North East London Integrated Care Partnership

Wednesday 11 January 2023; 13:00-15:00; Venue MS Teams

AGENDA

	Item	Time	Lead	Attached/ verbal	Action required
1.0 1.1. 1.2. 1.3.	**Welcome, introductions and apologies** Declaration of conflicts of interest Minutes of last meeting Matters arising	13:00	Chair	 Attached Attached Verbal	 Note Approve Note
2.0	**Approval of the interim Integrated Care Strategy**	13:10	Zina Etheridge	Attached	Approve
3.0	**Joint forward plan – an introduction**	14.10	Johanna Moss	Attached	Note
4.0	**Questions from the public**	14:40	Chair	Verbal	
5.0	**Any other business**	14:50	Chair	-	
Date of next meeting: Date to be agreed					

DRAFT

Minutes of the North East London Integrated Care Partnership

Wednesday 23 November 2022; 12:00-14:00; Held via MS Teams

Members:		
Marie Gabriel	(MG)	Chair, NHS North East London
Zina Etheridge	(ZE)	Chief Executive Officer, NHS North East London
Johanna Moss	(JM)	Chief Strategy & Transformation Officer, NHS North East London
Paul Gilluley	(PG)	Chief Medical Officer, NHS North East London
Eileen Taylor	(ET)	Acting Chair, East London Foundation Trust
Sultan Taylor	(ST)	Acting Chair, North East London Foundation Trust
Sir John Gieve	(JG)	Chair, Homerton Healthcare
Rt Hon Jacqui Smith	(JS)	Chair, Barts Health and BHR Hospitals Trust
Cllr Mary Durcan	(MD)	Cabinet Member, London Borough of City of London
Cllr Christopher Kennedy	(CK)	Cabinet Member, London Borough of Hackney
Cllr Gillian Ford	(GF)	Cabinet Member, London Borough of Havering
Cllr Neil Wilson	(NW)	Cabinet Member, London Borough of Newham
Cllr Mark Santos	(MS)	Cabinet Member, London Borough of Redbridge
Cllr Naheed Asghar	(NA)	Cabinet Member, London Borough of Waltham Forest
Rachel Cleave	(RC)	Healthwatch City of London
Catherine Perez Phillips	(CPP)	Healthwatch Hackney
Ian Buckmaster	(IB)	Healthwatch Havering
Veronica Awuzudike	(VA)	Community Barnet (Newham Healthwatch)
Matthew Adrienne	(MA)	Healthwatch Tower Hamlets
Dianne Barham	(DB)	Waltham Forest Healthwatch
Paul Rose	(PR)	Havering Compact
Jenny Ellis	(JE)	Redbridge CVS
Attendees:		
Charlotte Pomery	(CP)	Chief Participation & Place Officer, NHS North East London
Marie Price	(MP)	Director of Corporate Affairs, NHS North East London
Hilary Ross	(HR)	Director of Strategic Development, NHS North East London
Anne-Marie Keliris	(AMK)	Head of Governance, NHS North East London
Laura Anstey	(LA)	Chief of Staff, NHS North East London
Ashleigh Milsom	(AM)	Senior Public Affairs Manager, NHS North East London
Keeley Chaplin	(KC)	Minutes - Governance Manager, NHS North East London
Apologies:		
Cllr Maureen Worby	(MW)	Cabinet Member, London Borough of Barking & Dagenham
Cllr Gulam K Choudhury	(GKC)	Cabinet Member, London Borough of Tower Hamlets
Pip Salvador-Jones	(PSJ)	Barking & Dagenham CVS
Tony Wong	(TW)	Hackney CVS
Caroline Rouse	(CR)	Compost London (Newham)
Peter Okali	(PO)	Tower Hamlets CVS
Manisha Modhvadia	(MM)	Healthwatch Barking & Dagenham
Cathy Turland	(CT)	Healthwatch Redbridge

Item No.	Item title	Action
1.0	**Welcome, introductions and apologies**	
	The Chair welcomed members to the first meeting of the Integrated Care Partnership (ICP) Committee, which was established in July 2022. The ICP is responsible for developing and agreeing the overall integrated care strategy for the system. The committee is formed of eight north east London (NEL) local authorities and the Integrated Care Board (ICB), along with our NHS and wider system partners. The Chair advised that the meeting today would focus on ensuring a shared understanding of our role, the process underway to develop the Interim Integrated Care Strategy and would consist of workshops to explore emerging Care Strategy common themes. Our next meeting in January 2023 would be a formal decision-making meeting of the ICP and would receive the Interim Integrated Care Strategy for approval. The January 2023 ICP meeting and all other decision-making meetings would be held in public.	
1.1.	**Declaration of conflicts of interest**	
	The Chair reminded members of their obligation to declare any interest they may have on any business arising at the meeting which might cause them a conflict of interest. No additional conflicts were declared. Declarations made by members of the meeting are detailed on the register of interests included in the pack of papers and available from the governance team.	
2.0 2.1.	**NEL Integrated Care Partnership** Role and purpose of the 'committee' and terms of reference	
	As one of the biggest integrated care systems (ICSs) in the country, a wide and inclusive partnership has been established, with a smaller steering group to 'steer' the work of the partnership and strategy. The partnership will generally operate in workshop format to ensure effective contributions to the overall health and care strategy in north east London (NEL) in line with our collective purpose, four priorities and design principles. Decision making would however be as a whole Board and be in public. Five workshops have been held so far each focusing on one of the four priorities as well as the cost of living crisis with 120-200 people at each. Representatives from all organisations in the partnership attended, as well as service users, frontline staff, carers and patients. Members approved the NEL Integrated Care Partnership terms of reference.	
3.0	**Population health profile of North East London / context setting**	
	HR gave an overview of the population health profile for north east London. • This was produced to support and develop greater focus on population health for the system and was first produced in May 2022. • It will support the development of the Integrated Care Strategy for the partnership.	

	• The profile provides data across a range of key population health indicators with a particular focus on health inequalities as well as the four system priorities. • This will support the system's strategic work to build an understanding of health needs and inequalities across the system. • Place based summaries have also been produced to complement local joint strategic needs assessments (JSNAs) and provides one data set that can be referred to by all partners. • It highlights a very diverse population across NEL underlining widespread poverty and deprivation in many neighbourhoods which were exacerbated by the pandemic and the cost of living crisis. • The data supports the selection of the four system priorities – Babies, Children and Young People (BCYP), Long Term Conditions (LTC), Mental Health and Employment and Workforce. • A new data and analytics group has been created to oversee the suite of resources available. • The Directors of Public Health have met to discuss the recent Greater London Authority (GLA) survey of Londoners and will use this information to look at wider determinants of health such as income and housing. The Chair thanked HR for providing the detailed report to the Committee.	
4.0	**Overview of the ICP strategy**	
	ZE introduced the item to members noting the positive and widespread enthusiasm by all participants in the development of the strategy across north east London. JM introduced HR who has led on the development of the strategy, who reported: • The strategy sets the direction for the system and influences the next phase of planning including the joint forward plan which is due to be published in March 2023. • There has been tremendous engagement and participation. • The interim strategy will be presented to the next Integrated Care Partnership meeting in January 2023 for sign off. • It will align with local JSNAs and local Health and Wellbeing Board (HWBB) priorities. • Presentations have been widespread including to local HWBBs, Place Based Partnership groups and will be going to the Joint Overview and Scrutiny Committees across NEL. • The focus is on the four system priorities: 1. Babies, Children and Young People 2. Long Term Conditions 3. Mental Health 4. Employment and Workforce • An additional focus has been on the cost of living crisis. Discussion points included: • It would be good to include realistic targets on what will be achieved in the next 2-3 years to show improvements in health with clear measurable outcomes. This should include people defined targets not just government driven targets.	

	• The strategy sets the direction for the five-year delivery plan and the annual operating plan which will include detailed actions and data on the proposed aims and outcome. • Mental health should be embedded within all priorities and responsibility of all. The system workshops said that this is about the whole system and what each part of the system needs to do to support the priorities. • The ICP steering group will look at the impact in more detail and will report back to the wider partnership. • It is important that the system priorities reflect and flow through at place based and at partnership levels. The action plan will look at how we enable this to happen at place, collaboratives and across the system. • The strategy will include appendices on the priorities for the place-based partnerships and the provider collaboratives to ensure oversight of all.	
5.0	**How we work as a system**	
	The key emerging themes from the strategy engagement are: 1. Co-production with residents drawing on individual and community strengths and assets, rebalancing power 2. Greater focus on prevention across all parts of our system including primary prevention and wider determinants 3. Holistic and personalised care that is integrated seamlessly across service or organisational boundaries 4. A high trust environment supporting partnership working, collaboration and integration across all parts of our system, with the contribution all partners valued equally 5. Working as a learning health system to drive continuous development, improvement and shared learning 6. A relentless focus on equity underpinning all that we do Members were then asked to join discussion groups with a focus on the following questions.	
	1. Do you agree that these are the key areas to strive for in how we work as a system? Are we missing anything? 2. Are there particular areas we should prioritise in the context of the current economic climate? 3. What would success look like for the partnership in these areas? **Feedback from group discussions** **Group 1 / Group 3 - merged** • We are a system driven by evidence, data and insight, as well as learning. • There is a strong support for co-production with residents but this highlights that as a system we need to support them with the right infrastructure and enablers eg resources, time, data and insights. • A high trust environment reflected strongly as system partners but there is a gap in trust with residents and the institutions of the partnership and that this element may need to be reframed and look at the way we work to build on that trust with residents. • With the current economic climate there should be a strong connection with support into work such as quality of the working environment, income and equity is important and that connectivity may need a bit of work	

	• System failure and risk – could we include what happens when things don't work and provide an understanding on how as a system we work together to manage this. • Outcomes and what success should look like: o This should be data led with a strong prevention and collaboration theme. There was a lot of praise for the population health profile and should consider data resource with a focus on key areas – childhood obesity and work on vaccinations for CYP o There are different ways to measure success, eg data driven, audits, peer reviews etc in order to understand if successful. **Group 2** • Setting targets – could look at areas that can be achieved across whole of ICS and set ourselves 3/4 things that how we can improve population health outcomes in a different way, and develop a culture to develop these across a wider group. • Use of the voluntary sector in a more creative way to engage and work with communities • A potential gap is including trauma informed care. • Consideration of the use of language to convey messages, particularly in different communities being able adapt and be more flexible with messaging. • Climate crisis and sustainability missing from the six priorities and how do we link the climate emergency and sustainability work that is going on in each organisation including work with NHS Estates. **Group 4** • Accessibility was an area discussed and where we are with access to key services as being critical eg access to primary care • Ensuring equity of basic provision of services across North East London • The importance of the language being used has been raised during engagement eg ensuring we all have the same understanding of terms being used eg prevention, equity and co-production. • Being clear on what can be delivered and what is aspirational as experience of local residents and partners has been that expectations have not always been met. • Places have undertaken great co-production work with residents and innovation to tackle local problems but there may be variation across NEL which could be shared and inform learning and good practice. • Success measures that may be more difficult to demonstrate were: o Empowerment and how local residents feel more empowered. o Co-production is working in practice and how can this be demonstrated o Much stronger enabling structure for local community voluntary sector that can enable them to eventually take the lead – an example could be to have 1000 residents involved in each place-based partnership. o How can we demonstrate that integration is really happening?	
	The chair thanked everyone for their valued and insightful contributions to the discussions in their groups and would consider how these will be applied to the priorities, including • measuring outcomes, such as peer reviews and audits.	

	• including sustainability and environment and how we can build on these as a system in collaboration • demonstrating integration. • cross cutting themes will be reviewed with design and ambitions to inform the interim integrated care strategy. NW added that success measures should be qualitative as well as quantitative as well as empowerment. In Newham they are incorporating happiness and wellbeing indices which can be easily adopted across north east London.	
	Next steps	
	All input from conversations and engagement undertaken and detail from the slide decks will be converted into the first iteration of the strategy which will be shared with partners prior to Christmas for comment. The interim strategy will then be presented to the integrated care partnership meeting scheduled on 11 January 2023 for agreement.	
6.0	**Any other business**	
	No other business was raised	
	Date of Next meeting – 11 January 2023	

Integrated Care Partnership

11 January 2023

Title of report	Integrated Care System Strategy
Author	Hilary Ross, Director of Strategy, NEL ICS
Presented by	Johanna Moss, Chief Strategy and Transformation Officer
Contact for further information	hilary.ross1@nhs.net
Executive summary	• The final draft of the Integrated Care System (ICS) Strategy is shared for final feedback before publication online. • The interim strategy will set a clear direction for the current planning round including the new NHS Joint Forward Plan due for submission before the end of March 23. • As well as our system wide workshops we have engaged with provider collaboratives, place based partnerships and health and wellbeing boards on the development of the new strategy.
Action required	Approve
Previous reporting	Discussions have taken place with the Integrated Care Partnership (ICP) Steering Group and full partnership, the ICB Board and Executive Committee, the NEL CAG, place based partnerships and health and wellbeing boards.
Next steps/ onward reporting	The interim strategy will be presented to the Integrated Care Board for adoption at the board meeting on 25 January 2023.
Conflicts of interest	N/A
Strategic fit	• To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The strategy aims to set a new and ambitious direction for coproduction with local people and ensuring that tackling health inequalities and securing equity is core to all that we do across our system.
Impact on finance, performance and quality	While the strategy sets the overall direction for the system the financial, performance and quality implications will be set out through the Joint Forward Plan, which is the new five year delivery plan for the NHS, and annual operating plans.
Risks	There is a risk that the strategy does not sufficiently influence the new planning round due to tight timescales and resource constraints.

North East London Health & Care Partnership

NHS North East London

Update on development of NEL Integrated Care Strategy

Meeting of the NEL Integrated Care Partnership

11 January 2023

Progress update

- We have continued to develop the integrated care strategy following discussion and feedback from Health and Wellbeing Boards, place based partnerships and provider collaboratives; and following our series of workshops with stakeholders from across the system.
- The draft interim strategy included in this pack is to be discussed at a full meeting of the Integrated Care Partnership on 11 January – this follows a workshop held with them in December to review the four system priorities and six cross-cutting themes.
- Once we have received final feedback from the partnership we will publish a version of the interim strategy online pending publication of further guidance from the Department of Health and Social Care expected in June 2023.
- The interim strategy will inform the planning round in 2023/24 including the new Joint Forward Plan (NHS five year delivery plan) due to be submitted to NHSE before the end of March 2023 and the annual operating plan for the NHS.
- We will continue to develop the strategy including testing the actions and success measures with local people through a 'Big Conversation' planned for Spring 2023.
- We will develop the success measures outlined in the strategy into 'SMART' goals in order that our integrated care partnership can track and report progress to local people.
- In line with our learning system approach and partnership ethos, we are committed to continuing the dialogue with local health and wellbeing boards, place based partnerships and provider collaboratives to support ongoing alignment across the system.

Questions for the partnership

1) *Are there any important areas missing from our priorities or cross-cutting themes or anything we need to emphasise differently, particularly at this stage in order to influence the NHS Joint Forward Plan?*

2) Have we set the right level of ambition and scope in our success measures for the new system strategy recognising that further work will need to be undertaken to develop them into measurable goals?

North East London Health & Care Partnership

NHS North East London

Interim North East London Integrated Care Strategy

January 2023

Final Draft (v.6.1.23)

Introduction

Where we begin our story

In July our **Integrated Care Partnership (ICP)** was formally established. This is a statutory committee that brings together a broad set of system partners (including local government; the voluntary, community and social enterprise sector; NHS organisations; and wider partners) to work together to plan and deliver joined up health and care services.

*One of the first requirements of our ICP is to develop an **integrated care strategy** for north east London (NEL).*

Our partnership brings huge potential to work together as a system towards a much **greater focus on population health outcomes and tackling inequalities**. However, it is important to recognise and acknowledge the **challenging context** many parts of our system are facing at this point in time as we come together as a partnership to develop our new integrated care system. Our integrated care partnership serves one of the **most deprived populations** in the country where inequalities are stark. Our population is under increasing pressure in the wake of the recent **COVID-19 pandemic** which exacerbated health inequalities and brought longer term impacts to the physical and mental health and wellbeing of local people, impacting individuals, households and communities in ways that are still not fully understood. In addition, we know that the **cost of living crisis** is further impacting local people, the majority of whom (70%) have told us they are currently struggling in one or more aspects of daily life, be that in their health, housing, income, food or with loneliness.

Furthermore, these challenges are set to grow as **unprecedented population growth** redefines our communities over the coming decades, and the health and care needs of local people continue to increase in complexity as our overall population ages.

The **challenges currently facing our health and social care staff, teams and organisations** working within north east London cannot be underestimated. Services are currently seeing extreme winter pressures with unprecedented demand for care, particularly urgent care, from our population. There is huge demand for planned care which was so heavily impacted by the pandemic with an urgent need to address long waiting times and inequity. Our workforce has a high number of vacancies which places a greater burden on staff, increasing stress and burnout. There is also an additional challenge of managing the impact of industrial action.

These huge challenges create a 'burning platform' for action as an integrated care system – we cannot continue to work in the same way, doing the same things. Partners in NEL are clear that we need a **radical new approach to how we work as an integrated care system** to tackle the challenges we are facing today as well as securing sustainability for the future.

This **strategy is intended to provide the framework for our partnership** to do that. It does not provide all the answers or reference the full range of work we will need to do take this forward, but it signs us up as a partnership to a clear set of priorities, core themes for working differently and some key foundations for our system.

Our strategy in a nutshell

Partners are clear that a radical new approach to how we work as a system is needed. Through our engagement we have identified **six cross-cutting themes** which will be key to developing innovative and sustainable services with a greater focus upstream on population health and tackling inequalities.

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

Local employment and workforce is one of ***four*** **priorities that stakeholders across the partnership have agreed to focus on together as a system.** There are of course a range of other areas that we will continue to collaborate on, however, we will ensure there is a particular focus on the agreed system priorities and have been working with partners to consider how all parts of our system can support progress.

Broad engagement including a series of well attended system-wide stakeholder workshops, discussions with Health and Wellbeing Boards and place based partnerships has shaped our plans for improving outcomes and tackling inequalities as well as improving access and experience in these areas.

We recognise that a **well-functioning system** that is able to meet the challenges of today and of future years is built on **sound foundations.** Our strategy therefore also includes an outline of our plans for how we will transform our enabling infrastructure to support better outcomes and a more sustainable system.

It includes some of the elements of our new financial strategy which will be fundamental to the delivery of greater value as well as a shift in focus 'upstream'.

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

Our 6 crosscutting themes underpinning our new approach as an ICS

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

Our four system priorities for improving outcomes and tackling health inequalities

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

Our key areas for securing the foundations of our system

Improving our *physical* and *digital infrastructure*;
Maximising value through collective financial stewardship, investing in prevention and innovation, improving sustainability;
Embedding *equity*.

The north east London picture

A snapshot of our population

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

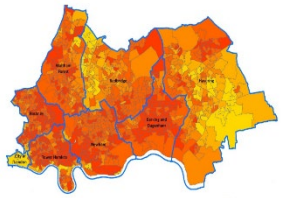
Our rich diversity. North east London is made up of many different communities and cultures and there is an opportunity to draw on a diverse range of community assets and strengths.

Our diversity underlines that a 'one size fits all' approach to services does not work for the people and communities of north east London.

Just over half (53%) of our population are of black, Asian or mixed ethnicity – we know that significant health inequalities exist between ethnic groups; this was highlighted and exacerbated by Covid-19.

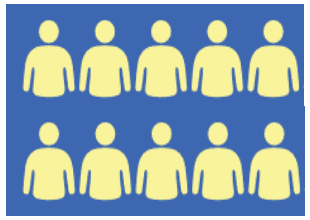
We are densely populated and growing rapidly. Our two million residents are spread from the densely populated, inner city areas of Hackney and Tower Hamlets out to Havering. By 2041, we expect to have an additional 400,000 residents, the equivalent of adding another borough's worth of people.

This means that we must take bold action now to improve our services, building capacity and resilience to create the best health and wellbeing outcomes possible for our future population.



We have high levels of deprivation. Nearly a quarter of our residents live in one of the most deprived 20% of areas in England; and overall, among our boroughs, Barking & Dagenham is ranked 21st, Hackney 22nd, Newham 43rd, and Tower Hamlets 50th most deprived of all (312) England local authority areas.

Poverty and deprivation are key determinants of health and our place based partnerships and provider collaboratives are seeing first-hand the impact that cost of living pressures are having on our communities.



We have a young population. While our 0-18 years population is broadly similar to England ie children and young people account for a quarter of our population (though this rises to nearly a third in Barking & Dagenham), it is our disproportionately large working age population that sets us apart from other parts of England.

Our inner London places tend to have a larger proportion of working age people currently, whereas outer London tends to have a larger population of older people leading to different health and care needs across places. However, this is changing as growth projections suggest large increases in older people over the coming decades, particularly in inner London, leading to over 260,000 additional over 60s projected by 2041, an increase of 115%.

While working age people tend to be healthier, this is not necessarily the case in NEL as all our places have a higher proportion of working age people unemployed and self-employed than the England average, and an estimated 13% of employed residents earn less than the London Living Wage. Almost a third of our population is living with one or more long term condition despite their relative 'youth'.

Many of our children are growing up in low income households. A quarter of children from Tower Hamlets, Barking & Dagenham and Newham, and substantial numbers in our other boroughs are growing up in low income households.

We know that this has a strong correlation with poorer health outcomes, and in particular the social and emotional wellbeing of children.

Children and families with the lowest 20% of household income are three times more likely to have common mental health problems than those in the wealthiest 20%.

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

Living in the context of the recent pandemic and cost of living increases

70% of our population is struggling in one or more aspects of daily life: finance, work, food, housing, loneliness; and groups more likely to struggle across multiple domains include people from an ethnic minority background, people with children, people of working age and people born outside of the UK.

Findings of a recent survey in NEL:

- 20% of our population have not had enough money to buy food when needed; this is more often true for ethnic minority groups, young people, those with long term health conditions, and those who don't speak English well or were born outside of the UK.
- 15% of residents unable to adequately heat their home.
- 14% consider their housing to be poor or very poor quality.
- 20% with loans struggle to keep up with debt repayments.
- 28% feel lonely some or often/all the time - this is especially so for the young or those with a long term health condition .

Reference: GLA Survey of Londoners (2022)

Our partnership in north east London

Our ambition and priorities

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."

Working together as a partnership we agreed four priority areas:

Babies, children and young people	To provide the best start in life for the **Babies, Children and Young People** of North East London
Long-term conditions	To support everyone at risk of developing or living with a **long term condition** in north east London to live a longer and healthier life
Mental health	To improve the **mental health** and wellbeing of the people of north east London
Local employment and workforce	To create meaningful **work** opportunities and **employment** for people in north east London now and in the future

Our partnership

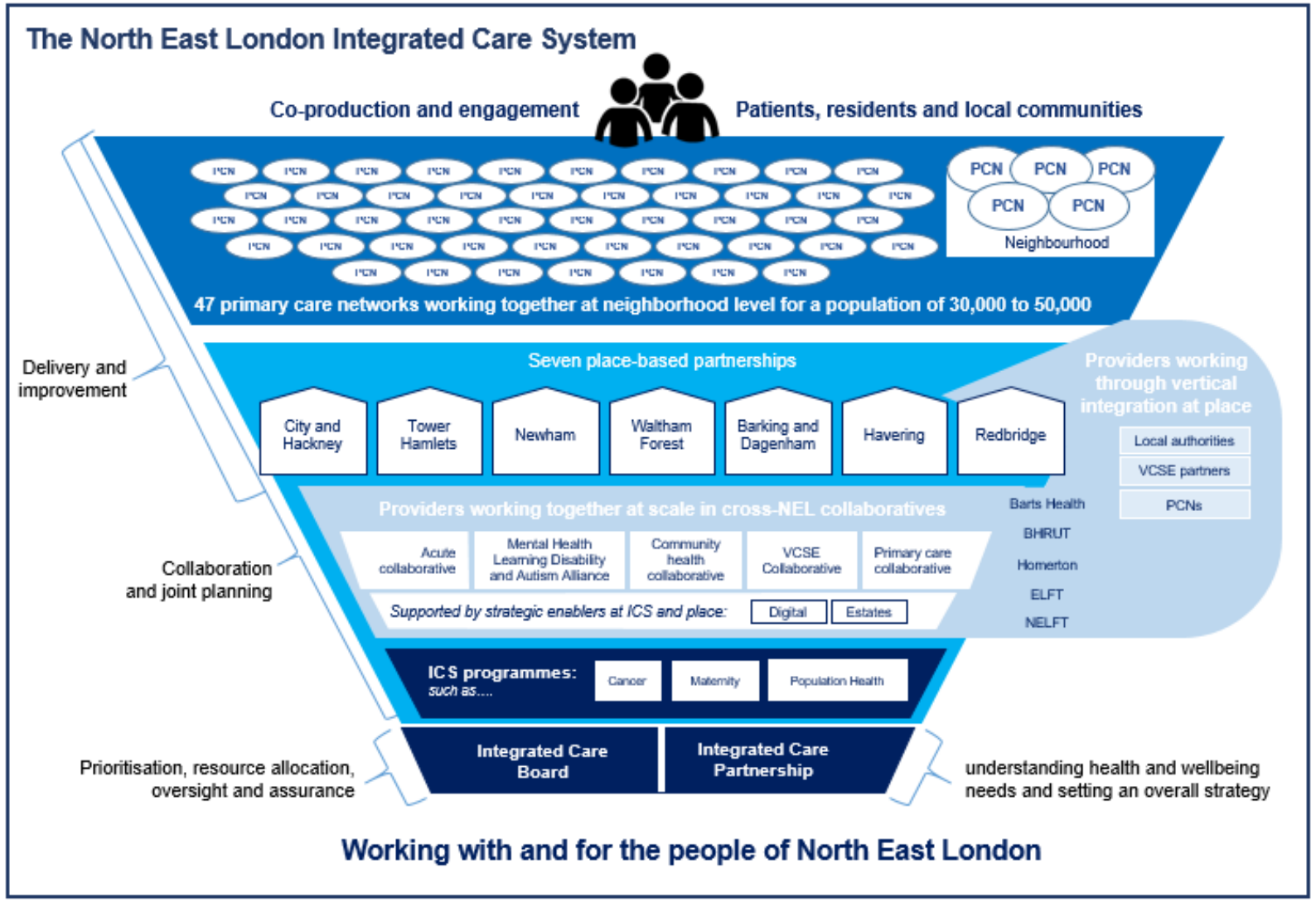
We are a broad partnership, brought together by a single purpose: to improve health and wellbeing outcomes for the people of north east London.

Each of our partners has an impact on the people of north east London – some providing care, others involved in planning services, and others impacting on wider determinants of health and care, such as housing and education.

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

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

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



How we work together as an integrated system – our six cross cutting themes

Tackling health inequalities

Our context

Nearly a quarter of local people live in one of the most deprived 20% of areas in England and more than 1 in 5 children in some boroughs live in poverty. People living in poverty experience poorer mental health, live in poorer quality housing and are less able to afford products and services than underpin good health. The recent pandemic and cost of living pressures bring additional challenges for our poorest residents and exacerbate existing health inequalities.

More than half of our population in NEL are from a minority ethnic background. The pandemic highlighted and widened inequalities between ethnic groups and evidence is clear that collecting ethnicity data, measuring and addressing ethnic disparities in healthcare access, experience and outcomes, and addressing racism and discrimination, are crucial to efforts to reduce health inequalities.

We estimate there are nearly 52,000 people in NEL with a learning disability. People with learning disabilities and autistic people have greater and more complex health needs and experience higher levels of unmet health need than the general population, and are more likely to face multiple barriers to accessing services. People with learning disabilities in NEL were 4.8 times more likely to die than those without during the first phase of the pandemic.

Housing is a key determinant of health, and homelessness and inadequate housing are significant and increasing problems across NEL. Mortality among people experiencing homelessness is around ten times higher than the rest of the population, yet many of these deaths are preventable. The homeless population face barriers to accessing health and social care services including stigma and discrimination and rigid eligibility criteria for accessing services. We need to ensure that the housing planned in NEL is of the mix and quality local people require to support better health outcomes and prevent further burden on our system.

We estimate that 17% of our population in NEL may provide informal care. Informal carers make a significant contribution to supporting the health of vulnerable people, yet evidence suggests that carers themselves are at risk of poor physical, mental and financial health outcomes.

NEL is the most deprived ICS area in London as well as one of the most deprived nationally. Deprivation is about more than poverty. It takes into account a range of factors in the population and environment including housing and education as well as income. Deprivation is associated with higher risk factors for poor health (for example poor diet and smoking) and poorer health outcomes.

Key areas for system action

- Applying a poverty lens to all our work. This includes paying particular attention to the health and social needs of people living in poverty, reviewing their access to and usage of services, tackling unmet need, and addressing the wider determinants through making every contact count and our role as anchors.
- Ensure we are measuring and addressing ethnic disparities including in our waiting lists, also a strong focus also on cultural competency, building trust and tackling racism as evidence tells us this will be key to tackling health inequalities.
- Support for carers running through all our priorities and other transformation programmes.
- Ensure all services are accessible, appropriate and effective for people with learning disabilities and autism, increase the number and quality of annual health checks and vaccinations for COVID-19 and flu and reviewing deaths to ensure we have up to date data and action plans to address health inequalities.
- Collaborate to improve health and care services for people experiencing homelessness and reduce the mortality gap between people who are homeless and the rest of the population.
- Build our understanding and recognition of intersectionality.
- Review the impact of local place based partnerships in reducing health inequalities and accelerate and invest in scaling up good practice.

What success looks like

In addition to the specific health inequalities measures set out in relation to our four priorities:

- Across north east London we are reducing the difference in access, outcomes and experience particularly for people from minority ethnic communities, people with learning disabilities and autism, people who are homeless, people living in poverty or deprivation and for carers.
- Healthy life expectancy is improved across NEL and the gap between our most and least deprived areas / those living in poverty and the wealthiest is reduced.
- We routinely measure and address equity in NHS waiting lists supported by improved ethnicity data collection and recording across health and care services leading to delivery of more inclusive, culturally competent and trusted services to our population.
- We understand digital exclusion and ensure new innovations do not widen inequalities.
- We are committed to becoming an intentionally anti-racist system where we prioritise anti-racism, understand lived experience of staff and local people, grow inclusive leaders, act to tackle inequalities, and review our progress regularly.

Prevention

Our context

More than 40% of children in NEL are overweight or obese. NEL has a higher proportion of adults who are physically inactive compared to London and England. Smoking prevalence in adults is higher than the England average in most NEL places, and 1 in 20 pregnant women smoke at time of delivery. All NEL places except Havering have worse screening rates for breast, bowel and cervical cancer than England, and vaccination rates tend to be lower with considerable variation between ethnic groups. Cost of living pressures are likely to make the situation more difficult with, for example, families not able to afford the costs associated with preventive dental care, travel for healthcare appointments, and maintaining a healthy diet.

Most NEL places have a higher prevalence of diabetes compared to the England average, and rates are increasing. For many conditions there are low recorded prevalence rates, while at the same time, most NEL places have a higher under-75 mortality rate compared to the England average. This suggests that there is significant unmet health and care need in our communities that is not being identified or effectively met by our current service offers.

Given the scale of the challenge around some of these risk factors and the population growth expected in NEL, our current services will be unsustainable unless we focus more, as a system, on prevention and early intervention.

Our ambition is to move beyond a medical model focused solely on needs towards a social model of ***health creation*** focused on strengths or assets where power is rebalanced, where local people and communities gain a sense of purpose, hope, and control over their own lives and environment and in doing so enhance their overall health and wellbeing.

Key areas for system action

- We will increase, over time, the proportion of our budget that is spent on prevention (both primary and secondary) and earlier intervention.
- Greater focus for all partners on primary and secondary prevention, supported by Population Health Management. Places will lead on primary prevention whilst primary care and clinical networks will strengthen their focus on secondary prevention.
- Greater system role in promoting social and economic development including action on the wider determinants of health through our role as ‘anchor’ institutions within north east London, where we are major employers of local people.
- Use the data we collect to identify and tackle unmet need, in particular among those living in poverty, people from minority ethnic backgrounds, and other priority groups.
- Work with the voluntary and community sector to support health creation in our communities.

What success looks like

In addition to the specific prevention measures set out in relation to our four priorities:

- We invest more in prevention as a system to reduce prevalence of long term conditions and mental ill health, equitably across all of our places.
- We identify and address unmet need including diagnosing more people early and increasing access to care and support, particularly for our most vulnerable or underserved groups.
- We invest in our community and voluntary sector to support prevention and early intervention in a range of ways to suit our diverse population.
- Through our role as ‘anchor’ institutions, we support social and economic development by employing local people furthest from the labour market and prioritising social value in procurement.
- We share and use data to identify the most vulnerable people living locally including those not using services and those frequently using services to provide more targeted and proactive support which better meets their needs.
- We routinely use Population Health Management data in planning and delivering our services.

Personalisation

Our context

Personalised care involves changes in the culture of how healthcare is delivered. It means holistically focussing on what matters to people, considering their individual strengths and their individual needs. This approach is particularly important to the diverse and deprived populations of north east London, where health inequalities have been exacerbated by the pandemic followed by the cost of living increase. Embedding personalised care approaches into clinical practice and care, which take into account the whole person and address all their needs will ensure our most vulnerable communities are supported in the years ahead.

We have built a strong foundation for personalised care over the last three years as a system, with an early focus on social prescribing and personal health budgets. Our vision is to make personalised care central to local population health approaches.

As part of delivering greater personalised care, we want to explore how we can strengthen our understanding and delivery of ***trauma-informed care*** based on the principles of safety, trust, choice, collaboration, empowerment and cultural competence. This is particularly important in the context of the recent pandemic, the cost of living crisis and the ongoing health inequalities experienced by many underserved groups across NEL.

Key areas for system action

- Digital: all of our social prescribing teams will have access to digital templates in primary care. We will develop similar shared digital platforms and solutions for other personalised care interventions such as care plans.
- Evaluation: we will implement our personalised care minimum data-set initially in social prescribing teams and then in other personalised care interventions to evaluate impacts on wellbeing measures like ONS4 (Life satisfaction, Worthwhile, Happiness, Anxiety).
- Workforce enablement: we will work with PCNs and place based partnerships to ensure the personalised care workforce – social prescribing link workers, care co-ordinators and health and wellbeing coaches are consistently supported with CPD - including training plans, leadership development, peer support networks and supervision.
- Supporting proactive social prescribing for identified cohorts: we will work with PCNs and place-based partnerships to support targeted social prescribing for identified cohorts including vulnerable people, specifically building expertise in tackling inequalities through increasing access and support for particularly underserved groups.
- Developing specialised social prescribing services: we will support the development of new specialist roles in response to local population health approaches, like children's social prescribers and social prescribers with expertise in violence reduction/knife crime. We aim for at least one PCN in each place based partnership to have a children and young people social prescribing service, in line with local needs. We will facilitate developing social prescribing across acute, mental health and community providers.
- Community chest programmes: we will invest in social prescribing community chests to increase resources in the community and voluntary sector locally targeted at addressing local inequalities and providing social value to our communities where it is needed most.
- Personal health budgets: we will support our place-based partnerships to expand their personal health budget offer according to local need and in line with our three main population health priorities.

What success looks like

- Staff have access to all the information they need in one place to enable them to provide seamless care to local people and can share this information safely through our IT systems.
- Local people including carers only need to tell their story once through their health and care journey.
- Local people are asked what matters to them in setting their treatment or care goals and can access a wide range of non-medical support in the community.
- Particularly vulnerable people and underserved groups are identified and given additional support to access services ensuring their experience and outcomes of care are equitable.
- Our staff are equipped to deliver trauma-informed care based on the principles of physical and psychological safety; trust; choice; collaboration; empowerment; and cultural competence.
- We will have at least one PCN in each place-based partnership with a CYP social prescribing service, in line with local needs.

Co-production

Our context
At the heart of our system is the shared commitment to co-production and meaningful participation with local people, communities and partners.

Our Working with People and Communities Strategy is a framework document which we are further developing through ongoing engagement with residents and communities, building on the good and wide-ranging practice in place across north east London. The strategy was developed in collaboration with our partners and local people, including public forums and community and voluntary sector groups and sets out our vision to ensure participation is at the heart of everything we do. As it evolves, our strategy will set out in more depth our shared ambition which is firmly aligned to co-production and to the active leadership of local people, service users, carers and patients.

Central to our ambition is our continued commitment to the development of an effective voluntary, community and social enterprise alliance which will ensure that the sector is fully embedded in our ICS, on an equal footing with our provider collaboratives. We also recognise and value the important role of our eight local Healthwatch organisations in communicating the voice of local people and providing insight through our partnership work at place level and their formal place in our governance and decision-making arrangements.

We are committed to ensuring we have a diverse and population focused clinical and care professional leadership, who are focussed on driving change and working hand in hand with local people.

We are committed to taking an asset based approach to participation and engagement, which moves away from focusing solely on needs and problems but truly values the capacity, skills, knowledge and connections which exist within our communities and local people.

Asset based approaches emphasise the need to redress the balance between meetings the health needs of our local people whilst nurturing the collective strengths and resources which exist within our communities. By working with our local people and building on these assets we are better equipped to reduce health inequalities and effectively promote good health and wellbeing.

Key areas for system action
Our commitment to co-production is rooted in a set of co-designed principles for participation, which are grouped under five overarching themes:

- Commitment: we are committed to putting people participation at the heart of our work, from the design of services to participatory budgeting
- Collaboration: we will talk to each other and identify where we can work together to achieve a high standard of participation with the communities we serve, sharing information, learning, resources and building on best practice
- Insight and evidence: we will share insight and produce plans based on evidence and feedback from local people, continuing to strengthen use of the NEL community insight system as an open resource for all partners
- Accessibility: we will ensure participation is accessible to all local people, supported by the development of an Accessibility Champions Programme
- Responsiveness: we will be responsive to the local voice and develop an approach built on reciprocity and partnership

What success looks like
- We can evidence how decisions taken by our boards are informed by the views of local people.
- We helped establish a community and voluntary sector collaborative and actively support and resource its development.
- We have developed models of co-production, learning from and embedding best practice, and train a wide range of health and care staff in co-production and power sharing approaches.
- We have established a vibrant and diverse community leadership programme, to empower local people to work alongside us as partners
- We can demonstrate how we have identified and engaged underserved groups and the full diversity of our local population.
- We use existing sources of insight from local people including carers to shape our strategies and plans at the earliest possible opportunity and resist repeatedly asking the same questions.
- We close the loop when we seek the views of carers and local people by feeding back.

High-trust environment

Our context

Our health and care partnership inherits a legacy of competitive and sometimes adversarial relationships between organisations, which often do not serve local people well. This is based in part on an old financial and contractual regime that encouraged the defence of organisational interests rather than a shared view of how all partners best work together to drive improvements to health, wellbeing, and equity.

This was always at odds with the commitment of partners and staff to do what is right for the people of north east London. With the new health and care partnership, we have the opportunity to ensure that our new ways of working reflect this commitment across our whole system spanning local authorities, the community, voluntary faith and social enterprise sector and health.

This includes defining how place partnerships, provider collaboratives, and NHS North East London each contribute to delivering local ambitions with all parts of the system coming together as equal partners. It also means defining the interfaces between these key building blocks of our system, and the hand-offs between the types of care that they are responsible for, which our experience tells us is critical to effective delivery.

Alongside this, we need to build the environment of high trust that enables seamless delivery across pathways spanning social care, primary and community care and secondary care regardless of organisational or sector boundaries. We define this as an atmosphere of constructive and ambitious engagement, in which each stakeholder acts on the basis of trust in the motivations and capabilities of all other partners.

Only building this truly collaborative and high-trust culture will enable our new partnership to work for local people and within and across local partners; without it, our new structures will have limited impact on the people of north east London.

Key areas for system action

- A co-designed mutual accountability framework will describe how place partnerships, provider collaboratives, and NHS North East London work together to deliver for local people.
- This will set out common ambitions, expectations, and ways of working, describing what each part of the system is accountable for and how each part will be supported to deliver its accountabilities – a critical foundation for trust in both system interactions and behaviours.
- We will also continue to invest in the cultural and behavioural development necessary to ensure that collectively we are making full use of the opportunities of the new partnership.

What success looks like

- Local people trust our services and advice because they feel that their voices are heard and our delivery is culturally competent.
- Partners feel actively engaged in, and know how best to contribute to, partnership work.
- This partnership work is undertaken in a spirit of constructive engagement and shared risk, guided by the aspirations and needs of local people, with issues tackled together without blame.
- All partners adopt an open-book approach to their aspirations, challenges, risks, and finances.
- All partners continually critique how effectively they work together and seek to improve collaboration.

Place partnerships and provider collaboratives

We have **seven place partnerships** working to promote the wider determinants of health and to integrate local health and care services

- Barking and Dagenham, City and Hackney, Havering, Newham, Redbridge, Tower Hamlets, and Waltham Forest

We also have **five provider collaboratives** working across north east London to deliver improvements to care at scale, to tackle unwarranted variation, to promote equity, to share learning, and to provide a strong voice for their member organisations

- the acute provider collaborative; the community collaborative; the mental health, learning disabilities, and autism collaborative; the primary are collaborative; and the voluntary, community and social enterprise sector collaborative

A learning system

Our context

As a system, we are continuously looking for ways that we can improve the quality of care that local people receive and many or our organisations have already invested in developing their improvement methodology and competencies among staff. Equally we are developing a good understanding of the make-up of our population – demography, prevalence of diseases and where there is unmet need [add link to NEL Population Health Profile] – but we do not yet use that information in a systematic way, for the benefit of our population.

Closer working between partners provides an opportunity to improve how we work; to improve how we share data and information between ourselves; and to improve how we learn from each other and spread new and innovative ways of working. We are building from a strong base and have begun the work to share data, including creating linked datasets that bring together information held by different organisations (such NHS trusts, primary care and local authorities) to allow clinicians and planners to better understand the needs of our population, including the wider determinants of health, such as housing and education.

We also doing pioneering research at Barts Life Sciences – a partnership between Barts Health and Queen Mary's University – which brings together scientists and clinicians to create new innovations that benefit the local population, and wider NHS.

As we move forward we will build on these successes to embed evaluation, continuous learning and quality improvement into all that we do.

Key areas for system action

- Give patients and (with patient consent) carers and clinicians involved in their care, better access to their care record.
- Improve data and insights, giving teams easier access to actionable population information, to support the identification of population cohorts for whom interventions will be most effective.
- Improve our evidence base to drive investment in the transformation of services and the deployment of interventions targeted at specific populations to improve health and care outcomes.
- Grow our analytical capacity and capability and ensure that analytics teams are collaborating effectively with clinical direction, including more consistent assessments of local population need across north east London (via JSNAs)
- Increase our appetite for innovation, and use evaluation to understand the impact we have to support scaling up rapidly where we see positive change
- Ensure that every part of our system has a clear methodology for learning and improvement while working towards common approaches across the system as far as possible over time.
- Develop our research strategy to ensure that we are attracting more research in our system, that research is addressing the most important questions for our population, and that more local people can participate in research.

What success looks like

- We use data, evidence and insights to build our understanding of our population and to drive our priorities.
- All staff consider quality improvement a key part of their role and are continually striving to improve services and outcomes for local people.
- We have systematic processes to continually identify people that are underserved by our current care pathways and make changes based on our learning.
- We innovate and enable shared learning to accelerate adoption of innovation, research and best practice throughout our system.
- We support and encourage research that is focused on improving health and care for local people and involve more local people in research.

Population Health (our responsibility)

A focus on improving physical and mental health outcomes, promoting wellbeing and reducing health inequalities across an entire population, including a specific focus on the wider determinants of health (such as housing, employment and education).

Population Health Management (our methodology)

A way of working to help frontline teams and system planners understand current health and care needs and predict what local people will need in the future.

It involves analysing data to identify population cohorts where interventions will add value, intervening, measuring the impact of interventions and incentivising those interventions that add value.

It also involves using the data to allocate resources optimally to population cohorts with the greatest need and to interventions that add most value.

Improving outcomes and tackling inequalities - our four system priorities

To provide the best start in life for the Babies, Children and Young People of north east London

Our context and case for change

Babies, children and young people comprise one quarter of our population and the GLA birth rate projections predict a significant annual increase in births in Newham and Barking and Dagenham. The population of babies born in NEL is also hugely diverse. More than one third of the population aged 0-18 is of Asian ethnicity, 14% of black and 6% of mixed ethnic backgrounds.

In all our places except Hackney and Havering we have a higher proportion of babies born with a low birth weight than the England average. Babies born to Black and Asian women in north east London are nearly twice as likely to have a low birth weight than those born to White women. Low birth weight increases the risk of childhood mortality and of developmental problems for the child and is associated with poorer health in later life.

In all our places except Havering, we have a higher percentage of children living in poverty than the England average (15.6%). There is a strong link between childhood poverty and poorer health outcomes including premature mortality. There is also evidence to show that children who live in poverty are exposed to a range of risks that can have a serious impact on their mental health.

Assessments indicate that 38,000 pupils in north east London need special educational support. 13,600 of these pupils have Educational, Health and Care Plans which outline the support they receive and these numbers are increasing.

In all places in NEL, overweight and obesity in children is higher than the England average (35%). Barking and Dagenham and Newham respectively have the highest and fifth highest rates in England. Dental decay in 5-year olds is also higher in all our places compared to England.

We saw physical and mental health outcomes deteriorate during the Covid-19 pandemic, particularly for vulnerable children and those with long term conditions within disadvantaged communities. In north east London at least 18,099 children and young people have asthma, 1,370 have epilepsy and 925 have type 1 diabetes.

We are currently seeing substantial pressures on child health urgent care services which is likely to be connected to the recent pandemic and cost of living pressures.

Currently there are 3,343 babies, children and young people in north east London with life limiting conditions requiring palliative and end of life care, and this number is gradually increasing. In years 2018 to 2020, there were around 100 infant deaths per year across north east London.

Key messages we heard through our engagement

Support for young people feels unequal, and varies depending on stage of life.

I want to be involved in decisions about my care, and I don't always feel that my needs are understood.

The care I receive feels rushed and impersonal, and has varied in quality across services and at different stages of my life.

What we need to do differently as a system

Create the conditions for our staff to do their best possible work including creating a safe multi-disciplinary learning environment spanning teams across north east London, provider collaboratives and place-based partnerships with a focus on co-production, quality improvement and trauma-informed care.
Focus on tackling health inequalities by working with our place-based partnerships to increase support for our most vulnerable children and their families particularly those with learning disabilities and autism, young carers, those living in poverty and insecure housing and those from a black and minority ethnic background, developing an enabling programme of work which addresses workforce challenges, supports data capture and benchmarking, and promotes better communication.
Develop clearly defined prevention priorities supporting place-based partnerships to focus on the most deprived 20% of the population and other underserved groups, as well as a focus across north east London on prevention priorities including obesity and oral health.
Develop community-based holistic care, including supporting family hub development building community capacity, aligning to family hubs and strengthening adolescent healthcare. Through social prescribing and multi-disciplinary teams we will enable links to community assets including the community and voluntary sector and put health inequalities at the heart of our work
Improve the experience and support available for children as they transition to adult services ensuring they receive consistent services which are designed with young people to meet their specific needs with an aspiration that young people will transition at a point that suits them and their development, rather than a rigid service threshold.
Prioritise our children and young people's mental health, recognising the importance of support, and timely access to information, advice and care. We will harness the potential of the digital offer and work with children and young people to design and deliver high quality, accessible services in a range of settings.
Improve support for vulnerable babies, children and young people, including those with long term conditions and special educational needs and disabilities. Helping our BCYP with asthma, diabetes and epilepsy, focussing on personalisation of care, and prevention. Supporting our children and families with special educational needs and disabilities through strengthening safeguarding, addressing workforce challenges and supporting data capture. Extending our services for autistic children and young people including the introduction of a new keyworker scheme.

What success will look like for local people

- *I have the same experiences and range of support for my development, health and wellbeing, no matter where I grow up in north east London*
- *I have the opportunity to access healthcare, education and care in ways that suit me and my goals*
- *I receive high quality and timely personalised care at a place of my choice*
- *I am treated with kindness, compassion, respect, information and communication is accessible and understandable*
- *I have opportunities to share my experience and insight, and seen change that I have influenced*
- *I have people who treat and look after me care as I move through the different stages of my life*
- *I am involved in decisions about my care*

What success will look like as outcomes for our population

- Reduce proportion of babies born with low birth weight in north east London
- Identify children living in poverty within our communities and ensure they are receiving the support they need to live a healthy life including equitable access to and outcomes from our health and care services
- Strengthen our focus on prevention, reducing levels of childhood obesity and dental decay, and increasing uptake of childhood immunisation
- Strengthen our support for children living with long term conditions and address health inequalities by reducing the number of asthma attacks, increasing access to prevention and self-management for children and young people with diabetes (particularly those living in poverty or deprivation and those from black and ethnic minority backgrounds), increasing access to specialist epilepsy support for children, including those with learning disabilities and autism and supporting all children better through the transition to adult services
- Improve access to children and young people's mental health services, and support young people better through the transition to adult mental health services
- Reduce the number of young people reporting that they feel lonely and isolated
- Collaborate between education, health and social care to ensure school readiness for all children and to meet the needs of children with special educational needs and disability

To support everyone at risk of developing or living with a long term condition in north east London to live a longer and healthier life

Our context and case for change

31% of local people have a long term condition (which is an illness that cannot be cured) such as diabetes or COPD. Living with a long term condition can impact on many aspects of a person's life, including their family and friends and their work. People with a long term condition are more likely to suffer from further conditions or complications over time, including poor mental health.

Long terms conditions account for half of GP appointments, 70% of inpatient bed days and 70% of the acute care budget. Currently the majority of national spend on long term conditions is in acute or hospital based treatment or care with less spent in the community or in primary care e.g. for diabetes £1bn is spent annually in primary care nationally versus £8bn in acute care.

Long term conditions cannot be cured but when identified early and managed effectively, the impact the condition has on a person and their life can often be alleviated or delayed. Some long term conditions can also be prevented completely through healthier behaviours. In the context of a growing and ageing population in NEL, we must drive a shift towards prevention and earlier intervention and ensure the sustainability of services.

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

Our population has a higher prevalence of type 2 diabetes, and several other conditions including hypertension and chronic kidney disease as well as a higher mortality rate for cardiovascular disease in the under 75s. One in five of our residents has respiratory disease. Further, there are likely to be high levels of unmet need – highest in our 'underserved' communities - that are not showing in the data but require proactive identification and better management.

Two-thirds of people with at least one long term condition have more than one mental health problem, including depression and/or anxiety, and there is a growing connection between living with a long term condition, social isolation and low self-esteem.

Key messages we heard through our engagement

Care for people with long term conditions feels unco-ordinated and fragmented.

I am not always clear who I can turn to with a problem, where I can access non-medical support in my local community or support with my emotional and psychological wellbeing.

I do not want to be asked to repeat my story to different professionals and I want my transition from service to service to be much better co-ordinated and supported.

What we need to do differently as a system

Better coordination of care, including between mental and physical health, and better transitions between different services, such as between child to adult services, supported by information sharing which we will strive to make a practical reality for staff in their work.

More consistent communication with people living with long term conditions and their carers, including in relation to their end of life care. Ensuring that people are at the heart of every conversation and that we focus on their holistic needs and strengths (not just their care).

Empower and resource local communities and voluntary organisations to assist with case finding and linking people through to appropriate care. Increase support for prevention and self-management, de-medicalising and destigmatising day to day support for long term conditions through social prescribing, increasing access to emotional and psychological support and widening peer support.

Support health creation within local communities increasing opportunities and support for making healthier choices, including starting health and well-being conversations in early years and working together to reduce the number of people in north east London living with risk factors such as obesity or smoking.

More intelligent identification of those with long term conditions or risk factors using population health management data and tools to support primary prevention which includes enabling earlier and more proactive action particularly among 'underserved' communities where there are high levels of unmet need and greater (proportional) investment in primary care in order to lead to short-term decreases in overall health system costs.

Focusing on improving end to end pathways including secondary prevention by detecting LTCs as soon as possible to halt or slow progress, encouraging personal strategies, and implementing programmes to improve health outcomes and prevent additional long-term problems.

Support people with long term conditions who may be adversely affected by poverty, particularly with costs of prescriptions which our evidence and engagement has shown has been a key issue during the cost of living crisis.

Lead by example as organisations that collectively employ a large number of people. Through our priority on workforce and local employment we will identify what more we can do as employers to encourage healthy behaviours and to support colleagues with long term conditions. We will also do more to value and support informal carers in recognition of the significant contribution they make to the health, wellbeing and independence of local people.

What success will look like for local people

- *I receive the support I need to make healthier life choices, increasing my chances of a long and healthy life*
- *If I develop a long term condition, it will be identified early and I will be supported through diagnosis; with my individual needs taken into account*
- *I feel confident to manage my own condition, and there is no decision about me without me*
- *I am able to access timely care and support from the right people in the right place*
- *I feel my quality of life is better because of the care and support I received*
- *I am able to care for my loved one, my contribution is recognised and valued and help is there for me when I need it*

What success will look like as outcomes for our population

- Reduce prevalence of obesity and we will be smokefree by 2030
- Increase earlier diagnosis including reducing the number of people with long term conditions diagnosed in an urgent care setting and increase early diagnosis of cancer
- Increase uptake of vaccines for people with chronic respiratory conditions to prevent more emergency hospital admissions
- Increase hypertension case finding in primary care to minimise the risk of heart attack and stroke within our population
- Increase the proportion of local people who say that they are able to manage their condition well
- Increase the proportion of local people who are able to work and carry out day-to-day activities whilst living with a long term condition
- Narrow the gap in outcomes for vulnerable or underserved groups e.g. people with learning disabilities and people who are homeless
- Improve the mental health and wellbeing of people with long term conditions and their carers

To improve the mental health and wellbeing of the people of north east London

Our context and case for change

Mental health affects how we think, feel and act, and has a profound impact on our day-to-day lives. It is strongly linked with wider health outcomes and therefore improvements here impact our overall ambition to improve the lives of people living in north east London.

It is estimated that at least a fifth of north east London residents have a common mental health problem like depression or anxiety, which is higher than the England average. We are also seeing an increasing need for mental health services to support people with severe and enduring mental health problems, with some of the biggest demand pressures in children and young peoples' mental health and eating disorder services. Equally we know that people with serious mental health problems endure worse physical health outcomes.

We have made great progress over the last several years in improving our services, with thousands more residents able to access evidence-based talking therapies, children and young peoples' mental health services (including in schools), specialist mental health care during and after pregnancy, and crisis and community mental health services that are far more integrated with primary care.

Yet, the Covid-19 pandemic and cost of living pressures have brought new challenges and have exacerbated the inequalities that were already present in our population. We must be mindful of the need to support those with long-standing needs who may be hit hardest, while also working proactively and preventatively to mitigate the risks of ever-greater numbers of people developing mental health conditions.

We still have further to go to ensure that people of all ages with mental and physical health conditions, including carers and people with dementia, get support in the areas that matter most to them, as early as possible. However, through honest and open conversations about equity, leadership, and representation with a diverse group of partners, we are beginning to think in a profoundly different way about how we can improve the quality of life of people with mental health needs in north east London.

Key messages we heard through our engagement

What matters to me is having the same experience and range of support regardless of where I live or go to school

What matters to me is challenging stigma about mental health
What matters to me is personal development and growth

What matters to me is using my lived experience to support and help others

What matters to me is accessing support in different ways that suits me and my goals, not just what is available and not when it is too late

What we need to do differently as a system

We must ensure that service users and carers are at the heart of everything that we do and that we prioritise what matters most to service users and carers, including delivering on the priorities set for us by service users and carers:

- **Putting what matters to service users and carers front and centre** so that people with lived experience of mental health conditions have an improved quality of life, with joined-up support around the social determinants of health
- **Enabling and supporting lived experience leadership** at every level in the system so that service users and carers are equally valued for their leadership skills and experience as clinicians, commissioners and other professionals
- **Embedding and standardising our approach to peer support across north east London** so that it is valued and respected as a profession in its own right, and forms part of the multi-disciplinary team within clinical teams and services
- **Improving cultural awareness and cultural competence** across north east London so that people with protected characteristics feel they are seen as individuals, and that staff are not making assumptions about them based on those characteristics
- **Providing more and better support to carers** so they feel better cared for themselves, more confident and able to care for others, and are valued for the knowledge and insights they can bring
- **Improving peoples' experience of accessing mental health services**, including people's first contact with mental health services, reducing inequality of access and improving the quality of communication and support during key points of transition
- **Understand and act upon local priorities for mental health,** through data and engagement with communities to understand the needs, assets, wishes and aspirations of our borough populations, and the unmet needs and inequalities facing specific groups

We must also ensure that mental health is everybody's business, for both children and young people and adults, whether this is through how we work together to tackle the wider determinants of health, or how we develop more integrated approaches to assessment, treatment and support for people with or at risk of mental and physical health problems.

We must innovate to improve outcomes and access to mental health services, including in particular where there are communities that are not accessing services as we would wish.

What success will look like for local people

Our draft success factors, developed with service users and carers, include the following (more detailed statements are being finalised with children and young people and adults):

- What matters to me is having the same experience and range of support regardless of where I live or go to school
- What matters to me is challenging stigma about mental health
- What matters to me is personal development and growth
- What matters to me is using my lived experience to support and help others
- What matters to me is accessing support in different ways that suits me and my goals, not just what is available and not when it is too late.

What success will look like as outcomes for our population

- Service users and carers are active and equal partners in everything we do, across children and young people and adults
- Care professionals focus on what matters most to service users and carers, including quality of life
- Improved preventative mental health and wellbeing offer - across our populations, places and partners - with a focus on tackling the wider determinants of poor health
- Improved access to mental health services for all our communities, including community and crisis services
- Improved integration of mental and physical health care, and with schools, social care and the voluntary sector
- Improved health and life outcomes for people with, or at risk of, mental health conditions, with particular focus on where there is inequity or unwarranted variation.

To create meaningful work opportunities and employment for people in north east London now and in the future

Our context and case for change

North east London has almost one hundred thousand staff working in health and care, with over 4,000 in general practice, 46,000 in social care, and around 49,000 within our trusts. Our workforce is the heart of our system and plays a central role in improving population health and care. Equally we have a growing population with a high proportion of working age people - we know that work is good for health and there is an opportunity for us to improve health in our local population and contribute to the local economy by upskilling and employing more local people into health and care roles within our system.

Alongside our paid workforce, our thousands of informal carers play a pivotal role in supporting family and friends in their care, including enabling them to live independently. Analysis undertaken by Healthwatch shows inequalities of experiences for carers who have poor experiences in accessing long term conditions (51%) and mental health services (70%), between 61% and 73% did not feel involved and supported.

Our employed workforce has grown by 1,840 people in the last year. Investment in primary care workforce has seen numbers grow by 3.7% in the last year, as well as a growth in training places for GPs. Retention and growth are a key part of all our workforce plans but we still have a number of challenges to overcome. We have an annual staff turnover rate of 23% and a high number of vacancies which places an additional burden on exiting staff as well as potentially impacting access to services. We have also heard from staff that burnout has been a growing problem, particularly since the COVID-19 pandemic. The interplay of increased workload and stress due to the pandemic is still having an effect. Sickness rates for north east London were higher than the national average of 4%, at 4.9%. Although we have the second lowest sickness rate in London, we know that mental health issues are the second highest reason for sickness, behind musculoskeletal problems.

To achieve our ambitions as an integrated care system we need to ensure that our workforce has access to the right support to develop the skills they need to deliver health and care services today as well as the skills to adapt to new ways of working, and potentially new roles in the future. Our workforce is critical to transforming and delivering the new models of care we will need to meet rising demand from a population that is growing rapidly with ever more complex health and care needs.

Underpinning this we will work to strengthen the behaviours and values that support greater integration, collaboration, and trust across teams, services, organisations and sectors.

Key messages we heard through our engagement

I value flexibility and work life balance over traditional rewards such as pensions

I want career development and career growth opportunities available to me locally

I felt over-worked before the pandemic and now it's really affecting my ability to work

I'm a local person with transferable skills but I don't feel local health and care jobs are accessible to me

I want the informal care I provide valued and supported

What we need to do differently as a system

Work together to employ more local people contributing to the local economy by upskilling and employing local people particularly those who are unemployed or at risk of unemployment which a range of routes into jobs including apprenticeships. Also invest in growing our own workforce from within, creating a consistent pipeline in partnership with our education institutions, and utilising system-wide approaches for all sectors.

Ensure we have efficient, streamlined, and accessible recruitment processes, promoting diversity and ensuring that under-represented groups have the opportunity to be employed in our services.

Work collaboratively to develop one workforce across health and care in north east London. We will work together to develop a deal that all employers will offer that enables career pathways across sectors with a focus on flexible career development and improved access to a consistent wellbeing and training offer shared across providers.

We commit to becoming a Living Wage system adopting the London Living Wage across north East London.

Prioritise retention of our current workforce, and create the opportunities for development across organisations to ensure that we have a stable and high performing workforce in all services. We will develop system approaches to career pathways, leadership and development.

Support the health and wellbeing of our staff, with a consistent offer of support for staff which recognises the challenges brought by the Covid-19 pandemic and current cost of living crisis.

Implement and continue to develop our new ICS clinical and care professional leadership model which will increase diversity and inclusion, and support development of current and future leaders for the system working hand in hand with local people.

Develop, recognise and celebrate our social care and voluntary workforce, prioritising specific retention programmes, ensuring that they have support when needed and feel valued equally for the contribution they make.

Value the contribution of carers and provide more and better support to them so that they are able to provide better support for others as well as improve their own health and wellbeing.

What success will look like for our people

- *Working in health and care in north east London, I feel valued and respected*
- *I have meaningful work and am able to support myself and my family financially*
- *I have access to training and career development opportunities whichever part of the local health and care system I am currently working within*
- *I feel I have local employment and volunteering opportunities across a range of health and care settings, regardless of my background*
- *I am able to care for my loved one, my contribution is recognised and valued, and help is there for me when I need it*

What success will look like as outcomes for our people

- Increase the number of local people working in health and social care, ensuring that our workforce is representative of the community it serves at all levels.
- Increase diversity and range of professional backgrounds reflected in our clinical and care professional leadership at all levels.
- Our carers feel supported, valued and provided with the skills to deliver personalised care to meet the needs of our residents.
- Staff will be able to transfer easily between employers in health and care.
- All staff in all sectors will have access to a consistent health and well-being offer.
- As part of our employment deal, a consistent offer of development, flexibility and mobility that all organisations in north east London sign up to, including recognition of skills across sectors and professions.
- We are increasing the ethnic diversity of board level and senior leadership to reflect the make-up of the population in NEL.

Securing the foundations of our system

Enabling infrastructure supporting integration

Infrastructure is defined as the individuals, facilities, and buildings required to deliver world-class care. A NEL Infrastructure Plan spanning the NHS, social care, and public health is required to ensure our staff have access to high quality facilities and can utilise growing technologies such as genomics and Artificial Intelligence (AI), to deliver better care and empower local people to manage their own health. This will be increasingly important in the context of demand that is set to increase significantly from already challenging levels due to NEL's unprecedented population growth, and ageing population with more complex health needs.

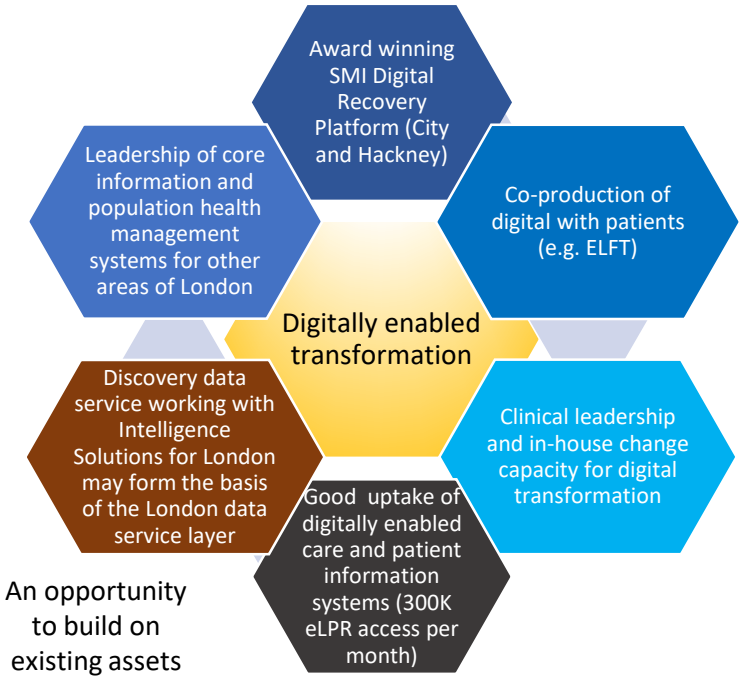
Physical infrastructure

Decades of austerity has led to funding not keeping pace with rising demand in both building capacity and essential maintenance. This coupled with a fragmented national approach to funding NHS buildings and infrastructure has led to capacity constraints across our system and a backlog maintenance adjusted sum of over c.£650 million. This is over 7 times higher than NEL's annual capital departmental expenditure limit or 'CDEL' which was £84m in 2022. In future we will develop a new, strategic approach to planning and improving our physical infrastructure by creating long-term assets that support the delivery of world-class care, promote quicker recovery and better enable staff to care for patients using the latest equipment and technology.

As part of this we are planning significant investment in our critical infrastructure including a full redevelopment of the **Whipps Cross hospital site** and a new £40m integrated health and wellbeing hub planned at **St George's in Havering,** bringing health and care partners across the borough together to deliver a new integrated model of patient focused care, opening in 2024. We are working closely with local authority partners to ensure health and care investment and capacity is present in all new regeneration areas to enhance and increase capacity in front line care for new and existing local people.

Digital infrastructure and innovation

As technology continues to develop, digital transformation will enable people to improve and manage their own health, tackling rising demand, integrating services, empowering our staff and lessening the impact of these services on the environment. Our work will focus on connecting systems together, minimising the number of different systems in use and utilising the huge amount of data available to improve care at a personal and population level.



We will build on the existing London Care Records programme to connect patient records in real-time across our provider partners to support direct care. This will mean that health and care professionals can access information from general practice, acute hospitals, mental health providers and social care in order to provide the best, personalised support for an individual. By fully implementing London Care Records across all partners we will deliver improved, joined up and better care for local people by enabling quicker and safer decisions. We will ensure that appropriate data held by NHS organisations and our local authority partners can be shared and linked to support better health and care outcomes for our local population. We will enable local people to have access to their records and to access remote care and advice. In future local people will need to tell their story only once across their health and care journey because all practitioners will have access to the same information**.**

Digital exclusion

Reducing digital exclusion is an essential component of our work to ensure we do not exacerbate health inequalities as we extend the range of services available digitally. We will reduce the number of local people and staff who experience digital exclusion by improving digital skills, connectivity and accessibility across our population as well as ensuring that alternative, in person, options are available for those who do not use digital services. We will monitor the access, experience and outcomes of different groups to digital and alternative service offers to ensure equity or access, experience and outcomes.

Maximising value from the money we spend and improving sustainability

As a health and care system we **spend over £4bn** every year on our population. We must ensure that money is spent as effectively as possible to meet the needs of our communities. We have a growing and ageing population which, over time, will have different needs to the people we serve today. This means that we will need to resource existing care services which are currently facing challenges in relation to demand, as well as investing in adapting our services for future needs and increasing our investment in prevention.

Collective stewardship - to meet the needs of our partnership, we are changing how money flows around the system. We are giving our partners a much greater say in how money is spent and are working together to consider the health and wellbeing of local people holistically. That means partners (such as trusts, primary care networks and local authorities) are taking **collective stewardship of the money we are spending on our population** and considering what we could change to improve population health and care outcomes. Reducing inequalities in the health and care outcomes of local people is a priority for the system and our financial regime will support this by **targeting additional funding towards those areas and populations with the worst outcomes**, and ensuring that **all local people can access core services**, whichever part of north east London they live in. We will also build on current arrangements for pooling resources between partners (under section 75 arrangements), and look to expand these to cover the full set of local and system outcomes, including wider partners and enabling more integrated care.

Investing in prevention and innovation - we will increase, over time, the proportion of our budget that is spent on prevention (both primary and secondary) and earlier intervention, to ensure local people are kept healthier for longer and, in turn, reducing the need for more specialist services. To support the transformation of health and care services, **we will set aside some of the funding we receive to specifically fund improvements that support sustainability**, such as technology which improves health and care outcomes for our population. Alongside this, we will **improve our use of evaluation, to build our understanding of how money is spent and what outcomes we are achieving** for our people and communities. We will use our shared data to develop the evidence base in support of continuously improving delivery and outcomes.

Improving sustainability of our system and core services - over half of our health and care budget (or approximately £2.6bn) is spent on secondary care provided by our trusts. We will continue to look for **productivity improvements** – in particular within our trusts – to ensure that we are maximising value for money, including reducing waste and avoidable spend, such as over-reliance on agency staff. The pandemic, cost of living pressures and rising inflation have added to system pressures and left us financially and operationally challenged as a system. Our trusts, with their substantial cost bases reflecting their large estates and workforces, have borne much of the financial pressure. We will **continue to support the financial sustainability of our trusts** and also the **sustainability of the key services** they deliver with a current focus on urgent and emergency care, and addressing waiting times and equity of access for planned care. Actions we will take to reduce avoidable demand for acute services include supporting greater streamlining and harmonisation of services and developing more **comprehensive multidisciplinary provision in neighbourhoods.** This work is already underway as part of the our implementation of the recent Fuller Review recommendations.

A relentless focus on equity

In addition to our focus on tackling ***health inequalities*** as described above, we are working to tackle ***unwarranted variation*** across all our services, ensuring that ***equity is embedded*** across all of our strategies, plans and ways of working. This means -

Equitable core service offer – we commit to understanding and implementing a core set of services particularly in community health and mental health services across NEL as well as addressing variation in local policies to ensure consistency and equity across our geography.

Place based partnerships and provider collaboratives – will have a detailed understanding of equity and unwarranted variation in relation to their health and care services and are improving equity of access, experience and outcomes for underserved groups working hand-in-hand with local people and communities.

Investment – we are establishing an equitable funding framework to allocate resources in ways that do not exacerbate but reduce health inequalities. Resources enable a baseline of consistent provision to support equity in outcomes, whilst at the same time being proportionate to need across groups and places.

Workforce – we will support inclusion within our current workforce staff and take action to develop a workforce that is reflective of the local community. This includes improving equity in recruitment, development, management and disciplinary processes, more diverse boards and senior management teams, and championing anti-racism across all parts of the system.

Quality improvement, safety and transformation – we will equip all staff (clinical and care professional and managerial) working on quality improvement (QI), patient safety, safeguarding and transformation with an understanding of health inequalities and equity through training, fellowships and shared learning. Rapidly scaling what works across the system.

Evaluating equity impacts – we will set out a requirement for evaluation of the health inequalities impacts of any changes through the use of the EQuality impact assessment process, developing understanding of how equity considerations can be continually built into service design and improvement.

Data and digital – we will strengthen our understanding and focus on population health and inequalities at a granular level for different population groups and especially for underserved people and communities, including through development of *Population Health Management* across the system.

Anchor institutions – we will address the wider determinants of health and reduce health inequalities, through providing employment for local people who are furthest from the labour market, increasing social value in procurement practices, and tackling climate action for a greener, healthier future.

Where we go from here

The three core elements of our interim strategy set a clear direction for the system ahead of the 23/24 planning round, and looking to the future will be the basis for our longer term planning as a system…

……Our 6 crosscutting themes underpinning our new approach as an ICS

……Our four system priorities for improving outcomes and tackling health inequalities

……Our key areas for securing the foundations of our system

As well as influencing the annual planning round for the NHS, the integrated care strategy is the 'umbrella' for the full range of strategies and plans across the partnership including local joint health and wellbeing plans, plans developed by provider collaboratives, and other system wide plans e.g. relating to people, sustainability, quality and finance.

In line with our learning system approach and partnership ethos, we are committed to continued dialogue with all parts of the system to support ongoing alignment.

While the strategy has been informed by existing insights via Healthwatch as well as feedback from local people and service users in some areas, the key messages, priorities and success measures will be tested further with local people through a 'Big Conversation' planned to take place in Spring 2023.

We will review our interim strategy in line with further guidance anticipated from the Department of Health and Social Care in June 2023.

We will also develop the success measures outlined in the strategy further to enable the partnership to track progress over time, ensuring we are making a measurable difference with and for the people of north east London.

Annex 1 – strategic alignment with local health and wellbeing priorities and provider collaboratives

Hackney

- Improving mental health
- Increasing social connection
- Supporting greater financial security

Redbridge

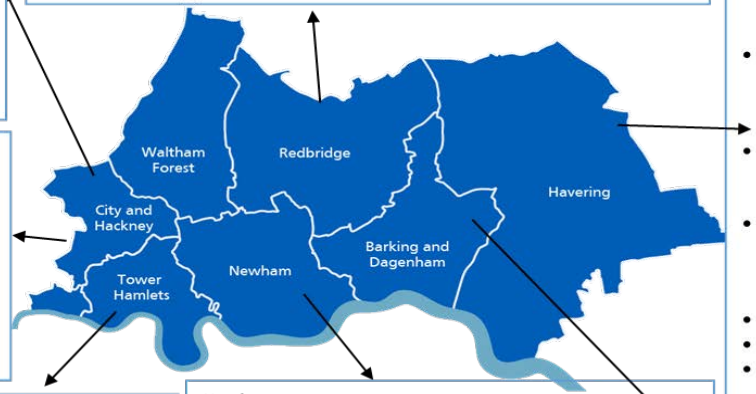
- Achieving the best start in life
- Diabetes prevention and management
- Mental wellbeing
- Cancer survival
- Living well in a decent home you can afford to live in
- End of life care

Havering

- Assisting people with health problems (back) into work
- Further developing the Council / NHS Trusts as 'anchor institutions'
- Provide strategic leadership for collective efforts to prevent homelessness and the harm caused
- Realising the benefits of regeneration for health and social care services
- Improve support to residents whose life experiences drive frequent calls on health and social care services
- Obesity
- Reducing tobacco harm
- Early years providers, schools / colleges as health improvement settings
- Development of integrated health and social care services for CYP and adult s at locality level

City of London

- Good mental health for all
- A healthy urban environment
- Effective health and social care integration



Tower Hamlets

- We can all access safe, social spaces near our homes, so that we can live active, healthy lives as a community
- Children and families are healthy, happy, and confident
- Young adults have the opportunities, connections and local support they need to live mentally and physically healthy lives
- Middle-aged and older people are enabled to live healthy lives and get support early if they need it – whether it is for their mental or physical health
- Anyone needing help knows where to get it, and is supported to find the right help

Newham

- Enabling the best start through pregnancy and early years
- Supporting our young people to be healthy and ready for adult life
- Supporting people around the determinants of their health
- Developing high quality inclusive services, ensuring equity and reducing variation
- Meeting the needs of those most vulnerable to the worst health outcomes
- Creating a healthier food environment
- Supporting active travel and improved air quality
- Creating an active borough
- Supporting a Newham of communities where people are better connected and supported
- Working towards a smoke free Newham
- Building a borough of health promoting housing
- Building an inclusive economy and tackling poverty

Barking and Dagenham

- Best Start in Life
- Early Diagnosis and Intervention
- Building individual and community strength

**Note these are joint health and wellbeing priorities which may evolve as place based partnerships become more established*

Provider collaboratives

- **Community collaborative -** The Community Health Collaborative brings together NHS Community Health Services to focus on population health needs that are best supported at an ICS or multi-borough level including working with local authority partners to achieve common standards and outcomes, reduce unwarranted variations, address inequalities in health outcomes, and improve access and experience of services.
- **Mental Health, Learning Disability and Autism Collaborative** - In North East London, the Integrated Care Board, East London NHS Foundation Trust (ELFT) and North East London NHS Foundation Trust (NELFT) have come together to form the Mental Health, Learning Disability and Autism Collaborative. Our aim is to work together to improve outcomes, quality, value and equity for people with, or at risk of, mental health problems, learning disabilities and autism in North East London.
- **Primary Care Collaborative** - This brings strategic primary care leadership together and will work at scale to agree the priorities that best support and improve primary care across North East London. Key programmes of work will include the delivery of the ICB strategy and the implementation of the Fuller review programme across North East London and will involve close working across the whole system with partners in place based partnerships and provider collaborative.
- **Voluntary, community and social enterprise (VCSE) alliances** - The VCSE alliance brings specialist expertise and fresh perspectives to public service delivery, and is particularly well placed to support people with complex and multiple needs and finding creative ways to improve outcomes for groups with the poorest health.
- **Acute provider collaborative -** Our acute provider collaborative is comprised of the three acute trusts across NEL. The organisations have agreed to work together across six clinical pathways (planned care, critical care, maternity, urgent and emergency care, cancer, and babies, children and young people) and three cross-cutting strategic themes (clinical strategy, research and specialised services).

Integrated Care Partnership

11 January 2023

Title of report	Joint Forward Plan – An Introduction
Author	Saem Ahmed, Head of planning and performance, NHS North East London
Presented by	Johanna Moss, Chief Strategy & Transformation Officer, NHS North East London
Contact for further information	saem.ahmed@nhs.net
Executive summary	• The Health & Care Act 2022 requires each Integrated Care Board (ICB) in England, and their partner NHS trusts and foundation trusts, to produce and publish a Joint Forward Plan (JFP). As well as setting out how the ICB intends to meet the health needs of the population within its area, the JFP is expected to be a delivery plan for the integrated care strategy of the local Integrated Care Partnership (ICP) and relevant joint local health and wellbeing strategies (JLHWSs), whilst addressing universal NHS commitments. As such, the JFP provides a bridge between the ambitions described in the integrated care strategy developed by the ICP and the detailed operational and financial requirements contained in NHS planning submissions. • Systems have significant flexibility to determine their JFP's scope as well as how it is developed and structured. Legal responsibility for developing the JFP lies with the ICB and its partner trusts. • ICBs and their partner trusts should review their JFP before the start of each financial year, by updating or confirming that it is being maintained for the next financial year. They may also revise the JFP in-year if they consider this necessary. • The purpose of the JFP is to describe how the ICB, its partner NHS trusts and foundation trusts intend to meet the physical and mental health needs of their population through arranging and/or providing NHS services addressing the four core purposes of the ICS, the universal NHS commitments and meeting the legal requirements of the guidance.
Action required	Discussion
Previous reporting	None
Next steps/ onward reporting	To be confirmed
Conflicts of interest	Not applicable

Strategic fit	• To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The JFP builds on the work developed through the Integrated Strategy which describes the four system priorities that aim to address inequalities focusing on core20plus5.
Impact on finance, performance and quality	• The impacts will be worked through the development of the JFP. • The JFP legislative requirements requires the JFP to reference finance, performance and quality.
Risks	

North East London Health & Care Partnership

NHS North East London

Update on Joint Forward Plan

4th January 2023

Saem Ahmed – Head of planning and performance

1. Introduction to Joint Forward Plan (JFP)

- The **Health & Care Act 2022** requires each Integrated Care Board (ICB) in England, and their partner NHS trusts and foundation trusts, **to produce and publish a Joint Forward Plan (JFP).** As well as setting out how the ICB intends to meet the health needs of the population within its area, the JFP is expected to be a delivery plan for the integrated care strategy of the local Integrated Care Partnership (ICP) and relevant joint local health and wellbeing strategies (JLHWSs), whilst addressing universal NHS commitments. As such, the **JFP provides a bridge between the ambitions described in the integrated care strategy developed by the ICP and the detailed operational and financial requirements contained in NHS planning submissions**.

- Joined up planning is required to address multi-year challenges such as:
    - **Addressing current operational priorities** and pressures as well as **actions that will support sustainable services going forward**, in line with the fore core purposes of the ICS.
    - Supporting **delivery of NHS commitments (performance measures) including LTP commitments, finance, workforce, activity measures and local priorities** described in the integrated care strategy and joint health and wellbeing strategies.
    - Set out how the resources of the whole system will be to effectively organise and deploy to deliver these priorities.

- Systems have **significant flexibility to determine their JFP's scope** as well as how it is developed and structured. Legal responsibility for developing the JFP lies with the ICB and its partner trusts.

- ICBs and their partner trusts should review their JFP before the start of each financial year, by updating or confirming that it is being maintained for the next financial year. They may also revise the JFP in-year if they consider this necessary.

- The purpose of the JFP is to describe how the ICB, its partner NHS trusts and foundation trusts intend to meet the **physical and mental health needs of their population** through arranging and/or providing NHS services addressing the **four core purposes of the ICS, the universal NHS commitments and meeting the legal requirements of the guidance.**

2a. Relationships between strategy and plans

Transformation or addressing inequalities and service redesign

Integrated Care Strategy – this sets ICP strategic priorities to meet the needs of our population

- Describes the needs of our population and the strategic challenge including health inequalities
- Discusses how we will address the needs of our population and address health inequalities through the 4 ICS priorities
- Describe how we will work differently as a system to deliver against the 4 ICS priorities
- Describe the impacts of the 4 ICS priorities on our population and workforce

Joint Forward Plan – Sets out how the integrated care strategy priorities and the NHS operational planning requirements will be met

- How it will deliver on Integrated Care Strategy priorities, key NHS priorities and NHS universal commitment (performance standards)
- What part of the system will be delivering the Integrated Care Strategy priorities, key NHS priorities and NHS universal commitment (performance standards)
- How it will exercise its core functions to deliver the Integrated Care Strategy priorities, key NHS priorities and NHS universal commitment (performance standards)
- How it will organise and develop the system to deliver the Integrated Care Strategy priorities, key NHS priorities and NHS universal commitment (performance standards)

Impact

Activity and performance trajectories

Operational Planning Guidance – Sets out what we aim to deliver in 23/24

- Activity trajectory for planned and unplanned care
- Cancer and elective performance trajectories
- Mental Health trajectories
- Out of hospital, primary care or place based trajectories

2b. Relationship of the JFP with other strategies and plans

Relationship	Progress update
NHS mandate The government's mandate to NHS England sets out our objectives, revenue and capital resource limits. This informs both our guidance on priorities and planning requirements.	• NHS priorities and operational guidance published on 23rd December 2023. • NEL is currently in the planning round for this through the system Operational Planning coordination group**.**
Integrated care strategy The Department of Health and Social Care has issued guidance on the development of integrated care strategies.	• Strategy currently under development. • At engagement stage with the wider system.
Capital Plans Before the start of each financial year, ICBs and their partner trusts must set out their planned capital resource use.	• Awaiting further guidance on this. • Further guidance to be published nationally on development of capital plans.
Joint strategic needs assessments (JSNA) JSNAs, developed by each responsible local authority and its partner ICBs, assess needs that can be met or be affected by the responsible local authority, its partner ICBs or NHS England.	• Local JSNA's have informed our Integrated Care Strategy and the development of our four system priorities.
Joint local health and wellbeing strategies Each responsible local authority and its partner ICBs will have produced a JLHWS.	• Health and Wellbeing strategies has informed our Integrated Care Strategy and we have highlighted and acknowledged the place based priorities, and identified where there are relationships between the four system priorities and the place based priorities.

3. Universal NHS requirements, core purposes and legal requirements

NHS universal commitments

	Area	Objective
Recovering our core services and improving productivity	Urgent and emergency care*	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
		Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
		Reduce adult general and acute (G&A) bed occupancy to 92% or below
	Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
		Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
	Primary care*	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
		Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
		Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
		Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
	Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
		Deliver the system- specific activity target (agreed through the operational planning process)
	Cancer	Continue to reduce the number of patients waiting over 62 days
		Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
		Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
	Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
		Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
	Maternity*	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
		Increase fill rates against funded establishment for maternity staff
	Use of resources	Deliver a balanced net system financial position for 2023/24
	Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
	Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
		Increase the number of adults and older adults accessing IAPT treatment
		Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
		Work towards eliminating inappropriate adult acute out of area placements
		Recover the dementia diagnosis rate to 66.7%
		Improve access to perinatal mental health services
	People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
		Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
	Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
		Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
		Continue to address health inequalities and deliver on the Core20PLUS5 approach

Four core purposes

- **Improving outcomes** in population health and health care
- **Tackling inequalities** in outcomes, experience and access
- Enhancing **productivity and value for money**
- Helping the NHS support **broader social and economic development**

Legislative requirement

- **Describing the health services** for which the ICB proposes to make arrangements
- Duty to **promote integration**
- Duty to have **regard to wider effect of decisions**
- Financial duties
- **Implementing any JLHWS**
- Duty to **improve quality of services**
- Duty to **reduce inequalities**
- Duty to **promote involvement of each patient and the public**
- Duty to **patient choice**
- Duty to **obtain appropriate advice**
- Duty to **promote innovation**
- Duty in respect of **research**
- Duty to promote **education and training**
- Duty as to **climate change**, etc
- Addressing the particular **needs of children and young persons**
- Addressing the particular needs of **victims of abuse**

4. Key principles in development of the JFP

Principle 1: Fully aligned with the ambitions of the wider system partnership

- The JFP should reflect the collective ambitions of the ICB, local NHS partners, local authorities and wider system partners to meet the health needs of the ICB's population.
- The JFP should describe delivery of ambitions articulated in the integrated care strategy (these may be in initial or outline form)

Principle 2: Supports subsidiarity by building on existing local strategies and plans as well as reflecting universal NHS commitments

- The JFP should be a single, cohesive plan. It should address both system and place priorities and universal NHS commitments.
- The plan should respect the principle of subsidiarity and be built from existing delivery plans at system or place (where these exist). The JFP is not intended to transfer planning or delivery activity to system level where this is best delivered at place but could be used to summarise or synthesise place level plans.

Principle 3: Delivery-focused, including specific objectives, trajectories and milestones as appropriate

- JFPs should be delivery plans with well-defined, measurable goals, annual milestones and trajectories. These should align with the detailed operational plans of the ICB and NHS provider partners and relevant plans of the local authorities in the ICS area.
- Plans should be appropriately ambitious and deliverable. As published plans, ICB and partner trusts should expect to be held to account for their delivery. ICB and NHS trust and foundation trust annual reports should describe progress in delivery.

5. Consultation and engagement

- **Close engagement with system partners is essential** to the development of the JFP, there we will need to work with the following partners;
    - the ICP (ensuring this also provides the perspective of social care providers)
    - primary care providers
    - local authorities and each relevant HWB
    - other ICBs in respect of providers whose operating boundary spans multiple ICSs
    - NHS collaboratives, networks and alliances
    - the voluntary, community and social enterprise sector
    - people and communities that will be affected by specific parts of the proposed plan, or who are likely to have a significant interest in any of its objectives, in accordance with the requirement to consult described below.
- As JFPs will build on and **reflect existing JSNAs, JLHWSs and NHS delivery plans**, we **do not anticipate their development will require full formal public consultation, unless a significant reconfiguration** or major service change is proposed.
- Previous local patient and public engagement exercises and subsequent action should inform the JFP. The ICB and its partners will need to consider how this is managed to maximise the benefits from engagement and fulfil these statutory duties efficiently.
- The JFP **must be reviewed and either updated or confirmed annually** before the start of each financial year.
- Must also show they have **discharged their legal duty under the Public Sector Equality Duty.**
- ICBs and their partner trusts **must include in their JFP a summary of the views expressed by anyone they have a duty to consult** and explain how they have taken them into account.
- **We will develop an engagement plan to support the development of the JFP.**

6. Outline of content

Legislative requirement	Content descriptor	What do we have across NEL already?
Describing the health services for which the ICB proposes to make arrangements	• The plan should set out how the ICB will meet its population's health needs. As a minimum, it should describe how the ICB and its partner trusts intend to arrange and/or provide NHS services to meet the physical and mental health needs of their population. • Sets out clearly and coherently how the ICB will address each of the four core purposes of ICSs over the 5-yr planning period. • Sets out, for each of the four core purposes, measurable, achievable and time-bound goals over the 5-yr planning period. • Identifies coherent, well-resourced and well-led programmes of work to achieve the ICB's goals for each of the four core purposes over the 5-yr planning period. • Demonstrates how the Board of the ICB, and the Boards of relevant partner NHS Trusts (& FTs), will exercise effective oversight on progress against the ICB's goals in respect of the four core purposes.	• Integrated Care Strategy describes the population health need and how these needs will be met
Duty to promote integration	• Plans should describe how ICBs will integrate health services, social care and health-related services to improve quality and reduce inequalities. This could include organisational integration (e.g. provider collaboratives), functional integration (e.g. non-clinical functions), service or clinical integration (e.g. through shared pathways, multidisciplinary teams, clinical assessment processes). • The ICB has planned and completed an inclusive process for identifying the JFP's key priorities over the 5-year planning period, and this process critically informs the content of the JFP. These priorities have been determined by a mix of a) functions vested in, and statutory duties placed upon, ICBs; b) universal NHS priorities; c) local health and well-being priorities, particularly those featuring in the ICP Strategy and in JLHWSs, and the ICB's role in achieving these priorities; and d) local socio-economic priorities.	• Integrated Care Strategy describes integration across NEL through place-based partnerships and collaboratives
Duty to have regard to wider effect of decisions	• The plan should articulate how the triple aim was considered in its development. It should also describe approaches to ensure the triple aim (a) health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing), (b) quality of healthcare services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) and (c) sustainable and efficient use of resources by NHS bodies is embedded in decision-making and evaluation processes.	• (a) Framework for tackling health inequalities and our system agreed priorities on the Integrated Care Strategy • (b) NEL Quality Approach framework

Legislative requirement	Content descriptor	What do we have across NEL already?
Financial duties	• The plan must describe how the financial duties will be addressed. This includes ensuring that the expenditure of each ICB and its partner trusts in a financial year (taken together) does not exceed the aggregate of any sums received by them in the year.	• Financial Strategy
Implementing any JLHWS	• The plan must set out steps the ICB will take to deliver on ambitions described in any relevant JLHWSs, including identified local target outcomes, approaches and priorities.	• Integrated Care Strategy describes the population health need and including the priorities from JSNAs and HWB strategies.
Duty to improve quality of services	• The plan should contain a set of quality objectives that reflect system intelligence. It should include clearly aligned metrics (on processes and outcomes) to evidence ongoing sustainable and equitable improvement. Quality priorities should go beyond performance metrics and look at outcomes and preventing ill-health, and use the Core20PLUS5 approach to ensure inequalities are considered. Plans should align with the National Quality Board principles.	• Integrated Care Strategy discusses inequalities in relation to the Core20Plus5 for adults and children
Duty to reduce inequalities	• The plan should set out how the ICB intends to deliver on the national vision to ensure delivery of high-quality healthcare for all, through equitable access, excellent experience and optimal outcomes. • ICBs must also be mindful of, and comply with, the requirements of the Public Sector Equality Duty, section 149 of the Equality Act 2010.	• NEL Quality Approach Framework
Duty to promote involvement of each patient	• The plan should describe actions to implement the Comprehensive model of personalised care, which promotes the involvement of each patient in decisions about prevention, diagnosis and their care or treatment.	• Integrated Care Strategy includes a section on personalised care may need to build on this
Duty to involve the public	• The plans should describe how: the public and communities were engaged in the development of the plan; the ICB and partner trusts will work together to build effective partnerships with people and communities, particularly those who face the greatest health inequalities, working with wider ICS stakeholders to achieve this and activity at neighbourhood and place level informs decisions by the system and how public involvement legal duties are met and assured.	• NEL Engagement Strategy

Legislative requirement	Content descriptor	What do we have across NEL already?
Duty to patient choice	• The plan should describe how ICBs will ensure that patient choice is considered when developing and implementing commissioning plans and contracting arrangements, and delivering services. The plan should also describe how legal rights are upheld and how choices available to patients are publicised and promoted.	
Duty to obtain appropriate advice	• The plan should outline the ICB's strategy for seeking any expert advice it requires, including from local authority partners and through formal governance arrangements and broader engagement.	• Describe the NEL governance arrangements including ICP committees place base partnerships and HWB boards
Duty to promote innovation	• The plan should set out how the ICB will promote local innovation, build capability for the adoption and spread of proven innovation and work with academic health science networks and other local partners to support the identification and adoption of new products and pathways that align with population health needs and address health inequalities.	• Integrated Care Strategy will include a section on research and innovation
Duty in respect of research	• The plan should set out how the ICB will facilitate and promote research, and systematically use evidence from research when exercising its functions. This could include considering research when commissioning, encouraging existing providers to support and be involved in research delivery, recognising the research workforce in workforce planning, and supporting collaboration across local National Institute for Health and Care Research (NIHR) networks. Plans should address the research needs of the ICB's diverse communities.	• Integrated Care Strategy will include a section on research and innovation • Care City – A partnership for innovation for NHS NEL
Duty to promote education and training	• The plan should describe how the ICB will apply education and training as an essential lever of an integrated workforce plan that supports the delivery of services in the short, medium and long term. • The plan should articulate the role of education and training in securing healthcare staff supply and responding to changing service models, as well as the role of trainees in service delivery.	• Integrated Care Strategy – priority around growing our own workforce within
Duty as to climate change, etc	• The plan should describe how the ICB and its partner trusts will deliver against the targets and actions in Delivering a 'Net Zero' NHS , including through aligning the JFP with existing green plans.	• NEL ICS Green Plan 2022-25
Addressing the particular needs of children and young persons	• This could include using data and gathering insights to ensure the plan identifies and sets steps for delivery of the longer-term priorities and ambitions for the ICB's population of children, young people and families.	• One of our four system priorities on our Integrated Care Strategy is Babies, children and young people

Legislative requirement	Content descriptor	What do we have across NEL already?
Addressing the particular needs of victims of abuse	• This should include related health inequalities and access to and outcomes from services. The plan should also cover the needs of staff who are victims of abuse. • This should include the use of data and lived experience to ensure the plan identifies and sets out steps for the delivery of longer-term priorities and ambitions for supporting victims, tackling perpetrators and the prevention of abuse, including through the commissioning of services.	

Recommended content	Content descriptor	What do we have across NEL already?
Workforce	• Evidence-based, integrated, inclusive workforce plans that ensure the right workforce with the right skills is in the right place to deliver operational priorities aligned to finance and activity plans.	• One of our four system priorities on our Integrated Care Strategy is Workforce. • Will have workforce plans as part of 23/24 operational planning
Performance	• Specific performance ambitions with trajectories and milestones that align with NHS operational plan submissions and pay due regard to the ambitions of the NHS Long Term Plan, as appropriate	• 23/24 operating plan will have performance trajectories
Digital/data	• Steps to increase digital maturity and ensure a core level of infrastructure, digitisation and skills. These actions should contribute to meeting the ambition of a digitised, interoperable and connected health and care system as a key enabler to deliver more effective, integrated care. This could include reducing digital inequity and inequalities and supporting net zero objectives.	• NEL Digital and Data Strategy
Estates	• Steps to create stronger, greener, smarter, better, fairer health and care infrastructure together with efficient use of resources and capital to deliver them. This should align with and be incorporated within forthcoming ICS infrastructure strategies.	• NEL Estates Strategy

Recommended content	Content descriptor	What do we have across NEL already?
Procurement/ supply chain	• Plans to deliver procurement to maximise efficiency and ensure aggregation of spend, demonstrating delivery of best value. This could include governance and development of supporting technology and data infrastructure to align or ensure interoperability with procurement systems throughout the ICS.	
Population health management	• The approach to supporting implementation of more preventative and personalised care models driven through data and analytical techniques such as population segmentation and financial demand modelling. This could include: developing approaches to better understand and anticipate population needs and outcomes (including health inequalities); using population health management approaches to understand future demand and financial risk; support redesign of integrated service models based on the needs of different groups; and putting in place the underpinning infrastructure and capability to support these approaches.	• Integrated Care Strategy include population health management and a learning health system • PHM approach already being developed across NEL
System development	• How the system organises itself and develops to support delivery. This could include: governance; role of place; role of provider collaboratives; clinical and care professional leadership; and leadership and system organisational development.	• Integrated Care Strategy describes how we arrange ourselves through collaboratives and place based partnerships
Supporting wider social and economic development	• How the ICB and NHS providers will support the development and delivery of local strategies to influence the social, environmental and economic factors that impact on health and wellbeing. This could include their role as strategic partners to local authorities and others within their system, as well as their direct contribution as planners, commissioners and providers of health services and as ‘anchor institutions’ within their communities.	• NEL Anchor Charter

7. Timeline and deadline