivery; Workforce resilience and redesign; Digital enablement and productivity; Prevention and population health improvement.

Interface with wider system priorities: Integrated Neighbourhoods; Single Point of Access & Care Navigation; Mental Health and SEND; Primary Care and Same Day Access; End of Life Care; Links with voluntary, community, faith and social enterprise partners

North East London Health & Care Partnership

Community Services - Delivering the three strategic shifts

The table below summarises how the Community strategic commissioning priorities will support the delivery of the three strategic shifts (Acute to Community, Treatment to Prevention and Analogue to Digital)

Community Service area	Timeframe	Acute to community	Treatment to prevention	Analogue to digital
Urgent Community Response (UCR)	2026–2027	Yes		
Virtual Wards (all age)	2026–2028	Yes		Yes
Community Intermediate Care	2026–2028	Yes		Yes
Frailty & ARI Pathways	2025–2027	Yes		Yes
Community Neurological & Stroke Rehab	2025–2027	Yes		Yes
Children & Young People Therapies Core Offers	2026–2029	Yes	Yes	Yes
Eliminate 52 week waits - all age, but for Paediatric Neurodiversity working on partnership with MHLDA	2026-2028	Yes		Yes
Adult Community Nursing Core Offer	2026-2027	Yes	Yes	
Single Point of Access (SPOA) / Care Navigation	2026–2027	Yes	Yes	Yes
Workforce & Productivity	2025–2030	Yes		Yes
Review of Core Contracts and rationalise smaller contracts	2026–2027 and annually	Yes	Yes	
Community Equipment stabilisation, review and recommissioning	2026-2828			
Community Beds	2026 – 2028	Yes	Yes	
Strategic Approach to Virtual Health	2026 – 2029	Yes	Yes	Yes

North East London Health & Care Partnership

End of Life Care (EOLC) - Strategic Commissioning Headline Goals

A focus on improving end of life care is not only about compassion, it is also about system sustainability. Poorly coordinated care can lead to avoidable hospital admissions, delayed discharges, and distressing experiences for patients and families. Strengthening end of life care is essential to deliver on the goals of integrated care, health equity, and value for populations. We will focus efforts around four areas:

ACCESS

Improved access to palliative and end of life care, 7 days a week, including access to syringe drivers to enable more care in the community and reduced hospital length of stay

A consistent route for advice and guidance for all clinicians, families and carers

EOLC services for the homeless

NEIGHBOURHOODS

Culturally sensitive, consistent Bereavement Services, including for children and young people after the loss of a parent

Out of hours emergency medication service

Increase the usage and quality of Universal Care Plans for EOLC adults

Neighbourhood EOLC model for all ages

Increased death literacy for patients, families and staff

Death Certificates issued in 24 hours to align with cultural norms

CONTINUING HEALTH CARE (CHC)

Move towards pre-commissioned, integrated palliative and EOLC

HOSPICES

Support growth of offer to move towards financial sustainability

Develop transition planning for children and young people moving to adult services

Underpinned by population health management approach and NEL EOLC Strategy

Alignment with EOLC programme: Proactive Care (LTCs, UEC), Community Care, Primary Care and Babies, Children and Young People

End of Life Care - Delivering the three strategic shifts

The table below summarises how the NEL EOLC strategic commissioning priorities will support the delivery of the three strategic shifts (Acute to Community, Treatment to Prevention and Analogue to Digital) over the next 3-5 years. *Note: subject to funding.*

Programme area	Service area	Timeframe	Acute to community	Treatment to prevention	Analogue to digital
Access	Improved access to palliative and end of life care for the whole population	2025/26 – 2030/31	Yes		
	Develop a consistent route for advice and guidance across all Places in NEL for clinicians, family, friends and carers	2026/27	Yes		
	Embed the pilot to implement a seven day community offer for EOLC across Waltham Forest *(also fits with Neighbourhoods)*	2025/26 – 2028/29	Yes		
	End of life care for the homeless	2026/27 – 2027/28	Yes		
	Terminally Ill Adults Bill implications	2028/29	Yes		
Neighbourhoods	Culturally sensitive Bereavement Services, including bereavement care and support for children and young people post the loss of a parent	2025/26 – 2028/29		Yes	
	Embed an out of hours services for emergency medications	2025/26 – 2026/27	Yes		
	Increase the percentage of completed and fully utilised Universal Care Plans (UCPs)	2026/27 – 2027/28			
	A consistent neighbourhood model of care for EOLC, including virtual wards, for all ages including increased usage of digital tools for efficiencies	2026/27 – 2030/31	Yes		Yes
	Outcome based and person-centred approach to palliative and end of life care for children and young people, through the use integrated personal budgets and an effective short break offer for children, young people and their families	2027/28 – 2030/31	Yes		
	Increased levels of death literacy across our communities, neighbourhoods and workforce	2026/27 – 2030/31	Yes	Yes	
	Death certificates within 24 hours to align with cultural norms	2027/28			
Continuing Health Care (CHC)	Pre-commissioned, integrated palliative and end-of-life care services	2027/28 – 2030/31	Yes		
Hospices	Support growth of offer to move towards a sustainable financial model (linking into Neighbourhoods intention above)	2026/27 – 2030/31	Yes		
	Person-centred approach to transition planning	2027/28 – 2030/31	Yes	Yes	

LTC - Overview of commissioning intentions

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The NEL LTC commissioning approach sets out that within five years, long-term condition care in North East London will be prevention-focused, delivered in the most appropriate setting, digitally enabled, and equitable across all boroughs, aligned with the NHS 10-Year Plan

We will support workforce wellbeing, retention, and development to enable the delivery of high-quality, clinically led services across all ages, while commissioning care that meets or exceeds national standards.

Prevention First

- Commissioning aligned to the draft NEL Prevention Strategy, tackling root causes of ill health, reducing health inequalities, and embedding proactive care across pathways
- A 'think family' model with communities and VCSE partners, addressing wider determinants such as housing, employment, and social support, and embedding prevention across the care pathway
- Prevention hardwired into every Integrated Neighborhood Team (INT), using predictive analytics to identify residents at risk earlier and enable timely interventions before conditions escalate, reducing avoidable admissions and improving outcomes

Equity and sustainability

- Scaling up award-winning services and best practice into a Core–Enhanced–Aspirational offer, ensuring all communities access a consistent baseline of care
- Reusing funds differently to move away from non-recurrent grants propping up core services, aligning resources to outcomes
- Co-design with residents and VCSE partners to ensure services are culturally competent and accessible, particularly for underserved groups (e.g. migrants, homeless people)

Holistic support in the right place

- **INTs for accessible, joined-up care: Integrated Neighbourhood Teams (INTs)** will provide accessible, joined-up care for people with lower-acuity and rising-risk needs. They will bring together primary care, community services, social care, and the VCSE sector to deliver proactive management, reduce duplication, and connect residents into wider prevention and wellbeing support.
- **Specialist hubs for complex needs:** People with complex or high-acuity conditions will be supported through **LTC hubs and renal-cardiometabolic clinics**, receiving coordinated, multidisciplinary care in the most suitable setting hospital, community, or integrated pathway with wraparound support for physical, mental and social needs.
- **Rehabilitation as a standard offer:** Consistent **community-based rehabilitation services** (stroke, cardiac, pulmonary) will be available across all boroughs, helping people recover faster, maintain independence, and reduce reliance on acute hospital beds.

Underpinned by population health management approach and digital as key enabler

The commissioning intentions address immediate challenges—such as Hybrid Closed Loop and stroke/neuro-rehabilitation—while also setting out multi-year priorities through the NEL LTC Framework, Integrated Neighbourhood Teams, and LTC/renal cardiometabolic hubs, with a strategic shift towards prevention and more proactive models of care.

Interfaces with the Community Programme, Prevention, Virtual Wards, Babies, Children and Young People, Primary Care, Integrated Neighbourhoods, End of Life Care, Specialised Services, Urgent and Emergency Care (UEC), Homeless Health, and the Equity and Inequalities Team.

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LTC High level - Delivering the three strategic shifts

LTC Speciality	High Level Commissioning Intentions		Work commencing	Acute to community	Treatment to prevention	Analogue to digital
Overarching	LTC Framework		26/27 onwards	Yes	Yes	Yes
	LTC proactive and preventative approach to multimorbidity's across LTCs and wearable technology		26/27 onwards	Yes	Yes	Yes
	INT and prevention and proactive care for LTCs		26/27 onwards	Yes	Yes	Yes
	Renal cardiometabolic clinics/LTC hubs		tbc		Yes	Yes
	Psychological support for children and young people with long term conditions		26/27 onwards		Yes	
Weight Management	Specific CI not captured in overarching	Complications with Excess Weight for children and adults	27/28		Yes	Yes
		Weight management including tier 2 and Tirzepatide	26/27 onwards	Yes	Yes	
Alcohol		Alcohol Care Teams (ACTs)	26/27		Yes	
Smoking		Smoking support for inpatients, maternity	26/27		Yes	
DiabetesT1 and T2		Type 1 diabetes including Young Adult Transition care, Type 1 Disordered Eating Service (TIDE) and Hybrid Closed Loop technology	26/27 onwards	Yes	Yes	Yes
		Type 2 Community Podiatry and Emergency weekend diabetes vascular services	27/28		Yes	
CVD		Heart failure virtual START HF (ORTUS platform) and wider HF pathway, Anticoagulation and cardiac rehab	26/27 onwards	Yes	Yes	Yes
Renal		CKD (renal cardiometabolic approach)	26/27 onwards	Yes	Yes	Yes
Respiratory		Children and Young People's Asthma, Diagnostic Spirometry & FeNO and Pulmonary Rehabilitation	26/27 onwards	Yes	Yes	Yes
Frailty		Digital solutions	27/28	Yes		Yes
TB		BCG under 16, LTBI and Non-Tuberculous Mycobacteria (NTM) services	26/27 onwards		Yes	
Stroke and Neuro		Community Stroke and Neuro rehabilitation, FND, acute beds and 2B neuro beds	26/27 onward	Yes		
Wider BYCP		Free prescriptions for care leavers, Sunrise Hub / Lighthouse CSA Service and national priorities	26/27 onward	Yes	Yes	Yes

North East London Health & Care Partnership

Primary Care - Strategic Commissioning aims and objectives

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

Our aim is to deliver on ambitious plans that transform primary care, offering patients with diverse needs a wider choice of personalised, health services through collaboration with partners across the health, social care and communities. A focus on improving access, prevention, personalisation, tackling inequalities and building trusting environments

Objective	How the primary care commissioning plan will deliver on our aims and objectives
Ensuring effective primary care contract oversight and management	Our plan establishes a consistent, outcomes-based contractual framework across all seven boroughs, with regular reviews to align contracts with population health needs. It includes robust performance monitoring using metrics like appointment volumes, patient satisfaction, workforce capacity and digital tool utilisation, supported by assurance processes and committee oversight reporting to NHS England. Quality and safety are overseen through CQC ratings, QOF achievement, and the Learn From Patient Safety Events (LFPSE) platform. The plan also includes a commissioning review programme, continuous engagement with patients and providers, risk management strategies and supports delivery through a transformation portfolio, delivery dashboard, and transparent reporting mechanisms to drive consistency, accountability, and continuous improvement in primary care.
Commissioning appropriate services in and for primary care	We will commission appropriate primary care services to improve health outcomes, access, and patient experience. It covers general practice, pharmacy, optometry, and dental services, including acute, urgent, and out-of-hours care. Our plan emphasises the Same Day Access model to enhance timely care. Local enhanced services will be reviewed to ensure consistency, equity, and an outcomes-focused approach, addressing health inequalities and vulnerable groups. It also highlights medicines optimisation, integration of long-term condition frameworks, and local incentive schemes to drive improvements. These commissioning intentions are informed by population health needs and strategic priorities, aiming for both immediate and long-term impact, aligned with system-wide shifts and equity considerations.
Developing the primary care workforce	We will meet the pledge to “bring back the family doctor” by expanding the GP workforce in line with population growth and population health need. We shall improve recruitment by expanding training opportunities; offering new career opportunities including fellowship, portfolio roles, enhanced and advanced roles; and the development of anchor networks. We shall improve retention by addressing staff resilience and wellbeing through coaching, mentorship and peer support. We will identify and address gaps in our workforce capacity and capability through targeted interventions and workforce planning. We will monitor workforce capacity and capability to develop insight, inform our interventions and improvements. Our workforce plan will develop a workforce that can lead and deliver integration with community and mental health services, digital access and population health management.
Improving patient access and experience	Our plan outlines aims to improve patient experience and access by incorporating resident feedback through various channels to enhance services, addressing access concerns with a focus on making it easier for patients to contact their practice, increasing appointments and face-to-face consultations, and improving digital inclusion. It aims to reduce variation in patient experience and outcomes, particularly in deprived and diverse communities and enhance accessibility for vulnerable groups through programmes like Safer Surgeries. The overall goal is to ensure patients can access high-quality primary care services when needed, with a focus on equity and reducing health inequalities.

Underpinned by population health management approach and the primary care outcomes framework

Interface: Urgent and emergency care, long terms conditions, neighbourhood development, Mental health, Community Care, Babies, Children and Young People

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North East London Health & Care Partnership

Primary Care - Delivering the three strategic shifts

Primary Care Commissioning Priorities	Outcome	Time frame	Community	Prevention	Digital
1. Primary care commissioning framework: Develop a primary care commissioning framework within our new primary care strategy for NEL	A comprehensive strategy to improve outcomes, access and experience	2026	✓	✓	✓
2. National commissioning					
General practice – provision is in place for the whole of the population for core general practice services	Patients can access high quality primary care services where and when they need them	On going	✓	✓	✓
Pharmacy and optometry– ensure provision is in place for the whole of the population for core pharmacy and optometry services, including Pharmacy First		On going	✓	✓	✓
Dental – ensure provision is in place for the whole of the population for core dental services, as well as acute, urgent and OOH care	Primary care contributes to all of the outcomes in the NEL outcomes framework	On going	✓	✓	✓
Medicines – Tirzepatide for weight management, supporting the medicines team		On going		✓	
Immunisations - Increase uptake (especially in children to meet WHO targets and vulnerable adults eg house bound) and reduce variation across NEL by raising awareness and confidence.		On going		✓	
3. NEL Local commissioning	Improved access, reduced waits				
To provide a consistent, equitable, and outcomes-focused offer across NEL, with services tailored to the needs of patients within each Place and neighbourhood, focussing on health inequalities and vulnerable groups.	Improved management of LTC leading to improved outcomes	On going	✓	✓	✓
Local enhanced services and incentive schemes reviewed in line with our commissioning review	Reduced admissions	2025-27	✓	✓	
LTC framework will be embedded within primary care commissioned services (Y1 to Y5)	High service quality	2025-30	✓	✓	✓
Our Same Day Access model will be revised and firmly embedded within primary care (joint work with UEC)	Value for money	2025-28	✓	✓	✓
Primary care will lead and support neighbourhood development and delivery	Dedicated and standardised service across NEL, improved LTC management	2025-29	✓	✓	
Medicines optimisation initiatives to improve population health, LTCs management and patient centred		2026-27			
4. Transformation/innovation/support					
IT and digital tools and initiatives will increase access and experience for patients as well as supporting interoperability between providers (supporting neighbourhood development and wider)	Grow and diversify workforce	2025-27	✓	✓	✓
Data, facilitation and support for providers will be reviewed and revised in line with a population health models	Support retention of the workforce		✓	✓	
Quality: Improve patient safety in primary care by supporting primary care organisations to adopt and adapt key elements of the new primary care patient safety strategy over time.	Increase access and experience	2025-27		✓	
FTSU Guardian service will be expanded to, and embedded within, all primary care services	Improve care quality	2026-27	✓	✓	
Workforce – Capacity and Capability: expand the number of PC HCPs in training. enable Fellowship , targeted offer of workforce planning to practices and PCNs where workforce numbers are below thresholds, professional development across key professional roles (medical, AHP, nursing, pharmacy), increasing coaching and mentorship capacity, expanding community of practice and peer support, acting on the feedback in the GPSS	Increase clinical and non-clinical leadership Culture of transparency and openness Improved patient safety in primary care	2026-27 2025-28	 ✓	 ✓	

North East London Health & Care Partnership

UEC strategic commissioning headline goals

The NEL Urgent and Emergency Care commissioning plans set out our approach to commission and deliver high quality, equitable and outcomes based across all for our population. Our goals aligns to the NHS 10 Year Plan taking a collaborative approach and clear focus on prevention, development of transformative care utilising alternative care pathways, optimising digital innovation and alignment where possible to same day care, community care and integrated neighbourhoods,

Reduce avoidable admissions and ED attendances and prioritise strategic commissioning in UEC which focuses on the three strategic shifts

- Hospital to community
- Analogue to digital
- Treatment to prevention

-Supported by UEC Block Deconstruct

Improve equity of access and outcomes across all communities

- NHS App embedded into pathways
- Natural Language Processing
- AI / Health Navigation
- Strategic transformation programmes including Care Closer to Home & 111 “evergreen” & 999 commissioning

Commission services to meet or exceed national standards for **National UEC constitutional and quality standards.**

_**Ambulance** response
_4 and 12 hours flow
_Discharge & LOS
_Quality standards,

minimising variation and creating an equitable offer of care for North East London residents.

Implement a single point of access for UEC across all access channels to assess and prioritise need safely and equitably through:

Alternative care pathways
Simplify access to urgent and emergency care services to ensure right care, first time, closer to home and enable flow optimisation.

Support workforce wellbeing, retention and development to deliver high quality, clinically-led services across all ages.

Linked to
Strategic commissioning
Workforce shift and changes linked with SDA, SPoA and INT

Underpinned by population health management approach and UEC outcomes framework

Alignment with UEC programme: Out of hospital; In hospital; Resilience and coordination; 111 commissioning and contract priorities in 2526 and plan for 2627 & 27/28

Interface with Alternative Care Pathways & Single Point of Access; Virtual Wards, intermediate and community capacity; Mental Health; Same Day Access; Babies, Children and Young People; Primary care; Integrated Neighbourhoods; End of Life Care.

North East London Health & Care Partnership

UEC - Delivering the three strategic shifts

The table below summarises how the NEL UEC strategic commissioning priorities will support the delivery of the three strategic shifts (Acute to Community, Treatment to Prevention and Analogue to Digital) over the next 3-5 years. There is an overarching deconstruct of the block for UEC commissioning intentions detail of which is highlighted in slide 7.

UEC programme area	Service area	Timeframe	Acute to community	Treatment to prevention	Analogue to digital
Out of hospital	111 contract and service	2025 - 2033	✓		✓
	Virtual care including Virtual Wards, Intermediate Care & Community	2026-2027 Timeframe is subject to funding	✓		✓
	Same Day Access	2026-2027 Timeframe is subject to funding	✓	✓	✓
	Care Closer to Home	2025 - 2030	✓	✓	✓
	Health Navigator	2025 - 2027	✓	✓	✓
In hospital	999 contract and service	Continual (reviewed annually)	✓		✓
	Urgent Treatment Centres including Front Door Streaming	2026-2027	✓		✓
	Hospital Flow	Ongoing	✓		✓
	Mental Health UEC (led by MHLDA Collaborative)	Ongoing	✓	✓	✓
Resilience and coordination	Single Point of Access (SPoA)/Integrated Care Co-Ordinator (ICC)	2026-2027 phased and subject to funding	✓	✓	✓
	System Coordination Centre	2025 - 2026	✓		✓
	Review of core and non-core contracts, including Place and deconstruct of the UEC Block	2026-2027 and annual	✓	✓	

NEL Vision for INTs

Everyone in north east London lives in a neighbourhood which supports and actively contributes to their physical and mental health and wellbeing

As partners across the system we will work closely together in local neighbourhoods. This means **creating an environment in which a range of assets, facilities and services are available to enable local people to start, live and age well and healthily.**

Our Vision

Based in and for local geographic communities

Coordinated and joined up

Strengths based – building on the assets of the individual, family and the local community

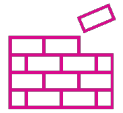
A culture of prevention in all interactions

Use the hyper local footprint to address local need

Targeting and seeking to reduce health inequalities

Our Approach

Use data to target our resources on those in most need



Build on existing integration work

Co-produce with communities

Recognise that this is a cultural change that will require new ways of working

This vision can be summarised into four strategic goals and desired outputs

Goal	Desired outputs
Work with and for local communities	1. Care delivery in a community settings wherever possible 2. Enable individuals and families to take greater agency over their health and wellbeing 3. Work effectively with local communities to co-produce solutions to the health and wellbeing issues which matter to them 4. Work in a strengths-based approach to build capacity in individuals, families and communities, enabling resilience 5. Leverage local assets, including community networks and partners, to support holistic wellbeing
Work in a proactive, preventative way to address rising need	1. Use data to identify and target resources for individuals and groups at the highest risk of health decline / deterioration 2. Prioritise early intervention, preventative and proactive care to address health needs before they escalate
Deliver integrated, accessible care	1. Neighbourhood to provide timely and coordinated interventions 2. Promote continuity of care for individuals with long term or complex needs 3. More targeted support for families and the highest users of services 4. Deliver care aligned with the Good Care Framework, ensuring services are trustworthy, accessible, competent and person centred
Support service sustainability	1. Consider aligned financial incentives to support the quality and financial sustainability of core services ensuring the most effective role for general practice at the heart of neighbourhood services 2. Address current and future workforce pressures through workforce and care pathway transformation

North East London Health & Care Partnership

Neighbourhood - Delivering the three strategic shifts

The table below summarises how the NEL UEC strategic commissioning priorities will support the delivery of the three strategic shifts (Acute to Community, Treatment to Prevention and Analogue to Digital) over the next 3-5 years.

Neighbourhoods programme area	Area	Timeframe	Acute to community	Treatment to prevention	Analogue to digital
Neighbourhood Teams	Develop an INT to support **adults with multi-morbidity** and complex needs, including proactive support to those with rising or unmet needs	2026-27	Yes	Yes	
	Develop an INT to support **BCYP** with complex needs, developing strong links with specialist teams and family hubs	2026-27	Yes	Yes	
	Develop a model of neighbourhood **mental health**	2027-28	Yes	Yes	
	Proactively identify and address the health and wellbeing need of older children and **adolescents**	2027-28	Yes	Yes	
Health Promotion	Ensure the neighbourhood team(s) is well **connected to the local community** and can support people's holistic needs	2027-28		Yes	Yes
	Actively address population health issues and **health inequalities** in a neighbourhood, working with residents and VCFSE partners	2027-28		Yes	Yes
Enablers	Embed a **PHM** approach including use of the Optum platform	2026-2027	Yes	Yes	Yes
	Address **digital exclusion** and maximising use of the NHS App	2027-28			Yes
	Support the **workforce** to deliver new ways of working in neighbourhoods	2026-2027	Yes	Yes	

Appendix

September 2025

National and local requirements to be delivered under business as usual operations (1/3)

- In addition to the transformative focus of these commissioning intentions, providers are expected to deliver all required operating plan targets and continue to pursue internal improvement programmes as part of their business as usual activities.
- Included here is an overview of the requirements, but it should not be seen as an exhaustive list

National guidance

- Providers should ensure they meet the requirements set out in the national operating planning guidance: NHS England 2025/26 priorities and operational planning guidance
- NHS England NHS Oversight Framework 2025/2026: NHS England » NHS Oversight Framework
- The plan for 2026/27 will be added once available.
- Providers should ensure they meet the requirements set out in the national elective reform plan: NHS England Reforming elective care for patients
- Providers should ensure they meet the requirements set out in the national Urgent and Emergency Care plan: NHS England Urgent and emergency care plan 2025/26
- Providers should ensure they deliver within the context of the national 10 Year Health Plan: NHS England Fit for the Future: 10 Year Health Plan for England
- Providers should ensure they deliver within the context of the national neighbourhood health plan: NHS England Neighbourhood health guidelines 2025/26

National and local requirements to be delivered under business as usual operations (2/3)

Financial expectations

All NHS providers will be expected to

- **Maintain in-year financial balance,** demonstrating monthly compliance within agreed financial plans and contracts.
- **Deliver Recurrent Cost Improvement Plans (CIPs)** and improve productivity in line with commissioning and financial arrangements.
- **Deliver the strategic commissioning asks** within the agreed financial envelope.
- **Use service line reporting** and costing data to help inform commissioning decisions and service delivery.
- **Work with other providers** to deliver our system strategy.
- **Work collaboratively** to reduce void costs and drive efficiency in the use of system estate
- **Develop options for working together** across organisational and geographical boundaries to consolidate back and mid office functions
- **Effective utilisation of cash and capital** both strategic and operational
- **Develop credible investment proposals** to support delivery of the 10-year health plan objectives

Data & Digital expectations

All providers are expected to

- Collect data in line with national requirements and to continuously i**mprove data collection** and quality, including for protected characteristics
- Connect into the **London Care Record (LCR)** to make patient records visible to other LCR users and connect your patient record systems to allow your clinicians to view patient data on the LCR. There may be an initial and recurring cost to doing this.
- Flow all necessary data (as defined by the ICB) into the **London Data Service** on a regular basis to enable risk stratification and other insights to be developed as required.
- Co-operate with moves towards the **Single Patient Record**, as outlined in the ten-year health plan.
- Have up-to-date **cyber response plans,** robust assurance process in relation to it and clear risk assessments of the cyber arrangements both on their own networks and for subcontractors in their supply chain

National and local requirements to be delivered under business as usual operations (3/3)

Quality expectations

The ICB has a range of quality expectations as outlined below:

- Demonstrate a clear executive-level line of accountability for quality, including safety, user and staff experience, vaccinations and safeguarding
- Demonstrate progress towards a strong patient safety culture and robust safety management system through the continued implementation of the NHS Patient Safety Strategy and associated frameworks
- Ensure robust processes are in place to comply with National Guidance on Learning from Deaths
- Maintain systems and processes that prevent abuse and assure quality across the life course
- Undertake continuous improvement work to address the most well-known patient safety issues (falls, pressure ulcers, medication errors, self-harm, diagnostic errors) and respond to emerging concerns (i.e. those identified via National Patient Safety Alerts)
- Comply with national safety improvement programmes and incentive schemes (i.e. maternity and neonatal) to address core patient safety issues and inequalities
- Ensure robust infection, prevention and control strategies and measures are in place to meet national standards and respond effectively to outbreaks
- Ensure systems are in place to promote vaccination programmes for eligible staff and patient groups
- Ensure they proactively seek, promptly respond to, and rigorously apply learning from patient and carer feedback
- Ensure timely and equitable access to services that promote coproduction of person-centred care
- Ensure they proactively seek, promptly respond to, and rigorously apply learning from staff feedback.
- Ensure safe cultures where staff are able and supported to speak out
- Plan for, and implement safe staffing arrangements, ensuring compliance with the Developing Workforce Safeguards and Safer Staffing Guidance
- Ensure robust processes are in place to ensure staff are safely recruited, appropriately trained and supported to continuously develop
- Ensure robust processes are in place to promote staff health and wellbeing, with a focus on promoting equality, equity and inclusion
- Demonstrate improvements in outcomes for service users, reducing health inequalities in national priority areas (maternity, mental health, COPD, cancer, hypertension, diabetes, asthma, epilepsy, oral health)
- Ensure services and treatments are delivered in line with national guidance and demonstrate proactive involvement in research and innovation efforts

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Havering Combatting Drugs Partnership (CDP) – Annual Report 2024/25
Board Lead:	Mark Ansell, Director of Public Health
Report Author and contact details:	Parth Pillai, parth.pillai@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 • Increase employment of people with health problems or disabilities • 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. • 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 • The prevention of obesity • Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups • Strengthen early years providers, schools and colleges as health improving settings
☒	The communities and places we live in • Realising the benefits of regeneration for the health of local residents and the health and social care services available to them • 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 • Development of integrated health, housing and social care services at locality level.
☐	BHR Integrated Care Partnership Board Transformation Board • Older people and frailty and end of life • Long term conditions • Children and young people • Mental health • Planned Care Cancer Primary Care Accident and Emergency Delivery Board Transforming Care Programme Board

Havering
LONDON BOROUGH

SUMMARY

The Havering Combatting Drugs Partnership (CDP) Annual Report 2024–25 sets out progress made in reducing drug and alcohol-related harms across the borough through joint working between the Council, NHS, police, voluntary sector and community partners.

The report describes how the CDP continues to strengthen treatment and recovery systems, improve partnership coordination, and respond to emerging risks such as synthetic opioids. Alcohol remains the greatest cause of substance-related harm locally, though drug misuse continues to present challenges linked to health, crime, and community safety.

Havering continues to perform strongly in key outcome areas. Treatment engagement and recovery rates are above both London and England averages for certain drug groups, with the number of adults and young people in structured treatment increasing during 2024/25. The partnership has successfully transitioned to the new Drug and Alcohol Treatment, Recovery and Improvement Grant (DATRIG), sustaining service capacity despite short-term funding cycles.

The CDP operates a whole-system approach, aligning enforcement, treatment, and prevention work. Key developments include improved data sharing, the implementation of a synthetic opioids preparedness plan, enhanced safeguarding training, and development of a Drug and Alcohol Review of Deaths (DARD) process.

Overall, the report demonstrates continued progress, strong governance, and a coordinated approach to reducing harm and improving recovery outcomes for Havering residents.

RECOMMENDATIONS

That the Board endorse the partnership's priorities for 2025/26, including:

- Embedding Project ADDER;
- Refreshing the local Substance Misuse Needs Assessment;
- Implementing the Children & Young People's Communications Plan;
- Implementing a DARD process; including review of the pilot DARD panel.
- Continuing work to improve opiate recovery, BBV testing and treatment and continuity of care rates.

REPORT DETAIL

See attached CDP Annual report

Havering
LONDON BOROUGH

IMPLICATIONS AND RISKS

The partnership's ability to sustain current service levels is dependent on continuation of national grant funding beyond March 2026.

The emergence of synthetic opioids presents an ongoing public health risk requiring local preparedness.

Rising service demand and cost-of-living pressures, may impact delivery capacity.

Strong partnership coordination remains essential to maintain progress and address inequalities in access and outcomes.

BACKGROUND PAPERS

Havering Combatting Drugs Partnership Annual Report 2024/25

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Havering Combatting Drugs Partnership (CDP) Annual Progress Report, October 2025

Executive Summary

The Havering Combating Drugs Partnership (CDP) is now in its fourth year of operation. Its main aim is to promote cooperation between partners to reduce harms caused by drugs and alcohol in the London borough of Havering. Quarterly CDP meetings provide an opportunity for CDP members to gain an understanding of the needs of residents, share best practice, review progress, improve collaboration and jointly resolve emerging issues.

In Havering, in terms of health impacts, alcohol continues to be a bigger cause of harm than drugs. Emerging issues are the increasing availability of high-potency synthetic opioids in London, online selling of drugs and changing drug use patterns, such as the rising use of Ketamine.

Our commissioners and our local service provider smoothly transitioned across from the end of the Supplemental Substance Misuse Treatment and Recovery Grant (SSMTRG) to a Drug and Alcohol Treatment, Recovery and Improvement Grant (DATRIG). Havering is not in receipt of Rough Sleeping Drug and Alcohol Treatment Grant (RSDATG) and Housing Support Grant (HSG). Havering is in receipt of the Individual Placement and Support (IPS) grant. We are awaiting confirmation of future grant funding beyond the end of March 2026. Despite the short-term nature of the current confirmed grant allocations, our commissioned services continue to work together with partners to deliver the best possible outcomes for our residents.

Between July 2024 and July 2025 notable achievements include:

- Adults in treatment with our drug and alcohol service provider has risen to 1,018 (May, 2025).
- Young people in treatment with our drug and alcohol service provider has more than doubled as of May 2025.
- The production of a synthetic opioids preparedness plan.
- Completion of the Children and Young People's (CYP) service improvement framework from ADPH London.
- The drug and alcohol indicator dashboard has been reviewed and updated to align with CDP priorities.
- Multi agency safeguarding training around substance use for adults and children provided by CGL

1. Contextual Information on Combatting Drugs Partnership (CDP) in Havering

1.1. CDP Footprint

London Borough of Havering

1.2. Governance (also see Appendix A):

- The Senior Responsible Officer (SRO) is a Director of the Council, currently the Director of Public Health.
- An Assistant Director of Public Health chairs the CDP partnership board.
- The SRO reports to central government via the Office for Health Improvement and Disparities (OHID).
- The partnership is accountable to the Havering Community Safety Partnership (HCSP) and Havering Health and Wellbeing Board (HHWB).
- In addition, progress updates are reported to the Havering Place-based Partnership Board, Havering Safeguarding Adult Board (SAB), Havering Safeguarding Children's Partnership and the Community Safety Partnership.
- Requests are made to existing partnership groups where actions are within their remit, with the aim of minimising the need for new working group establishment.
- Progress on the CDP action plan, derived from the Drugs and Alcohol needs assessment, is monitored by a CDP support group, comprised of relevant Council officers, substance misuse provider and mental health trust.

1.3. Membership:

See Appendix B

1.4. Senior Responsible Officer:

Mark Ansell, Director of Public Health

1.5. Scope:

The CDP covers a wide remit of all substances, which have the potential for addiction and abuse, except tobacco and caffeine.

Mandated responsibilities:

- To conduct a joint needs assessment to review local substance misuse data across sectors and evidence.
- To work closely with partners to *identify* local strategic priorities, lead the production of a local *substance misuse strategy* and implement *action plans* as appropriate within agreed timescales and scope.
- To develop a whole systems approach to *monitor and measure* the progress of the local substance misuse strategy, action plan and the outcomes outlined by the strategy.

Local responsibilities:

- To performance manage relevant government grants especially DATRIG and IPS.
- To respond to any published national and local strategies, guidance and directives as they relate to alcohol and drug misuse.
- To coordinate the delivery of the local strategy action plan to realise improvements in performance.
- To respond, develop and monitor solutions to interagency issues, as they arise, in order to deliver the drug strategy.
- To represent the Havering local system in communicating with national and regional bodies.
- To share best practice across the partnership to improve integration across the local system and outcomes for young people, adults and families most at risk of harm from substance misuse in Havering.
- To bring to life the principles of comprehensive treatment and recovery alongside other evidence-based approaches to reduce initiation in and continued use of drugs and alcohol.
- To oversee Drug and Alcohol Review of Deaths.

2. Summary of the drugs and alcohol landscape in Havering

2.1. Key Findings from Havering CDP's local needs assessment (Jan 2023) updated for 2024/25:

Reducing Supply

- Havering has more alcohol selling premises per square kilometre rate (5.2) in comparison to the England average (1.3) in 2021/22. The number of premises has remained largely unchanged in 24/25 and continues to be above the England average.

- Police knowledge of drug supply chains can be viewed at the end of this section

Drug and alcohol Misuse

- Alcohol-related deaths among males have increased over the past three years from 43.4 per 100,000 population in 2021 to 58 per 100,000 in 2023, a rate lower than the England average 62 per 100,000 (2023).

- In the past 12 months (April 2024 - April 2025), the rate of alcohol-specific deaths in Havering was 5.98 per 100,000, lower than both the London average of 10.1 and the England average of 13.5 per 100,000.

- Deaths from drug misuse in Havering increased slightly from 2.6 per 100,000 in 2020–2022 to 2.9 per 100,000 in 2021–2023. Both rates remain below the England averages of 5.2 and 5.5 per 100,000 respectively.

Increasing engagement in treatment

- The number of adults in treatment has risen from 995 in January 2023 to 1,018 as of May 2025, indicating a gradual increase over the two-year period.

- The proportion of opiate and/or crack cocaine users in Havering not currently engaged with treatment was 64.2% as of March 2025. This rate is lower than the London average of 70.9% but remains above the England average of 56.8%.

- The proportion of adults with alcohol dependency not currently engaged in treatment was 76.3% as of March 2025. This rate is lower than the London average of 77.6% but slightly higher than the England average of 75.9%.

- The number of young people in treatment has more than doubled from 2022/23 to 2023/24. 65% of the young people in treatment are male and 35% are female[1].

- CGL Wize UP, our young people's service for under 18's, have carried out group work and targeted interventions in 7 educational settings and staff training around substance misuse awareness at in educational settings.

Improving recovery outcomes

- Since 2020, the proportion of service user's successfully completing treatment has increased from 56% of all treatment exits to 62% in 2024.

- As of March 2025, 39% of adults in treatment were showing substantial progress, defined as being drug-free in treatment or having sustained reductions in drug use. This is higher than the London average of 36% but slightly below the England average of 39.9%.

- In Havering, 97% of non-opiate users and 99% of non-opiate and alcohol users, out of those in treatment, are in effective treatment. Both figures are above the corresponding averages for London and England as of May 2025.

- The proportion of service users in effective treatment for opiate use in Havering is 91%, slightly below the London and England averages of 92% and 93% respectively as of May 2025.

Reducing drug-related crime

- In the last 12 months (April 2024 - March 2025), Neighbourhood crimes reporting in Havering have slightly increased since last year to now 34.1/1,000, however still remains lower than the London average

- July 2024 – July 2025, there were 1,398 drug offences, 784 instances of these were possession of drugs, and 614 were instances of trafficking of drugs.

- Drug possession crime has been decreasing in Havering. For the last 12 months (July 2024 – June 2025) at 2.6 per 1000, lower than London average.

- However, drug trafficking crime has increased for last 12 months (July 2024 – June 2025) and is at 1.6 per 1,000, still lower than London average of 2 per 1,000. This is a result of the increased resources from Project ADDER.

Reducing drug and alcohol related deaths and harm

- Hospital admissions for drug related mental and behavioural disorders per 100,000 remains higher than the England average and will be investigated further.

- The rate of hospital admissions for episodes for mental and behavioural disorders due to use of alcohol has decreased in 2023/24 to 53.0 per 100,000, a decrease of 7.1 from the previous year. The Havering rate is now lower than England, which is at 62.8 per 100,000.

- Alcohol-related mortality has slightly decreased in 2023 with the latest data showing 35.7 deaths per 100,000 residents from 36.7 the previous year, alcohol

[1] This is the latest data available from NDTMS.

related mortality remains lower than the England average but remains above the London average of 33.7.

- Alcohol-related admissions to hospital for under 18s in Havering per 100,000 (0-17 year olds) at 13.9 remains lower than the England average of 22.6 per 100,000 in 2021/22-23/24 (fingertips).

- Safe Adventures was the October 2024 Half Term Reading Scheme. The Scheme targeted children aged 4-11 years and supported families in having difficult conversations around substance misuse, domestic violence, and consent. The pilot scheme featured reading stands in Harold Hill and Romford Library, with guest speakers from the London Fire Brigade and Schools Patrol officers reading and interacting with the children.

2.2 Police Insight and action

The Metropolitan Police's Project ADDER (Addiction, Diversion, Disruption, Enforcement and Recovery) is a network of specialist police teams working across all 32 London boroughs to better connect local policing teams with treatment services, health, and criminal justice partners and deliver a joined-up response to London's drug challenges.

The Project ADDER team in the East Area BCU (Havering, Barking & Dagenham, Redbridge) works with key partners to reduce harm to individuals and communities by directing users into treatment and onward to recovery from addiction and relentlessly and uncompromisingly pursuing those at every level of the drug supply chain.

For the 12 months until the end of August 2025, 1364 drug offences were recorded in Havering. This is an increase of 53.1% from the previous 12 months. This increase reflects a trend across London and is indicative of the ongoing work across London to target drug supply chains, as well as tackle anti-social behaviour and drug linked offending in our communities.

Project Adder has championed the use of the DTOA (Drug test on Arrest) scheme in the East Area BCU since June 2024. Project Adder officers have worked with custody teams to introduce DTOA as a performance indicator to increase its prioritisation, and have worked with East Area officers to raise the profile and benefits of the scheme across different strands from public protection to neighbourhood policing. The scheme tests for the presence of Class A drugs on arrest, for individuals aged 18 and over, and after charge, for individuals aged 14 and over following the committal of a trigger offence or non-trigger offence where there is a reasonable ground of contribution or causation by the drugs.

There were 45 drug tests on arrest in Havering custody in July 2025, with 57% being positive for drugs, and 37 in August 2025 with 65% positive for drugs such as heroin, crack and cocaine. The MPS average of positive readings for July and August were 47% and 43% respectively.

DTOA for domestic offences shows 44% (9 tests completed) of people being positive for drugs in July 2025 and 50% (4 tests completed) of people being positive for drugs in August 2025.

The Drug Intervention Programme (DIP) aims to engage substance-misusing offenders in drug treatment. It requires them to present for their appointment with a drug treatment worker.

Project ADDER works closely with government departments, and the National Crime Agency's "Project Housebuilder" to understand the threat nationally and locally from Synthetic Opioids. This approach ensure MPS and wider partnership preparedness to the threat posed by dangerous synthetic opioids – specifically Nitazenes, as well as improved review of drug- related deaths. East Area BCU also has a death oversight panel at which Project ADDER is represented

Project ADDER launched an internal 'substance misuse referral app' in August 2024 across the Metropolitan Police Area, enabling front line officers and staff to refer consenting adults to local commissioned treatment providers for support with alcohol and drug issues. Between April 2025 and end of June 2025, East Area Officers completed 40 referrals for Havering residents. The project is being extended in the near future to include young persons.

East Area BCU and Project ADDER officers continue to work closely with the partnership to utilise Criminal Behaviour Orders as an opportunity to divert offenders with entrenched substance addictions into support programmes, and to encourage the use of CBO's as a tool to increase engagement with drug and alcohol services.

2.3 How the CDP is addressing drug and alcohol harms:

Havering Council continues to invest and manage its two main contracts for the delivery of both young people and adult treatment and recovery services with Change, Grow, Live (CGL), our community drug and alcohol treatment provider. Both the Wize Up service for under 18's and the Aspire service for over 18's, play a vital role in helping address drug related harm in the local area, working in close partnership with a range of agencies to support young people and adults recover from substance misuse.

CGL have reported cost pressures relating to the cost of living crisis and the council have responded by granting uplifts to both contracts. Both contracts have been in place for 5 years, meaning that both services are well established locally.

Current figures show that as of July 2025, those in treatment showing substantial progress is at 39%, higher than the London average (36.5%), however slightly lower than the England average of 39.9%. Havering is outperforming London and England in the following indicators:

- Proportion in treatment who are in stable accommodation, reported at 87% as of March 2025, higher than the London average of 83% and England average of 86%.
- LBH's proportion in treatment who are in paid work (30%), voluntary work (2.5%) and in training or education (3.2%), is above London and England averages.

2.3.1 Grant funding

DATRIG and the Individual Placement and Support (IPS) grant have increased investment, capacity and specialist interventions to enhance the delivery of services during this reporting period.

In terms of the IPS grant which is for two years (2024-26) is funding the delivery of a service in partnership with Barking & Dagenham and Redbridge Councils, with Havering Council acting as the lead authority; Havering CGL as the lead provider. With a multi-agency, multi-borough steering group formed early in 2024 to coordinate and monitor the grant, the specialist employment service (IPS service) remains fully staffed (from June 2024) and embedded into the adult treatment and recovery services across the three boroughs. Local performance data shows that the service is on track to meet its local targets for referrals. In October 2025 the IPS service had 63 referrals since August 2024 30 which were engaged and 16 job starts.

2.3.2 Local Drug Information System (LDIS)

The LDIS alerts partners to changes in the supply and use of drugs locally, particularly where an immediate response is required to mitigate the risk of harm e.g. the circulation of potent synthetic opioids. Change Grow Live (CGL), our commissioned provider for drug treatment services, leads on LDIS provision in Havering. CGL can verify intelligence through the constant interactions between staff, other agencies and service users. This enables CGL to respond to an increased risk of harm by:

1. Directly warning clients through the provision of harm minimisation materials and increasing the provision of naloxone to people.
2. Informing all partners in the borough of emerging dangers when required, to contribute to control measures and further amplify information to people who may not currently be in contact with treatment services.

The chair of the LDIS and the holder of PIN list is the service manager at CGL, which is unusual in London. In Havering in 24/25, the number of LDIS alerts remained low, although an alert was issued in response to the incident in Ealing.

2.3.3 Drug and Alcohol Review of Death (DARD) panel

Havering has reviewed its processes for a DARD panel and is about to pilot a borough wide process in response to the government guidance released in 2024. The pilot will look at deaths in treatment over a 12 month period and then progress once mortality data is available, to a DARD process to look at all alcohol and drugs deaths. Our main barrier in this work has been the engagement of our east London coroners.

Havering is aligning its DARD process with Havering Safeguarding Adults board for governance and for procedures. Following each quarterly DARD panel, seven-minute summaries will be produced and disseminated across Havering to improve practice. The DARD panel consists of all major partners in the borough, with a core membership group and associate members who will attend when required.

2.4 Progress with delivery

During 24/25, Havering CDP continues to operate under a business-as-usual model, with a 5-year strategy in place, along with a rolling action plan. Strong links continue between participating agencies and other relevant local partnerships.

Progress is outlined below, against the themes of the CDP strategy, and in Appendix C, performance against the national and local outcomes frameworks is shown.

Theme	Priority	Action	Progress
Breaking Supply Chains	Community safety/vigilance, street policing, council enforcement assets	Better sharing of ASB data	JET meetings fortnightly where key ASB cases are discussed. ASB data now shared with CDP members.
	Establishment of joint analytic group and a set of baseline data sets	Establishment of joint analytic group and a set of baseline data sets	Established and now meet when needed.
Delivering a world-class treatment & recovery system	Engagement of adult offenders released from prison	Improve joint working between prisons and community services by increasing the proportion of referrals and engagement of adult offenders released from prison (from 30% to 60%)	The current 12mth rolling figure stands at 48%
	Community pharmacy substance misuse service provision	Review how community pharmacies provide needle exchange services to include mechanisms of taking action where there is an observed problem with a patient.	11 pharmacies all providing supervised consumption and 4 of which provide needle exchange (previously 3).
	Adults dependent on prescribed drugs	Review the needs of adults dependent on prescribed drugs and agree recommendations to improve prevention, training and awareness, treatment and/or guidance, support to reduce dependency.	PH and Medicines Management working together to work through data of prescription drug abuse. GP survey completed to find views of GPs. Actions identified moving forward.
Generational shift in demand	Links to World class treatment and recovery system	First time users with children <5yrs- CGL to do a home visit with awareness of what's a risk vs what's a safeguarding concern	CGL Wize-Up have appointed a new Children's and Families worker who will be visible in CGL adults service for maximum family support

			across both services. There is also scope for the Childrens and Families worker to attend weekly to the MASH team to raise awareness to statutory services
Reducing risk and harm to individuals, families and communities	Reduction risk and harm to communities	Inspection of products in vape shops	Numerous underage sales operations completed. Seizures of non-compliant tobacco and vapes worth thousands of pounds completed. Public Health team are also starting a Vaping Needs Assessment.

2.5 How we involve the local community in the CDP

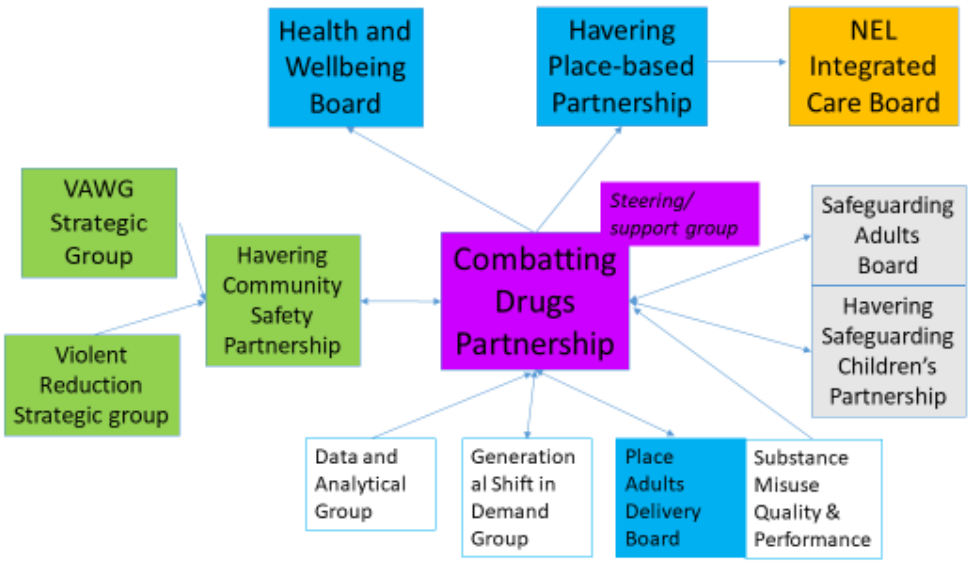
CGL actively involves service users and their families through service user forums, online and in-person feedback and discussion at the end of a service users' treatment journey during their discharge meeting. Healthwatch are active members of the CDP and the support group meetings, which provides some community views.

3. Priorities for the coming year

In 2025/26, we will be focusing on:

- Continuing to embed project ADDER.
- Completing a refresh of the substance misuse needs assessment.
- Implementing the CYP communications plan across Havering.
- Piloting and implementing the DARD process.
- Improving rates of drug recovery, especially in relation to opiate users.
- Working with our commissioned provider to improve the Continuity of Care performance.
- Embedding the synthetic opioid preparedness plan.
- Working with the ICB and local acute trusts on the abuse of prescription drugs.

Appendix A. Havering CDP Governance (Revised June 2024)



Appendix B. Havering CDP Membership

The membership consists of senior representatives, able to make decisions on behalf of the organisations / teams as listed below: -

- SRO and Chair – Director of Public Health
- Elected members – Lead members for Adults and Health and Children
- Public Involvement Lead and Communities – Head of Communities
- Data lead: DPO & Cyber Security Manager
- Community Safety Partnership and Crime Prevention– Community Safety and intelligence Manager
- Police and Crime Commissioner rep (MOPAC rep)
- Metropolitan Police rep: Detective Chief Inspector
- Probation Service representative
- CGL Lead Service Manager
- NELFT mental health services representative
- BHRUT A&E representative: Lead A&E nurse or manager
- Healthwatch representative
- Local Authority Housing representative
- Jobcentre Plus/ DWP representative
- Adult Social care representative
- Children Services representative
- Schools & Education: Assistant Director for Education
- Safeguarding Board representative
- NEL ICB - Lead Commissioner for Mental Health
- NHS medicine Management: Head of Medicine Management
- Local Pharmaceutical Committee: Chief Executive or deputy
- GP representative
- Voluntary Care Sector representative
- Interfaith Forum Representative
- Youth offending service: Group Manager Children services
- Representative for people affected by drug-related harm
- Licensing team representative
- Communications representative: Local Authority Head of Communications
- Partnership Lead and Public Health representative – Public Health Principal

Appendix C. DATRIG

Following the change from a Supplemental Substance Misuse Treatment and Recovery Grant (SSMTRG) to a Drug and Alcohol Treatment and Recovery Improvement Grant (DATRIG); Havering received an allocation of £377,801.00 from the Office of Heath Improvement & Disparities (OHID) for 2025/26 (excluding the London Consortia grant portion).

DATRIG-Funded Roles – 2025/26 Local Plan

The February 2025 submission of the Local Plan outlines the following roles to be funded through the Drug and Alcohol Treatment Resilience Investment Grant (DATRIG) in 2025/26:

- Quality and Safeguarding Lead
- Children and Families Worker
- Recovery Coordinators (Mental Health Outreach, Opiate, Alcohol, Non-Opiate)
- Criminal Justice Lead and Practitioner
- Team Lead

These roles are critical to delivering integrated, person-centred support across treatment and recovery pathways.

With the focus on progress in treatment in the DATRIG grant, Havering has set ambitions in relation to this and concerning numbers in treatment, continuity of care and Tier 4 placements.

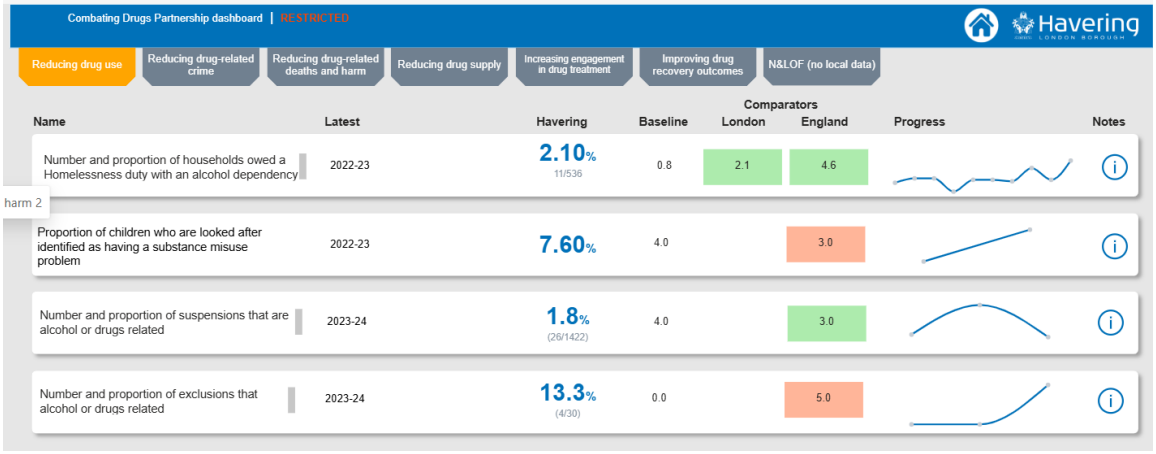
Numbers in Treatment	March 2022	Recent performance (September 2024)	Ambition 2025/26
All adults “in structured treatment”	937	1093	1129
Opiates	274	310	320
Non Opiates (non-opiate only)	343	365	375
Alcohol	320	418	434
Young people “in treatment”	45	78	85

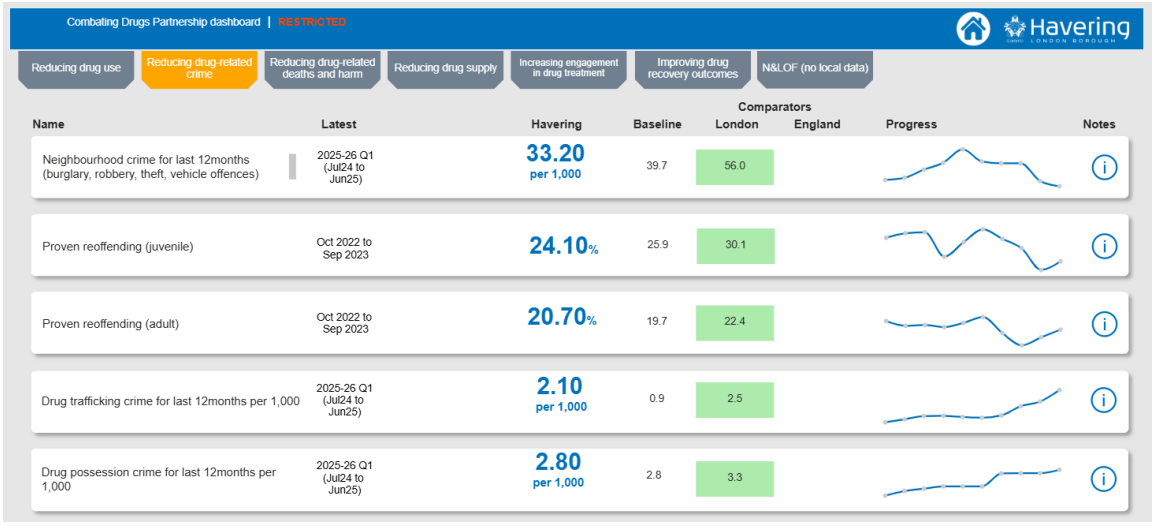
Continuity of care	March 2022	Recent performance (September 2024)	Ambition 2025/26
Local planning (%)	39%	48%	60%

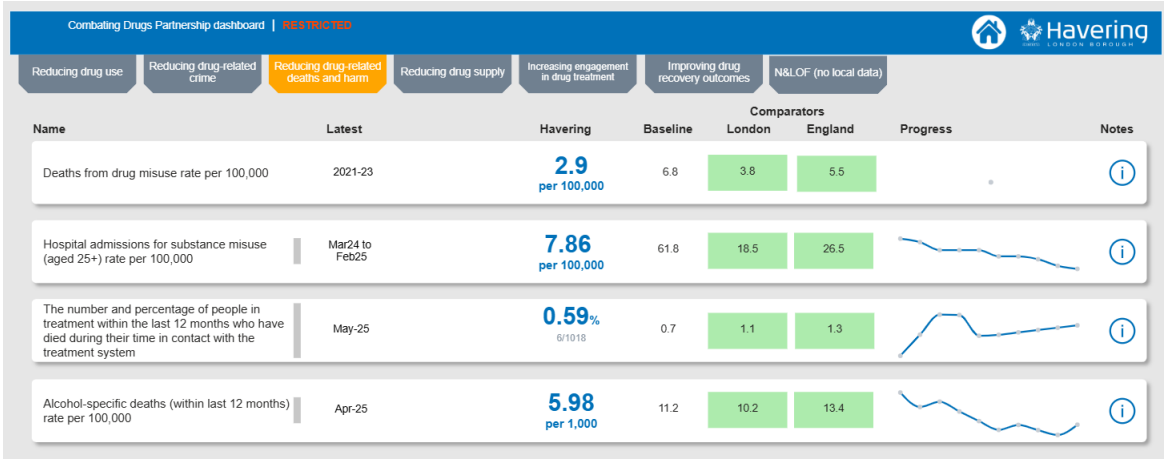
Continuity of care refers to resettling offenders leaving prison and engaging them into the local treatment service.

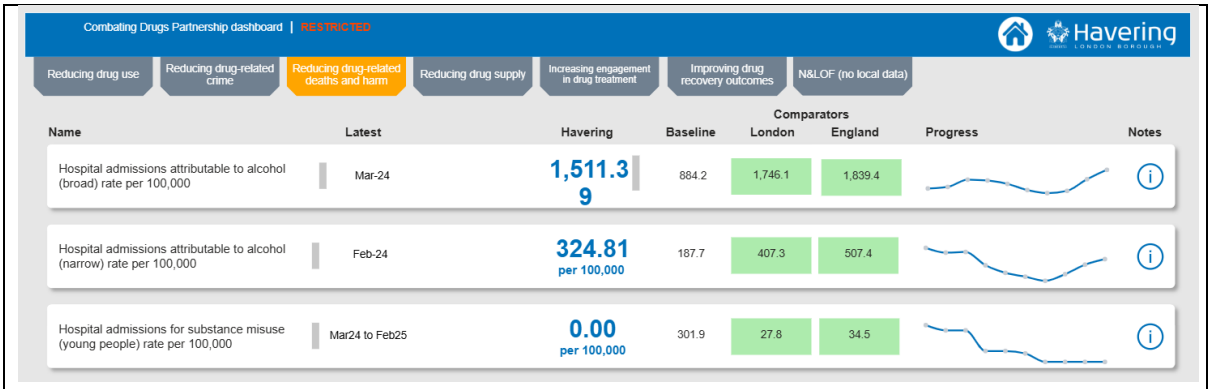
Residential rehabilitation (tier 4)	March 2022	Recent performance (September 2024)	Ambition 2025/26
Local planning (number	6	4	6

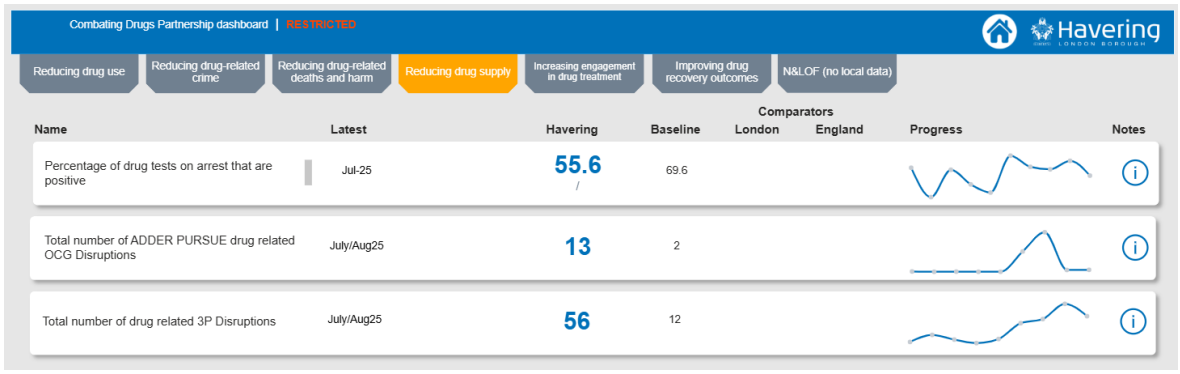
Appendix D. National and local outcomes frameworks

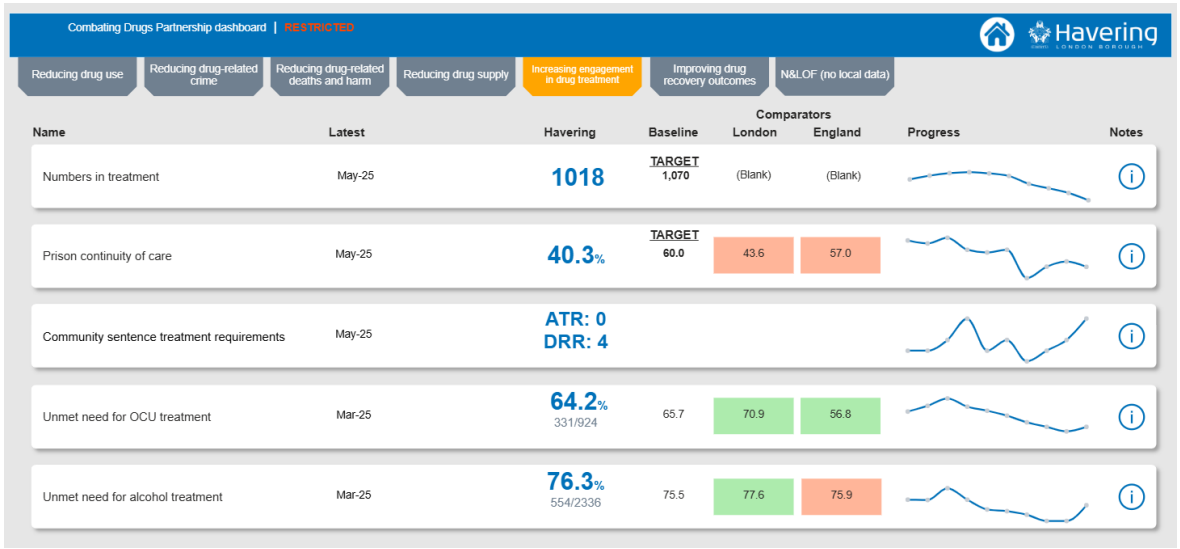







Combating Drugs Partnership dashboard | RESTRICTED
Havering
Reducing drug use
Reducing drug-related crime
Reducing drug-related deaths and harm
Reducing drug supply
Increasing engagement in drug treatment
Improving drug recovery outcomes
N&LOF (no local data)
Comparators
Name
Latest
Havering
Baseline
London
England
Progress
Notes
Hospital admissions attributable to alcohol (broad) rate per 100,000
Mar-24
1,511.39
884.2
1,746.1
1,839.4
Hospital admissions attributable to alcohol (narrow) rate per 100,000
Feb-24
324.81
per 100,000
187.7
407.3
507.4
Hospital admissions for substance misuse (young people) rate per 100,000
Mar24 to Feb25
0.00
per 100,000
301.9
27.8
34.5


Combating Drugs Partnership dashboard | RESTRICTED
Havering
Reducing drug use
Reducing drug-related crime
Reducing drug-related deaths and harm
Reducing drug supply
Increasing engagement in drug treatment
Improving drug recovery outcomes
N&LOF (no local data)
Comparators
Name
Latest
Havering
Baseline
London
England
Progress
Notes
Percentage of drug tests on arrest that are positive
Jul-25
55.6
69.6
Total number of ADDER PURSUE drug related OCG Disruptions
July/Aug25
13
2
Total number of drug related 3P Disruptions
July/Aug25
56
12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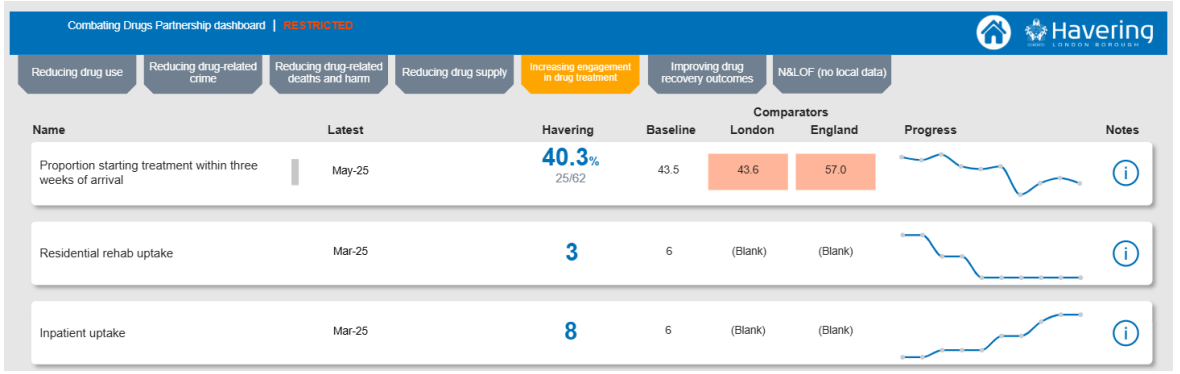
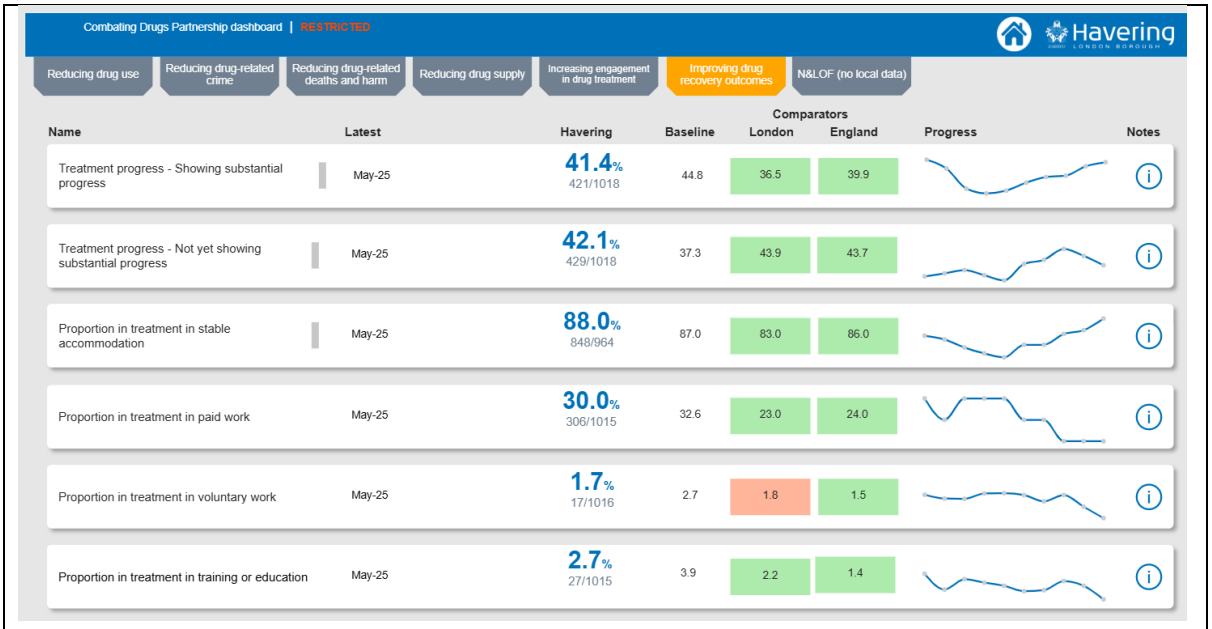
Reducing drug supply
Increasing engagement in drug treatment
Improving drug recovery outcomes
N&LOF (no local data)
Comparators
Name
Latest
Havering
Baseline
London
England
Progress
Notes
Numbers in treatment
May-25
1018
TARGET
1,070
(Blank)
(Blank)
Prison continuity of care
May-25
40.3%
TARGET
60.0
43.6
57.0
Community sentence treatment requirements
May-25
ATR: 0
DRR: 4
Unmet need for OCU treatment
Mar-25
64.2%
331/924
65.7
70.9
56.8
Unmet need for alcohol treatment
Mar-25
76.3%
554/2336
75.5
77.6
75.9


Combating Drugs Partnership dashboard | RESTRICTED
Havering
Reducing drug use
Reducing drug-related crime
Reducing drug-related deaths and harm
Reducing drug supply
Increasing engagement in drug treatment
Improving drug recovery outcomes
N&LOF (no local data)
Comparators
Name
Latest
Havering
Baseline
London
England
Progress
Notes
Proportion starting treatment within three weeks of arrival
May-25
40.3%
25/62
43.5
43.6
57.0
Residential rehab uptake
Mar-25
3
6
(Blank)
(Blank)
Inpatient uptake
Mar-25
8
6
(Blank)
(Blank)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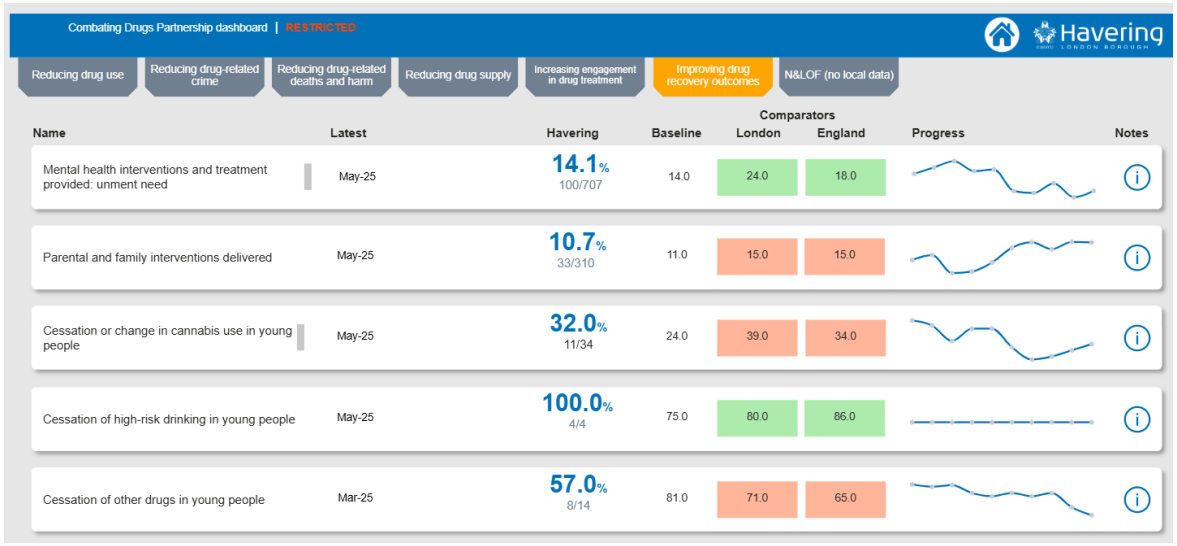
Reducing drug-related crime
Reducing drug-related deaths and harm
Reducing drug supply
Increasing engagement in drug treatment
Improving drug recovery outcomes
N&LOF (no local data)
Comparators
Name
Latest
Havering
Baseline
London
England
Progress
Notes
Treatment progress - Showing substantial progress
May-25
41.4%
421/1018
44.8
36.5
39.9
Treatment progress - Not yet showing substantial progress
May-25
42.1%
429/1018
37.3
43.9
43.7
Proportion in treatment in stable accommodation
May-25
88.0%
848/964
87.0
83.0
86.0
Proportion in treatment in paid work
May-25
30.0%
306/1015
32.6
23.0
24.0
Proportion in treatment in voluntary work
May-25
1.7%
17/1016
2.7
1.8
1.5
Proportion in treatment in training or education
May-25
2.7%
27/1015
3.9
2.2
1.4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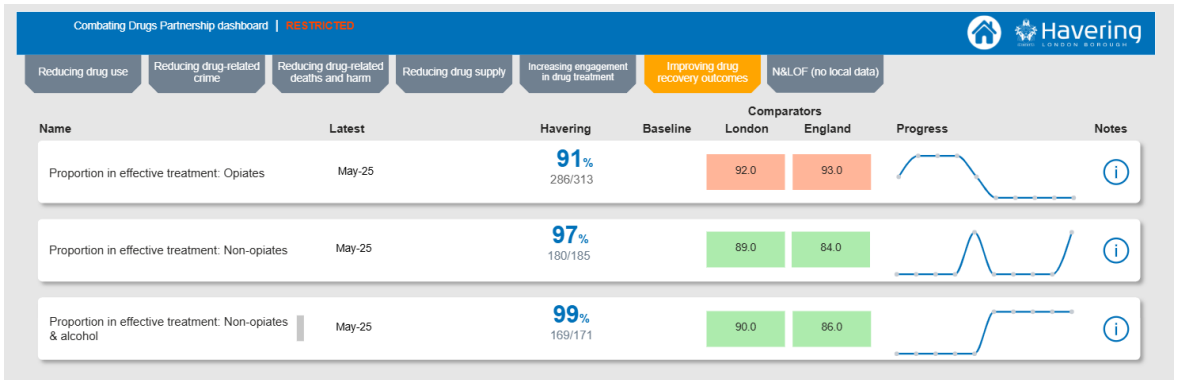
Reducing drug-related crime
Reducing drug-related deaths and harm
Reducing drug supply
Increasing engagement in drug treatment
Improving drug recovery outcomes
N&LOF (no local data)
Comparators
Name
Latest
Havering
Baseline
London
England
Progress
Notes
Mental health interventions and treatment provided: unment need
May-25
14.1%
100/707
14.0
24.0
18.0
Parental and family interventions delivered
May-25
10.7%
33/310
11.0
15.0
15.0
Cessation or change in cannabis use in young people
May-25
32.0%
11/34
24.0
39.0
34.0
Cessation of high-risk drinking in young people
May-25
100.0%
4/4
75.0
80.0
86.0
Cessation of other drugs in young people
Mar-25
57.0%
8/14
81.0
71.0
65.0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Reducing drug-related crime
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Reducing drug supply
Increasing engagement in drug treatment
Improving drug recovery outcomes
N&LOF (no local data)
Comparators
Name
Latest
Havering
Baseline
London
England
Progress
Notes
Proportion in effective treatment: Opiates
May-25
91%
286/313
92.0
93.0
Proportion in effective treatment: Non-opiates
May-25
97%
180/185
89.0
84.0
Proportion in effective treatment: Non-opiates & alcohol
May-25
99%
169/171
90.0
86.0

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